

A HIGH-PERFORMING NHS?

A review of progress 1997-2010

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The King's Fund seeks to understand how the health system in England can be improved. Using that insight, we help to shape policy, transform services and bring about behaviour change. Our work includes research, analysis, leadership development and service improvement. We also offer a wide range of resources to help everyone working in health to share knowledge, learning and ideas.

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Executive summary

With a general election imminent, the NHS has once again emerged as a priority among voters in England, and political parties are competing to be seen as the best qualified to improve the service. Opposition parties paint a picture of an NHS with major deficiencies while the Labour government believes that the NHS is 'good' but needs further transformation to become 'great'. These calls for further reform follow an unprecedented increase in funding for the NHS since 2000.

This review assesses how far the investment and accompanying reforms since 1997 have transformed the NHS in England into a high-performing health system. The review focuses on England because health policy has now diverged from that in the devolved administrations of Scotland, Wales and Northern Ireland. It has drawn on official data, government and other official reports and academic research to assess how much progress the NHS has made in eight domains since 1997. The review asks whether the NHS is: accessible; safe; promoting health and managing long-term conditions; clinically effective; delivering a positive patient experience; equitable; efficient and accountable.

Access

In 1997, there were long waiting times for hospital and other kinds of care. The NHS offered highly variable access to care in terms of the range of drugs and treatments on offer in different parts of the country.

Since 1997, there have been major and sustained reductions in waiting times for most hospital treatments. Now most patients are seen, given tests and treated within 18 weeks of referral by their GP. More progress is needed in some specialties and services which are not included in the targets. Sustaining short waiting times might prove challenging as funds tighten in the future.

There have also been improvements in the number and variety of primary care services, and most people can access GP services within the target of 48 hours. Progress is needed in access to out-of-hours care. The government has identified public demand for some kinds of hospital care to be delivered closer to home, but progress in shifting care out of hospital settings has been slow.

The creation of the National Institute for Clinical (now Health and Clinical) Excellence (NICE) represented a big step forward in delivering evidence-based and consistent guidance to the NHS on what drugs and treatments are clinically effective and cost effective. Uptake of approved drugs has improved consistency of service across the NHS but variations in access to drugs have not been eliminated.

Patient safety

Before 1997, data about the scale and nature of patient safety incidents in England was not comprehensive and patient safety had not been prioritised as a policy issue.

The government has responded to the emerging global knowledge about the scale of patient safety incidents. There has been a successful campaign to reduce the rates of two health-care associated infections in the NHS. For other types of adverse events the establishment of the National Patient Safety Agency, with its systems for collecting and analysing information on adverse events, has been a significant development.

Ongoing increases in the number of reported safety incidents reflect improved reporting and coding, but under-reporting continues to be a major obstacle, particularly in primary care, and will have to be addressed in the future. New sources of data or new analyses of existing data need to be explored for their potential to shed light on patient safety to create a more complete picture.

There have also been considerable efforts made to learn from adverse events and disseminate that learning to the NHS front line. But it is clear that there is some way to go on creating a fully open culture of reporting within NHS organisations.

Promoting health and managing long-term conditions

There has been significant progress in tackling smoking – one of the biggest risks to future population health – through a combination of NHS action and legislation. It is too soon to see the benefits of the most radical legislative action – the 2007 ban on smoking in public places – but the effects are likely to accelerate falls in smoking rates and associated ill health.

This review has found that progress has been more elusive in reducing harm from alcohol and rates of obesity. Consumption of alcohol has increased since 1998, accompanied by a rise in alcohol-related hospital admissions and rates of liver disease, suggesting more aggressive, cross-departmental action will be needed in the future. The prevalence of obesity is rising in adults and children, despite government targets to halt the increase. There has been improvement in rates of exercise and aspects of healthy eating, but it is too soon to evaluate some of the more recent government initiatives to reduce obesity. However, the predictions of significant increases in obesity-related ill health in the future mean that the next government will need to sustain investment in initiatives delivered by the NHS and all other relevant agencies.

There has been a range of new initiatives since 2004 to better support those with chronic conditions, including incentives for GPs to manage patients with chronic conditions, training for patients to manage their conditions themselves and more intensive support for those with complex needs from nurses and other primary care professionals. GPs have responded well to the incentives and achievement has been high against the performance indicators. Other initiatives have been popular with patients and carers though they have not yet delivered significant improvements in terms of avoidable admissions to hospital. This aspect of NHS activity, much of which is delivered outside acute hospitals and in conjunction with social care services, will also need sustained investment and action in the future.

Clinically effective

This review considered the progress made in relation to the three major health conditions which account for the most NHS spending: cancer, cardiovascular disease and mental ill health. Mortality from cancer and cardiovascular disease has fallen substantially since 1997 and suicides have also reduced.

Some work to improve clinical effectiveness through national, evidence-based guidelines had already begun in 1997. National Service Frameworks and the creation of NICE have substantially increased the availability of evidence-based standards.

In addition to the greatly improved waiting times for cancer diagnoses and treatment, there has been progress in improving the quality of surgery and access to cost-effective drugs for patients with cancer. Adherence to guidelines is improving rapidly but is still variable, as is the timely use of radiotherapy. Even though mortality and survival rates for several cancers have been improving they still lag behind those of other European countries and effort will need to be sustained in the areas already identified as needing further work, for example, early diagnosis and access to radiotherapy.

There have been notable improvements in access to cardiac surgery and recommended standards of stroke care, and these have contributed to falling mortality for cardiovascular disease. However, variations in quality persist within England and between England and comparable countries. For both cancer and cardiovascular disease significant progress has been made in the collection and publication of data on outcomes. It is important that this data is made available to clinicians and commissioners to drive further improvements.

In mental health services, access to specialist early intervention and crisis resolution teams for acute illness has improved and is judged to be one of the best systems in Europe. This has led to reductions in acute admissions, but long-term reductions in symptoms and improvements in the quality of life of service users have been more difficult to achieve. The quality and scope of clinical guidelines on all kinds of mental health problems have improved dramatically, and access to talking therapies – recommended by NICE – is being rolled out for more common mental disorders. Future demands on health and social care services are likely to rise, particularly because of increases in cases of dementia.

Patient experience

Overall public satisfaction with the way the NHS is run has been increasing steadily for the past few years.

Understanding how patients experience the NHS has been transformed through the creation of one of Europe's largest patient experience surveys. These surveys have found that while overall patient ratings of care are positive for hospital, primary and community mental health services, there has been very little change over time. Most patients report being treated with dignity and respect but progress still needs to be made in relation to choice, involving patients with their care and some aspects of the hospital environment. Results are worse for users of inpatient mental health services, and there are systematic differences by age, self-rated health status, ethnic group and region.

Surveys and other methods of understanding patients' experiences are being used for improving services locally, but effort and investment will be needed to encourage trusts to build on this to create a complete picture of whether care is truly patient centred.

Equity

From 1997 there was a clear shift in government policy towards reducing inequalities in health outcomes, and goals were put in place to reflect this ambition. Infant mortality has reduced and life expectancy has improved for all social groups in England; however, progress has been faster among less deprived groups. As a result, targets to reduce gaps in infant mortality and life expectancy between the most deprived areas and the national average have not been met. This is despite a series of initiatives to improve life expectancy and reduce infant mortality having been concentrated on the most deprived areas of

England, including more intensive targeting of prevention activities. Questions remain about the extent to which reducing inequalities has received adequate investment and commitment from the NHS, especially given the competing priorities. Future policy needs to identify which inequalities to target and how initiatives should be designed when evidence of effectiveness is often limited.

The basic funding structure of the NHS – a tax-funded system with almost no financial barriers to accessing services – has remained unchanged. Compared to patients in other countries, users of the NHS face few financial barriers to accessing necessary services.

Continuing variations in the supply and use of services suggest that access to services is inequitable – for example, there are more GPs in the more affluent areas. There is some evidence from research that not all of those in equal need are getting equal access, but this is not always routinely monitored in the NHS. It will be important for commissioners of NHS services to monitor equity of access, particularly if greater efforts are made to reduce demand on services because of budget restraints.

New legal requirements on the NHS to ensure equitable access for all patients regardless of age, gender, disability, ethnicity, religion and sexual orientation, as well as deprivation, represent a big challenge in the future.

Efficiency

Historically, the NHS has had relatively weak incentives to improve its productivity and comparatively crude measures of its effective use of resources. Since 1997, there have been developments in productivity measures – although further refinements are needed. On these revamped measures, however, NHS productivity overall has declined over the last decade despite the introduction of stronger incentives through new hospital payment systems and quasi-market reforms in part designed to bear down on production costs.

Higher pay costs have absorbed more than half of the increase in the financial resources that became available to the NHS since 2002. On the other hand, substantial savings have been made in the cost of medicines and other goods and services used.

There is substantial scope for further savings through more efficient delivery of hospital and other services, such as reducing lengths of stay in hospitals, increasing the rate of day case surgery, and using lower-cost drugs.

Accountability

Since 1997, accountability of NHS trusts to the government has been strengthened, particularly through the use of targets and strong direct performance management. The use of targets has been criticised, but they have also brought benefits to patients including shorter waiting times. Any future government needs to be aware of all of the potential consequences for patients of removing or reducing the number of targets.

NHS trusts are also accountable to local commissioners, but it is clear that primary care trusts are still at a fairly early stage of development in their capacity to use commissioning as a lever, in part due to several years of reorganisation.

There have been significant developments in creating more locally accountable services, for example, through the creation of foundation trusts with members and elected governors. The impact of these changes has so far been limited, but in some cases they have improved trusts' relationship with, and awareness of the priorities of their local population.

One of the government's most striking contributions in this area has been to set up independent regulators of health care organisations to inspect and assure the quality of services. Further work is needed to clarify the roles of different regulatory bodies while ensuring that regulation is sufficiently powerful.

Professional regulation has also been overhauled, with the aim of making the professions more responsive to public rather than professional interests, but many of the changes are still very recent.

There has also been effort to make the system more accountable to individuals, notably through the NHS constitution. How successful this proves to be will depend on the extent of public awareness and arrangements for redress, both of which are still to be developed.

Conclusion

Since 1997 there has been considerable progress in moving the NHS towards being a high-performing health system. In common with health systems around the world, the NHS has made advances in setting standards for high-quality, safe care based on the best available evidence and measuring improvements from patients' perspectives. Waiting times for hospital care have been reduced, and access to primary care has been improved. There has been progress in making the NHS more accountable and transparent to government and taxpayers.

Work remains to be done to fill in the gaps we have identified: unwarranted variations in access, utilisation and quality of care even where national guidelines exist; ensuring that patients' experiences have a real impact on the quality of care locally; and, above all, ensuring there is adequate investment and energy in tackling the preventable causes of ill health and better support and care for those living with chronic conditions.

In summary, there is no doubt that the NHS is closer to being a high-performing health system now than it was in 1997. It is capable of delivering high-quality care to some patients, in some areas, some of the time. Even though there are considerable financial challenges ahead, the next government must aspire to create an NHS that can deliver quality to all patients, in all areas, all of the time – in a way that is demonstrably fair, efficient and accountable to the society that pays for it.

Introduction

With a general election imminent, the political parties are once again competing to be seen as the best qualified to reform the NHS. That the NHS needs more change seems to be beyond question: both main opposition parties have marshalled evidence to claim that the NHS is inadequate and requires further reform. The government's response is to defend its record of investment and achievements since 1997, while at the same time setting out its own ambitious plans for reform, to transform the NHS 'from good to great' (Department of Health 2009o).

Before the 2005 general election, The King's Fund published a review of the government's record on the NHS. The review found that the government had met many of its own targets and pledges, such as those on increased funding, reduced waiting times, more staff and buildings.

In this report, we once again attempt to provide an independent review of the evidence about the NHS in England, to help inform the debate both before and after the election. This time, we aim to assess the extent to which the government's policies since 1997 have transformed the NHS into a better, or high-performing health system. We also assess the scale of the task facing a future government, by identifying the remaining challenges and areas of unfinished business.

What does a high-performing health system look like?

There have been many efforts to define a high-performing health system, using different approaches and measures (Arah *et al* 2003; Commonwealth Fund 2008, Department of Health 1999c, Maxwell 1984; OECD 2010; WHO 2000, 2008b). Some have taken specific measures or indicators, such as length of stay, or waiting times for particular operations, and have used these to draw conclusions about the performance of the health system as a whole. Some have focused on factors such as use of information and communications technology (ICT), rapid adoption of new technology or a well-developed primary care system, on the assumption that if these are in place, performance will be good. Others have focused on the outputs of a good health system, such as healthy lives or greater equity.

Based on a review of these various definitions, we have identified eight broad criteria, set out in the box overleaf.

Criteria 1–5 consider the NHS from the viewpoint of its users, while criteria 6–8 highlight other dimensions of performance relevant to a publicly funded system. From its inception, the NHS has promoted equity of access to services – equal access for those in equal need – but this is now combined with a more recent concern to promote more equal health outcomes. Given its main source of funding, taxpayers and the public in general have an interest in whether the funds allocated are used efficiently. Furthermore, there must be an effective system of accountability: to ensure that the NHS is achieving high standards of care, and that where weaknesses or failures occur they are put right.

Criteria for a high-performing health system

1. **Access** A high-performing health system ensures that people have access to a comprehensive range of services in a timely and convenient manner.
2. **Safety** A high-performing health system minimises the risk of accidental injury or death due to medical care or medical error.
3. **Health promotion** A high-performing health system supports individuals to make positive decisions about their own health and how to manage the negative effects of long-term conditions.
4. **Clinical effectiveness** A high-performing health system delivers services to improve health outcomes in terms of successful treatment, the relief of pain and suffering, restoration of functions and, where these are not feasible, adequate care and support.
5. **Patient experience** A high-performing health system delivers a positive patient experience. This includes giving patients choices and involvement in decisions about their care, providing the information they need, and treating them with dignity and respect.
6. **Equity** A high-performing health system is equitably funded, allocates resources fairly, ensures that services meet the population's needs for health care, and contributes to reducing health inequalities.
7. **Efficiency** A high-performing health system uses the available resources to maximum effect. This requires productivity in the delivery of care, supported by economy in the purchase of the goods and services that a health service needs to deliver care.
8. **Accountability** A high-performing health system can demonstrate that it is achieving high standards of care, taking into account the views of those who it serves, and has in place effective systems to remedy poor performance.

Background: the government's approach to NHS reform 1997-2010

There has been a great deal of policy activity since 1997, including 26 Green and White Papers, and 14 Acts, resulting in changes to legislation and new ideas on a range of topics, from learning disability to dentistry. Nevertheless, there are some broad themes to the approach adopted during this period, most concisely summed up by Simon Stevens in 2004 while he was health policy adviser to the former Prime Minister, Tony Blair (Stevens 2004). This section is based on that analysis, supplemented by more recent information from government policy documents.

The overall context is an unprecedented increase in funding to the NHS, which in real terms has doubled since 1997 (Department of Health 2009g). The political decision to increase funding was made by Tony Blair in 2000, with the aim of raising spending on health to the European Union average in order to resolve the chronic underfunding that was believed to be at the root of poor performance relative to other European countries.

This increased funding was accompanied by a three-pronged approach to NHS reform, which took shape in the early 2000s (*see the box overleaf*).

Strategies for NHS reform 1997-2010

Approach 1: Support for providers

- **Increased supply of health professionals** There has been a substantial increase in the numbers of doctors, consultants, nurses and other staff, and in their pay.
- **Modernising/building new hospitals and other infrastructure** There has been a large building programme of hospitals and primary care facilities (many of them financed via the Private Finance Initiative).
- **Support for learning and improvement** Various new government bodies have been established, such as the Modernisation Agency and its successor the NHS Institute for Innovation and Improvement, along with other initiatives designed to support NHS trusts to improve performance such as reducing waiting times.

Approach 2: Top-down challenges

- **Targets and national standards** These include national targets such as for waiting times and to reduce mortality from cancer and heart disease; National Service Frameworks, which set standards for care of major diseases, such as diabetes; and more detailed national guidance on treatments and drugs issued by the National Institute for Health and Clinical Excellence (NICE).
- **Inspection and regulation** The government has established new regulators of NHS organisations and private-sector providers, and has set new requirements for the regulation of individual professionals.
- **Published performance information** The Department of Health, the regulators and the NHS Information Centre now publish a large amount of data on NHS performance – some aimed at the public, and some aimed at NHS organisations for the purposes of commissioning and service improvement.
- **Direct intervention from the centre** Where care has fallen below national standards, the Secretary of State and the regulators have the power to intervene.

Approach 3: Bottom-up or local challenges

- **Commissioning** Primary care trusts (PCTs) carry out most of the commissioning (planning and purchasing) of services locally. They have been the object of sustained policy effort since their creation in 2002, to improve the quality of commissioning by holding services to account through better use of data and better engagement with local trusts, local authorities and the community.
- **Patient choice** Since 2006, all patients have been offered a choice of hospital for non-urgent treatment, with the aim of putting competitive pressure on unresponsive hospitals.
- **Financial incentives** Patient choice has been accompanied by an overhaul of the hospital payment system, known as Payment by Results (PbR). Within this system, for each episode of care (for example, a hip replacement) a hospital is paid a fixed payment, based on average costs across all hospitals. This means that efficient hospitals, with below-average costs, can increase their income by performing more operations. Financial incentives have also been used to encourage GPs to improve the quality of primary care, in a scheme known as the Quality and Outcomes Framework (QOF).

- **New entrants and competition** New independent providers of hospital and primary care services have been encouraged to bid for local services. Between 2003 and 2008, the Department of Health commissioned a series of independent-sector treatment centres to boost capacity for specific high-volume operations, such as cataract excisions, that had long waiting lists.
- **Local accountability** 2004 saw the introduction of a new form of local accountability, when the government introduced foundation trusts (FTs). These trusts have governors elected from the local community, with some limited powers. Eventually, all trusts are expected to become foundation trusts, although progress has faltered of late. In addition, the overview and scrutiny powers of local councils have been extended to health services.

Adapted from Stevens 2004

The three approaches have been implemented in parallel, but the government's enthusiasm for the component parts has tended to wax and wane over time. For example, there has been a retreat from the top-down target strategy and, most recently, a step back from the principle of competition (at least at the level of ministerial rhetoric), by referring to the NHS as the 'preferred provider' (Burnham 2009).

In 2007, the government commissioned the leading surgeon Ara (now Lord) Darzi to conduct the Next Stage Review of the NHS (Department of Health 2008d). The review's recommendations, published the following year, focused on improving the quality of services through mechanisms such as:

- providing better benchmarking performance data to clinicians and clinical teams to incentivise them to improve their performance
- introducing new pay-for-performance mechanisms for hospitals
- requiring organisations to publish annual Quality Accounts.

(Department of Health 2008f)

The NHS Next Stage Review also recommended the development of an NHS Constitution and subsequent public service policy from the Prime Minister's office has taken up this idea of enshrining into law service users' rights to access services within particular time frames and of a particular standard (HM Government 2009a).

Implementation of the policies proposed in the NHS Next Stage Review is still under way. In this review, therefore, we aim to assess how far the NHS has progressed recognising that these more recent policies have had little time to take effect.

About this review

This review looks at the progress made by the NHS in England towards becoming a high-performing health system. The eight criteria set out above form the basis for this review. Each section considers three key questions:

- What was the situation before 1997?
- What policies has the government developed since then, and what progress has been made?
- What more needs to be done in order for the NHS to achieve the goal of a high-performing health system?

Since 1997 English health policy has diverged from those of the devolved administrations of Wales, Scotland and Northern Ireland. This report focuses on England only.

The report draws on evidence from official data sources (mostly government or NHS reports), reviews by regulators and other official bodies such as the National Audit Office and the Audit Commission, charitable organisations (particularly those concerned with particular client groups), and the academic literature. Where appropriate, it makes comparisons with other countries' health systems, but these should always be interpreted with caution, as different countries collect health data in very different ways.

Many of the government's policies – such as the introduction of competition, or the attempt to create a primary care-led NHS – are not ends in themselves, but rather means of promoting the eight criteria set out above. This report does not aim to separately assess the effectiveness or otherwise of the various overarching policy approaches that have been used to drive improvements in England. However, it does seek to identify, where possible, how government policies have contributed to these objectives and where they have fallen short.

The final section sets out where we consider the next government should focus its efforts, in order to guide the development of the NHS towards becoming a high-performing health system.

1 Access

Criterion 1: A high-performing health system ensures that people have access to a comprehensive range of services in a timely and convenient manner.

Key points

- In 1997, there were long waiting times for hospital care and other kinds of care. There was a growing public awareness of rationing and variable access to services and drugs in different parts of the country.
- There have been major and sustained reductions in waiting times for most hospital treatments and improved access to primary care. However, further improvements are needed in access to out-of-hours care and to GPs and other services outside hospitals. Sustaining short waiting times for hospital treatment might prove challenging as funds tighten in the future.
- Progress has been made to reduce geographic variations in access to drugs and other treatments with the creation of the National Institute for Health and Clinical Excellence (NICE), though some variations still remain.

The NHS has always been ‘free at the point of delivery’, with some exceptions, such as charges for prescription drugs, optical services and dentistry. So there has been no significant financial barrier to access for most care. But other barriers may make access difficult. Services may not have the capacity to treat all those who might wish to use them, so people have to wait for treatment. Services may be difficult to access easily, because of their opening hours or location. And decisions made locally about which drugs, treatments and procedures to make available may mean there are geographic variations in access to services. Some of these may be warranted – reflecting differences in local needs – but others may be less rational, and open to challenge and criticism.

This chapter assesses the progress that has been made in improving timely and convenient access to hospital and primary care services in England, and examines efforts to ensure the accessibility of cost-effective drugs and treatments across the country.

The situation in 1997

By 1997, failure to provide timely and convenient access to care was perhaps the most salient weakness of the NHS. With the introduction in 1991 of the Patient’s Charter (HM Government 1991) a start had been made to commit the NHS to reducing waiting times for hospital treatment. As a result, very long waiting times (of two or more years) had been eliminated. But in 1997 there were more than 1 million people waiting for hospital treatment, and waits of up to 18 months for treatment following an initial hospital consultation were still common.

Evidence from patient surveys and the Audit Commission suggested that waiting times for treatment within accident and emergency (A&E) departments and to see a GP were also sometimes very long (Department of Health 1999c, Appleby and Phillips 2009, Audit Commission 2001). So, in 1997, although a start had been made in reducing very long waiting times, the NHS was not providing timely access to care.

In the 1980s a start was made at national level in defining what should *not* be available on the NHS, with the introduction of the limited list in 1985. This list defined items that would not be available free on prescription. There was a further commitment in the early 1990s, following the high-profile experiment to prioritise services in Oregon, USA, that decisions to ration services would become increasingly explicit and transparent. A number of sources of advice became available on what drugs or treatments were effective or ineffective, but none were binding on trusts or health authorities (Cullum *et al* 2004). By the mid-1990s research suggested that health authorities continued to rely on implicit rationing by clinicians (through delay and treatment decisions) (Klein *et al* 1995).

As more new drugs became available, local health authorities refusing to fund them found themselves subject to legal challenges by patients (Dyer 1997). One particularly high-profile case – that of Child B, a young leukaemia sufferer who was refused a second transplant operation by Cambridge Health Authority – sparked further political debate about the legitimacy of denying care on cost rather than clinical grounds (Price 1996). It was against this backdrop of growing public awareness and political debate about rationing that the Labour government were elected.

Progress since 1997

Waiting times

There has been huge progress in improving speed of access to hospital treatment, including tackling long waiting times for diagnostic tests and surgery, and improved access to GP and other forms of primary care. This represents a major achievement for the NHS.

Figure 1 Total inpatient waiting list, England, 1996–2009

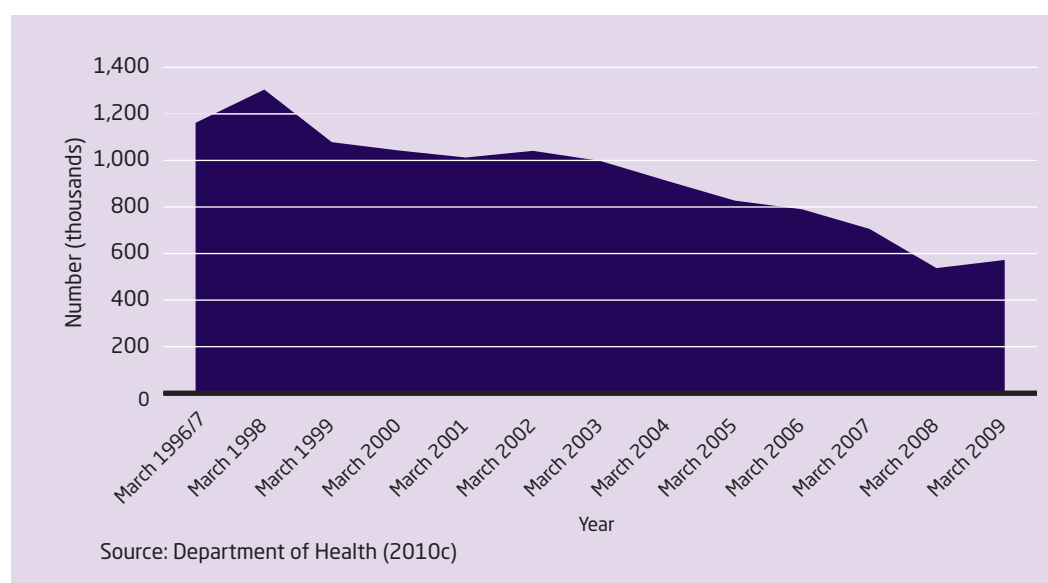
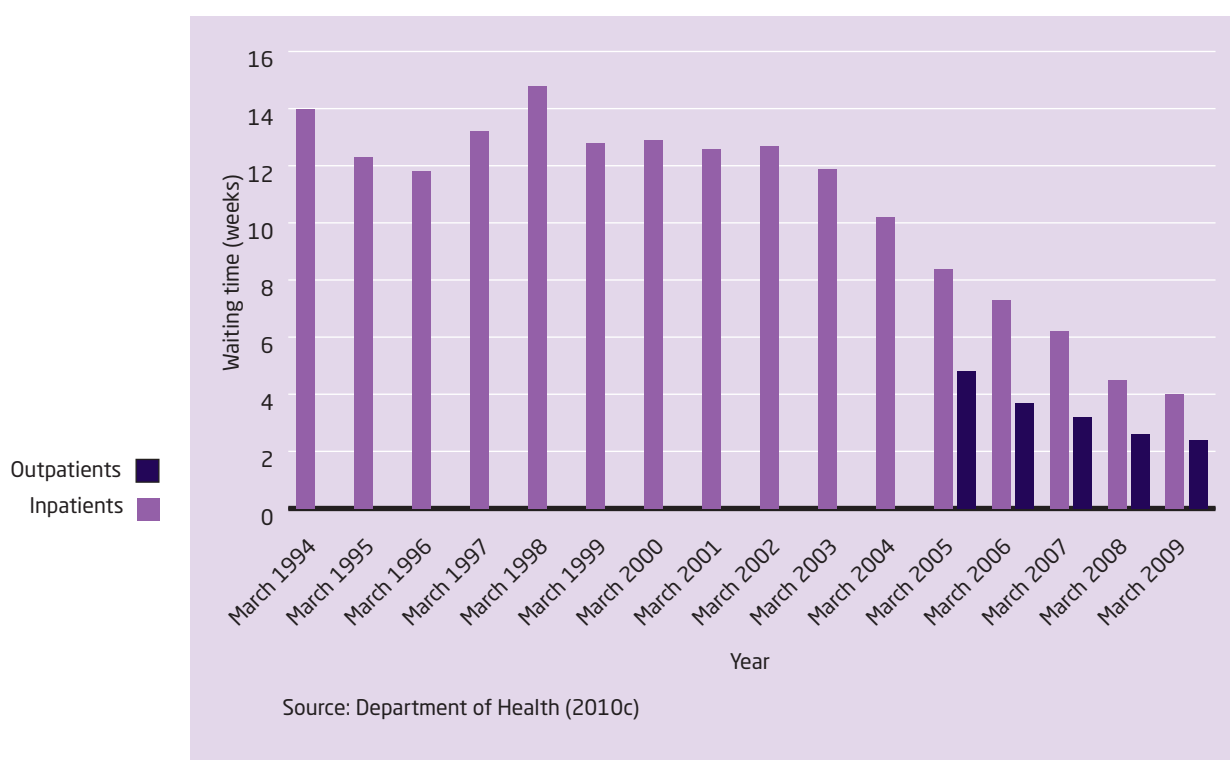


Figure 2 Median waiting times (weeks), inpatients and outpatients, England, 1994-2009



Hospital services

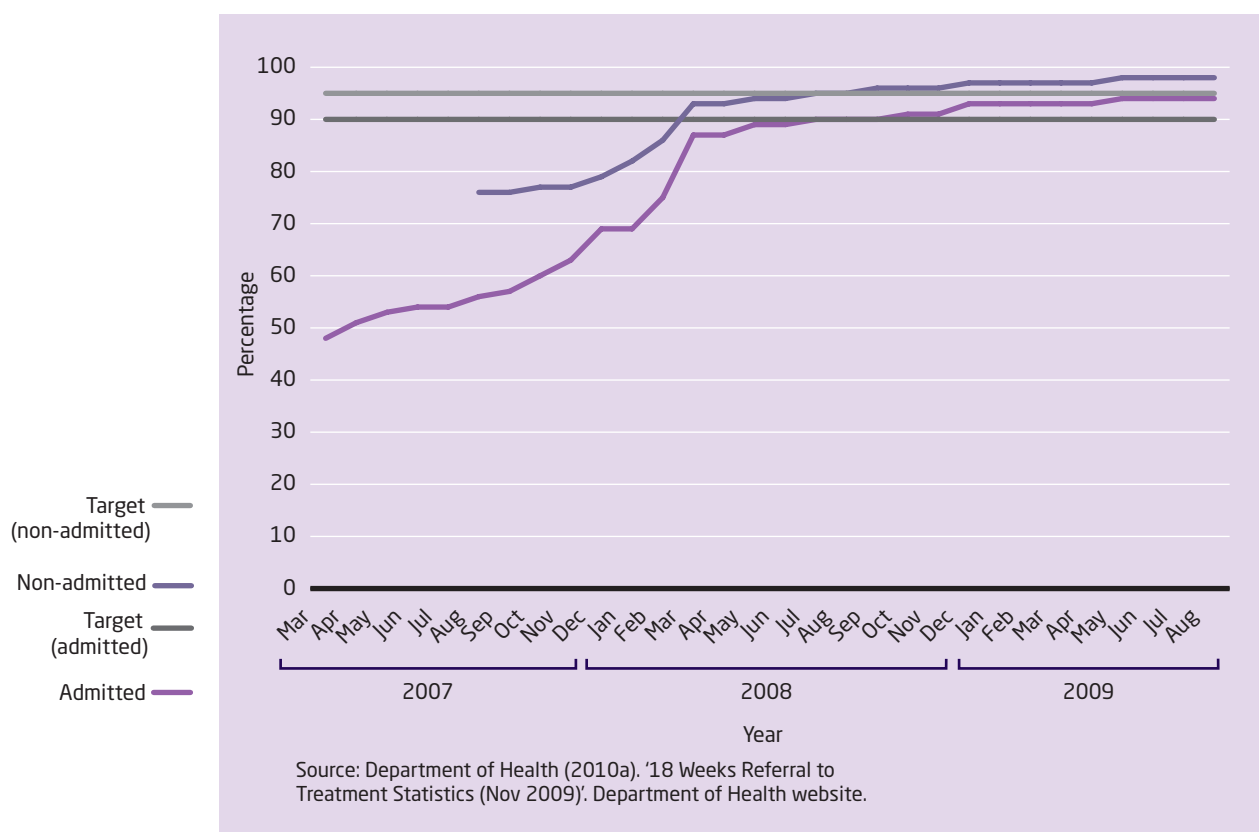
In 1997 the Labour party made an election pledge to reduce the number of people waiting for hospital treatment by 100,000. This reduction was achieved by March 2000, and further reductions were secured in the following years. In 2008, waiting lists were lower than at any time since records were kept (on the current basis), but since then have shown a slight rise (*see* Figure 1 opposite).

The government went on to set targets for reducing waiting times for initial consultation and treatment that were much more demanding than those embodied in the 1991 Patient's Charter. The government pledged to halve the maximum waiting time for outpatient appointments from more than six months to three months, and to reduce the maximum waiting times for treatment from 18 months to six months. These were achieved by 2005.

Average waiting times have fallen too. There was a slight rise in 1997, but since then waiting times for consultation and treatment alike have fallen dramatically (*see* Figure 2 above).

However, the most recent improvement in speed of access to hospital treatment has been driven by the creation of a new target in 2004. The initial targets covered only two parts of the total time patients waited: the time from referral to an outpatient consultation, and the time from the decision to treat a patient to the date of the treatment (inpatient). There were often long delays in between, as patients waited for diagnostic tests. In 2004, the NHS Improvement Plan introduced an 18-week 'referral-to-treatment' target for all conditions treated by a consultant, to be achieved by the end of 2008. The 18-week target took into account the whole time spent waiting, from initial referral to treatment. To allow for some unavoidable delays (whether for clinical reasons or through patients' choices) this target applied to 90 per cent of admitted patients and 95 per cent of non-admitted patients eligible for treatment under the target.

Figure 3 Percentage of patients (admitted and non-admitted) seen within the 18-week target, England, 2007-9



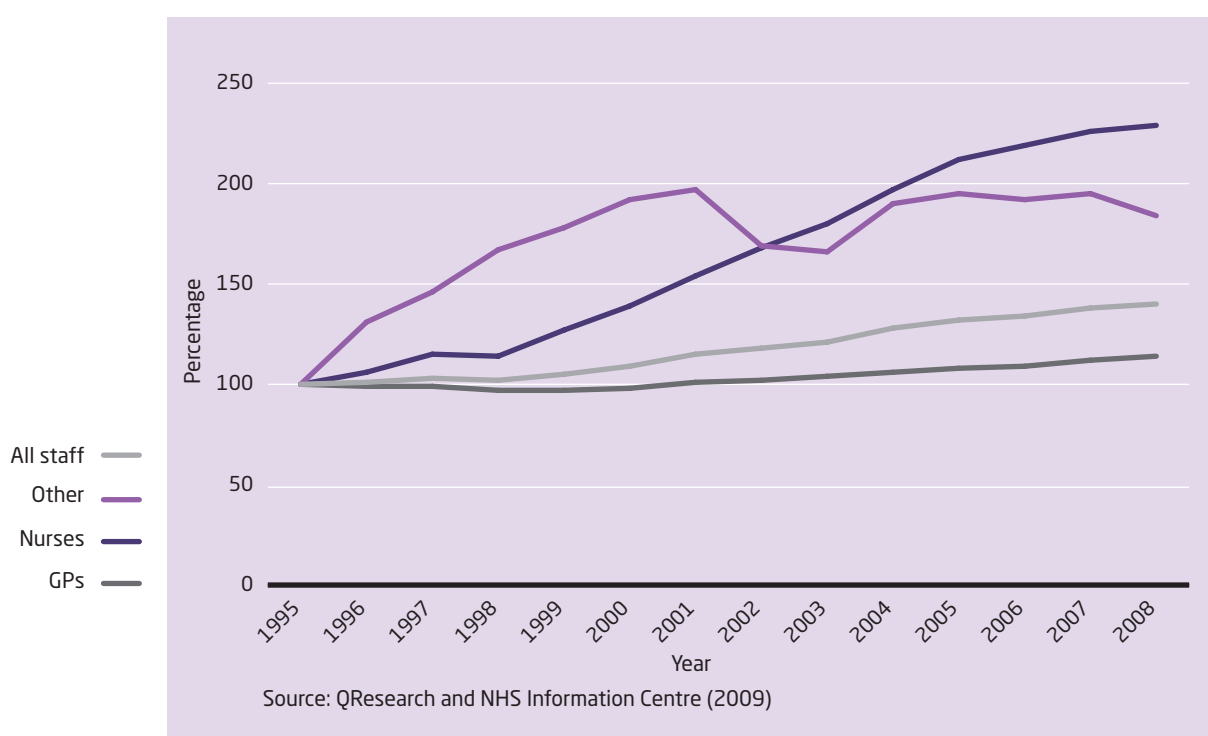
It has now been met for nearly all patients and both targets have been hit. Figure 3 (overleaf) shows that 93 per cent of admitted patients and 98 per cent of non-admitted patients wait less than 18 weeks for treatment. Most waits of more than 18 weeks are for trauma and orthopaedic or neurology services.

Separate access targets were set for cancer. An 'end-to-end' target of 62 days from GP referral to treatment, and a 31-day target from diagnosis to treatment were set in 2000. These targets, and others set specifically for cancer since 2000, have been met for nearly all patients.

However, there are patients with other diseases also requiring rapid treatment who have not benefited from central government targets: a recent study of patients waiting for carotid endarterectomy (to prevent stroke) found that only 20 per cent were treated within the two weeks recommended by NICE (Halliday *et al* 2009).

Achievement of the 18-week target for most patients has in part been brought about by substantial increases in the number of operations and diagnostic tests carried out. Between 1998/9 and 2007/8, the total number of procedures carried out in hospitals rose from 6.5 to 8.6 million, and growth in some specific procedures was much greater: cataracts increased by 49 per cent, hip replacement by 43 per cent, and certain types of coronary angioplasty (PTCAs) by 257 per cent (NHS Information Centre 2010c). Meanwhile, from 2006 to 2009 the number of MRI scans more than doubled, and CT scans increased from 165,000 to 262,000.

In 2003 the government introduced independent sector treatment centres, which provided planned operations and diagnostic tests to NHS-funded patients; the aim of this was to reduce waiting times. Their contribution to NHS activity overall has been very small – 1.79 per cent of all NHS elective activity in 2007/8 (Audit Commission 2008).

Figure 4 Change (%) in GP practice consultation rate by staff type, 1995-2008

However, it has been greater for some procedures, such as arthroscopies (9 per cent in 2006/7) and hip operations (7 per cent in 2006/7) (Audit Commission 2008).

GP and community services

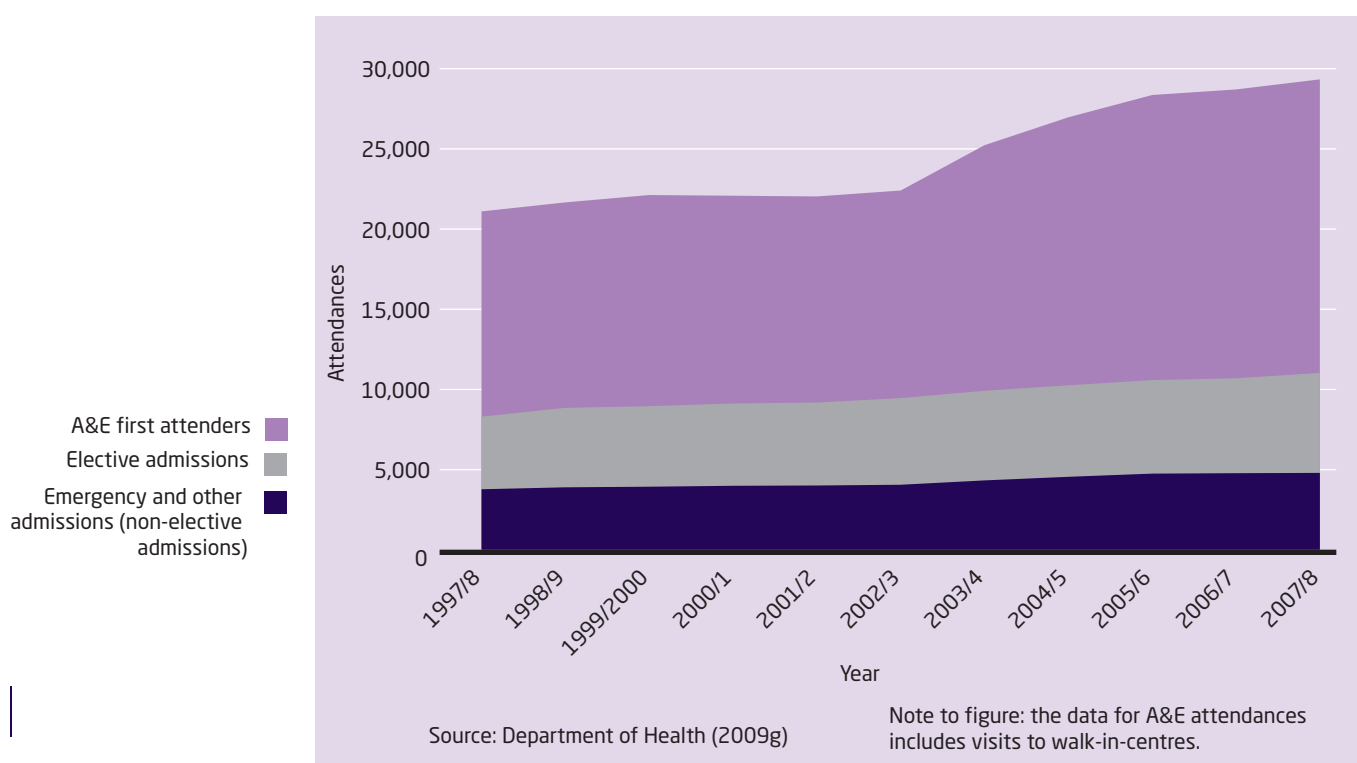
The NHS Plan promised that patients would be able to see a primary care professional within 24 hours, and a GP within 48 hours. This has not yet been fully met. The GP Patient Survey for 2007/8 (NHS Information Centre 2009d) found that 87 per cent of patients were able to see a GP within 48 hours.

Following concerns that practices were preventing patients from booking advanced appointments in order to focus resources on meeting the target, the survey also measures the proportion of people able to book an appointment more than two days in advance. In the same year it found that 77 per cent of respondents said they were able to do so.

Waiting times for services in the community (such as community mental health services, or physiotherapy) are not yet covered by targets. Waits for such treatment are not systematically measured, but what data does exist suggests that they can be very long, measured in months or years rather than weeks (RNID 2007, Mental Health Foundation 2008, Muscular Dystrophy Campaign 2009). The government has accepted in principle that waits for these services should be covered by targets and is currently piloting the measurement systems required (Department of Health 2009b).

Access to primary care and care in the community

The government has taken action to expand access to primary care. The NHS Plan outlined a target for 2,000 more GPs over five years (Department of Health 2000c). This was easily met, with the number of full-time equivalent (FTE) GPs increasing by 3,500 within that period. There also has been an increase in contacts with GP practice staff, including a substantial increase in contact between patients and nurses (*see* Figure 4 above).

Figure 5 Hospital activity trends, 1997/8-2007/8

Research carried out for the Department of Health in 2005 suggested that people placed a high priority on local access (Opinion Leader Research 2006). The subsequent White Paper *Our Health, Our Care, Our Say* proposed a number of initiatives to transfer some services from hospital sites into other settings closer to people's homes (Department of Health 2006c). There have been a number of objectives for this drive to move care outside hospital – notably to reduce costs – but increasing access has also been important. Initiatives include more services in GP premises, new specially built health centres, polyclinics and community hospitals, and the further development of alternatives to hospital services, such as GPs and pharmacists with special interests. This was followed up by a commitment made in 2007 (Department of Health 2007d) that a new health centre (or polyclinic) should be established in each primary care trust (PCT) area to provide a base for the transfer of hospital services.

There is no systematic data that allows the extent of any service shift to be estimated and hence the scale of any access benefits. However, a recent Audit Commission report (2009) found no evidence to show that primary care trusts had been successful in moving care out of hospitals. As Figure 5, above, shows, use of hospitals continues to rise. (The figures for A&E attenders include the numbers using walk-in centres, currently about 3 million people, much less than the rise in A&E first attenders during this period.)

A major focus has been on increasing the number of practices, especially in 'under-doctored areas', including through 'golden hello' schemes, initiatives to encourage private companies to enter the market and, most recently, the establishment of new health centres in each PCT area. By 2009, 50 new GP-led health centres had been opened under this programme, along with 65 new practices in previously under-served areas (Department of Health 2009y). However, concerns remain that more deprived areas still have disproportionately fewer GP services (*see* Section 6, pp 77–87).

Despite the fact that more than 80 per cent of patients said they were satisfied with GP opening hours, the GP Patient Survey for 2007/8 (NHS Information Centre 2009d) found

Figure 6 Percentage increase in GP practices offering extended opening hours, 2008/9

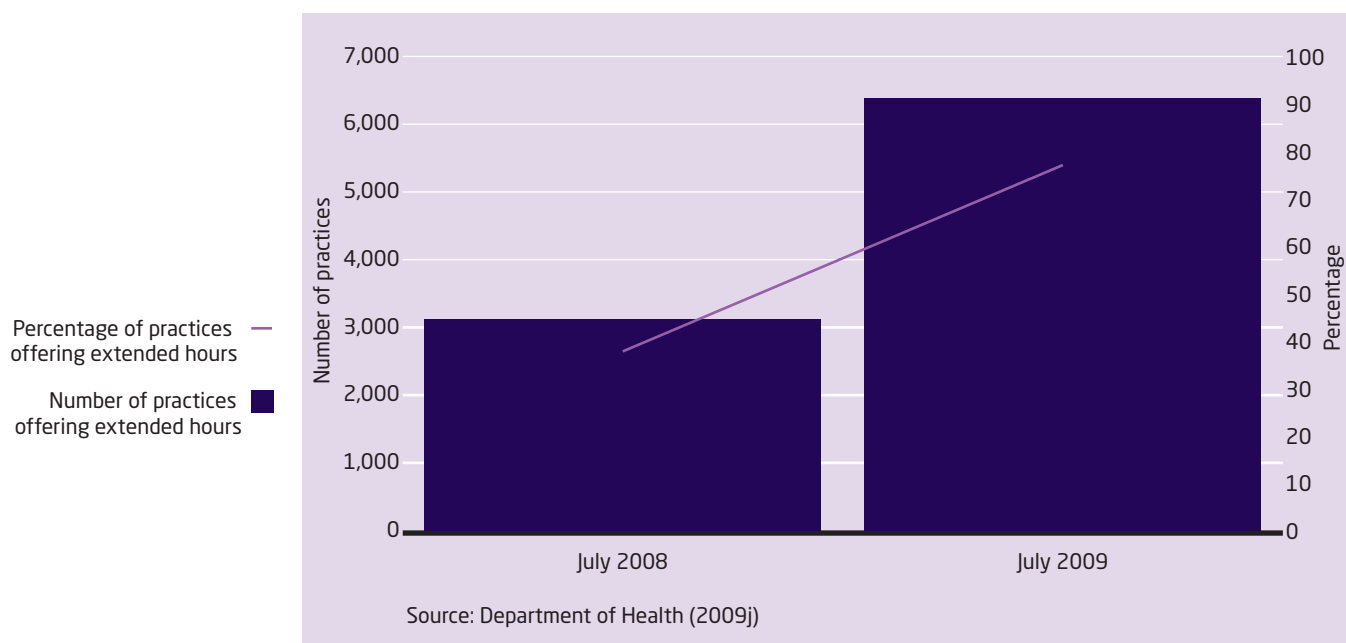
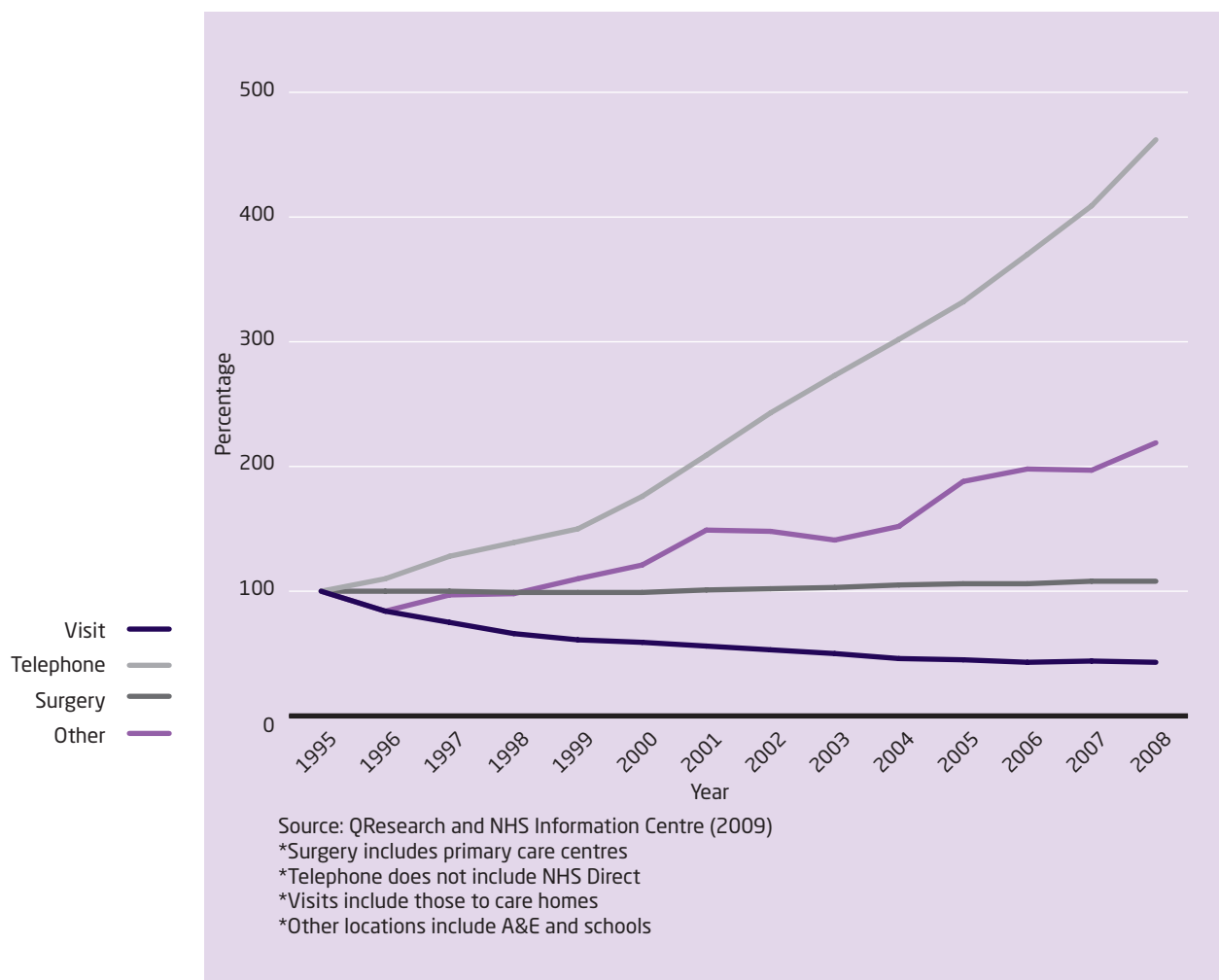


Figure 7 Change (%) in GP consultation rates by location, 1995-2008



a sizeable minority who were not satisfied with existing opening hours. The government responded to this by offering financial incentives for GPs to open longer hours. By July 2009 more than 75 per cent of practices had agreed to open longer at evenings or weekends, compared to 38 per cent the previous year (*see* Figure 6 on previous page).

Meanwhile, contacts with GP services have risen slightly (*see* Figure 7 on previous page), with the fastest growth taking place in telephone contacts, but there has been a decline in the rate of home visits.

Much of this growth in telephone contacts is due to the changes in out-of-hours services, defined as GP services required at night (18:30–08:00) and the weekends. The way these services are provided changed radically after the new GP contract was introduced in 2004. Up to that point, GPs remained responsible for these services, though most discharged this responsibility through co-operatives rather than providing the care directly themselves. The terms of the new contract led to many GPs deciding to opt out of responsibility for organising out-of-hours care, transferring the responsibility to primary care trusts (although many GPs may still provide care as part of co-operatives). New forms of provision have been developed, sometimes managed and provided in part by the private sector.

These new arrangements have not succeeded in creating a satisfactory system in all parts of the country. People are unsure how to access services out of hours (*Which?* 2006; National Audit Office 2006) and the availability of the service itself varies between different parts of the country (Colin-Thomé and Field 2010). Access to out-of-hours non-emergency care is also a problem in other developed countries. In a 2007 international survey of adults conducted by the Commonwealth Fund, the UK ranked fourth of seven countries, with fewer UK respondents reporting difficulties in accessing services than those from Australia, Canada and the USA (Commonwealth Fund 2007).

Finally, although general practice remains by far the most common point of first contact with the NHS for patients, to make access to primary care services more convenient the NHS Plan announced a programme of walk-in centres in the high street, or at transport hubs. There are now more than 90 of these, although some appear to be lightly used (O’Cathain *et al* 2009). The programme as a whole appears not to have reduced demand for GP services (Maheswaran *et al* 2007).

Access to drugs and treatments

The National Institute for Clinical Excellence (now Health and Clinical Excellence) (NICE) was established in 1999 to determine which new and existing drugs, treatments and procedures should, and should not, be available throughout the NHS. NICE also provides advisory guidelines for clinicians on caring for particular conditions and on promoting healthier lifestyles, though these are not mandatory.

According to the former Secretary of State for Health, Frank Dobson, NICE was designed to end the so-called postcode lottery, putting a stop to the situation where ‘adjacent health authorities look at different evidence in different ways and come to different conclusions’ (Laurance 1999).

NICE has approved most of the drugs and other forms of intervention (such as medical devices, diagnostic techniques and surgical procedures) that it has assessed as part of its technology appraisal programme, with over 80 per cent receiving a ‘yes’ or ‘partial yes’ (*see* Table 1 opposite).

The introduction of NICE has led to greater clarity about what, in principle, is available on the NHS, and what is not. However, it has not eliminated variation in access to drugs and treatments. There is evidence that local implementation of NICE appraisals and

clinical guidance is sometimes slow, because of resource and other constraints (House of Commons Health Committee 2007).

Table 1 Summary of NICE technology appraisals 2001-9

Decision	No of appraisals since March 2001	%
Yes	100	27.0
Partial yes	204	55.1
Only in research	22	5.9
No	39	10.5
Non-submission	5	1.4
Total	370	

Source: NICE (2009)

Variations in the availability of drugs that are licensed and available to be prescribed but not yet appraised by NICE also persist. Where there is no appraisal from NICE, some primary care trusts have decided not to pay for particular drugs. Some patients have successfully used legal processes to reverse such decisions. Other patients, in other areas, paid for these drugs themselves but were then refused NHS treatment for other aspects of their care, as they were treated as private patients.

Following a review of this situation (Richards 2008) the government has allowed patients to receive NHS care while paying privately for drugs not approved by NICE in some circumstances. It has also put in place a number of measures designed to speed up access to newly licensed drugs, in order to reduce the number of people affected. In 2009, the government published further proposals designed to speed up access to drugs before a NICE appraisal (Department of Health 2009s).

Looking forward

Speed of access to most NHS hospital and primary care services has greatly improved over the last decade. For some services not yet covered by targets, waiting times can still be very long.

The next government will need to ensure three things:

- that the gains in speed of access are not lost as the NHS responds to the new financial environment
- that all patients requiring rapid treatment receive it
- that waiting times in other services not currently subject to 18-week targets are tackled. This is particularly important if targets and rigorous performance management are less favoured as a lever for change, in favour of patient-focused rights, entitlements or guarantees of treatment within certain time limits.

There has been significant investment to make access to services more convenient – increased numbers of GPs in under-doctored areas, new walk-in centres and GP-led health centres with extended opening hours – yet there remain some people who are still not able to see their GP at times that suit them and confusion about out-of-hours services. Care must be taken to ensure that gains in access secured by new community-based services do not come at a higher cost than existing hospital care, and that they do not compromise the safety of patients.

The government has made substantial efforts to standardise the drugs and interventions available to patients across the country, and the National Institute for Health and Clinical Excellence has been recognised as a world leader in its field. However, local priority setting by PCTs means that there remain differences in access to services. Some of these may be

appropriate – reflecting variations in local need – but others may be arbitrary. There is a real chance that variations will increase with greater devolution of responsibility and a tighter financial climate. The challenge will be to ensure that these are based on sound evidence and can be defended in the face of public scrutiny.

2 Patient safety

Criterion 2: A high-performing health system minimises the risk of accidental injury or death due to medical care or medical error.

Key points

- Up until 1997, data about the scale and nature of patient safety incidents in England was far from comprehensive, and there had been limited policy development to improve patient safety.
- Since 1997, there has been considerable progress in this area. The establishment of the National Patient Safety Agency, with its systems for collecting and analysing information on adverse events, has been a significant development. However, the agency is still limited by a lack of capacity to enforce or follow through on learning.
- Progress has been made in reducing rates of MRSA and *C difficile* infections in hospitals.
- It is difficult to draw firm conclusions on the scale of other adverse events and safety failures. Increases in the number of reported safety incidents reflect improved reporting and coding, but under-reporting continues to be a major obstacle, particularly in primary care. There needs to be effort to explore the potential of using new or existing data sets to improve information on patient safety.
- There is still some way to go before a strong safety culture is firmly embedded in some parts of the service. In the meantime, organisations need to find more effective ways of encouraging and acting on feedback from patients, carers and staff.

Health care can prevent, detect, treat and manage illness, but it can also cause harm. Patient safety incidents range from those that cause little or no harm (such as some types of documentation errors) to those causing significant harm (such as falls in hospital) to the potentially fatal (such as wrong route administration of chemotherapy).

While serious failures of care are rare, they are devastating for those involved. Issues of patient safety have perhaps had greatest public profile in response to failures in safety or poor performance at particular hospitals – such as those revealed by the inquiry into children’s heart surgery in Bristol – or by particular individual clinicians, such as the serial killer Harold Shipman. This section looks at the broad approach taken to patient safety between 1997 and 2010, and assesses the extent to which patient safety has improved overall across the NHS.

The situation before 1997

Inquiries into failures in care provided by institutions or individuals have taken place regularly since the inception of the NHS. However, the need for more systematic effort to address patient safety only began to emerge in the 1990s, both in the United Kingdom and internationally. As evidence demonstrating the magnitude of errors in hospital care began to grow (Brennan *et al* 1991), concern about patient safety began to rise among professionals, and the issues moved slowly into the public and policy spotlight. The issue became a major international health care priority with the publication of the US Institute of Medicine's seminal report *To Err is Human*, which set out the scale of the problem, saying that deaths due to medical error in hospitals were more common than deaths due to vehicle accidents, breast cancer or HIV/AIDS, and argued for a system-wide, nationally led response to improve patient safety (Institute of Medicine 2000).

In the United Kingdom, the health White Papers of the mid-1990s did not prioritise patient safety as a distinct policy topic, although the overall policy ambition was to provide a health service that was safe, high quality and cost effective (Department of Health 1996b).

However, several specific patient safety initiatives were set up in the decade preceding 1997. For example, the National Confidential Enquiry into Perioperative Deaths (NCEPOD) was established in 1988, supported by government funding. NCEPOD continues to work towards improved standards, and safer medical and surgical care, by reviewing the management of patients undergoing particular interventions and publishing the findings from their surveys and research. It published important reports throughout the 1990s highlighting patient safety issues, such as death rates in out-of-hours surgery (NCEPOD 1997).

The formal regulation of medicines and medical devices also developed during the 1980s and 1990s, led by European-wide initiatives, with the establishment of the Medicines Control Agency in 1989 and the Medical Devices Agency in 1994, to ensure the safety of new medicines and medical devices.

Data about the scale and nature of patient safety incidents in the 1990s was patchy, with evidence particularly lacking in primary care (Department of Health 2000d). There were no national standards for identifying safety failures, and rates of incident reporting varied widely. One study showed that one in five NHS trusts did not have reporting systems, and one in three offered no training to staff on what to report (Dineen and Walsh 1999).

In 2000, the evidence was collated in an independent report for the government, *An Organisation with a Memory*, which serves as an approximate baseline. It found that adverse events in which harm is caused to patients occurred in 10 per cent of admissions to NHS hospitals (about 850,000 adverse events each year). Meanwhile, there were around 6,610 adverse incidents related to medical devices each year, including 400 deaths or serious injuries. Annually the NHS paid around £400 million in settlement claims (Department of Health 2000d).

Progress since 1997

In 1997, the government highlighted patient safety in its first health White Paper, *The New NHS* (Department of Health 1997). Following the later government publication *An Organisation with a Memory* (Department of Health 2000d), patient safety became a distinct policy priority (Department of Health 2001a). This echoed – and in some areas, led – the emerging international focus on patient safety prompted by *To Err is Human* (Institute of Medicine 2000).

We explore recent progress by looking at:

- national systems and support
- evidence on safety from routine data
- patient safety in primary care
- work to tackle infections associated with health care, such as MRSA
- safety of medicines
- the need to create a safety culture inside organisations.

National systems and support

Central to the government's policy on patient safety was the creation of a national support structure. In 2001, it announced a 'whole system' patient safety framework comprising a new national body (the National Patient Safety Agency, or NPSA), a national safety reporting system, national standards, an integrated approach to inspection, and a commitment to more patient safety research.

The NPSA was charged with collecting, collating and analysing information on adverse events, ensuring lessons are learned and fed back into practice, and, where risks are identified, producing solutions, setting national goals and tracking progress. Its work includes three particular patient safety initiatives:

- **The National Reporting and Learning System (NRLS)** – a system set up to provide systematic reporting and learning from adverse events and near misses involving patients. While slow to establish, the NRLS has undoubtedly led to greater reporting of safety incidents, and is improving at feeding this information back to the NHS in a timely and useful way. Today it is one of the most comprehensive such systems in the world, although it has been criticised for a relative lack of focus on investigating the root causes of serious safety events (House of Commons Health Committee 2009b).
- **The National Clinical Assessment Service (NCAS)** – a service that gives confidential advice and support to the NHS on managing poor clinician performance in cases that are not sufficiently serious to be referred to professional regulatory bodies.
- **National Confidential Enquiries** – three enquiries set up to independently examine fatal health care incidents in the areas of patient outcome and death, maternal and child health, and suicide and homicide by people with mental illness. The NPSA is responsible for commissioning and monitoring these.

Partly in response to the National Audit Office's review of patient safety policy in 2005 (NAO 2005), the related report of the Public Accounts Committee (House of Commons Public Accounts Committee 2006) and the review by the Chief Medical Officer (CMO) in 2006 (Department of Health 2006d), new initiatives were developed to increase the effectiveness of this national support system for patient safety. In particular, efforts were made to better translate national policy and requirements into real widespread movements for change and improvement at the local level.

The CMO's 2006 review *Safety First* expressed a desire to move from the 'awareness' of patient safety, which it argued had been successfully achieved by national initiatives, to safety becoming the genuine top priority of all people working in the NHS (Department of Health 2006e).

As a result of this review, a new National Patient Safety Forum was set up to bring all the main organisations involved in patient safety together, which then launched the Patient Safety First Campaign to encourage local leadership for patient safety. The NPSA established the Patient Safety Direct programme, to improve clinician engagement

with reporting and safety improvements. Working with and alongside the NPSA, the NHS Modernisation Agency – and its successor, the NHS Institute for Innovation and Improvement – has sought to promote the use of patient safety techniques such as routines and alerts. They have also promoted use of checklists, such as the World Health Organization Surgical Checklist (Panesar *et al* 2009).

Alongside this, Patient Safety Action Teams (PSATs) have been jointly established between the NPSA and each strategic health authority, and the Safer Patients Initiative (SPI) from the Health Foundation has been developing exemplar patient safety hospitals across the United Kingdom and helping to share best practice.

The government has also tried to reform the national system for clinical negligence claims, where patients take legal action as result of being harmed by substandard NHS care. A report by the Chief Medical Officer in 2003 had found the current system to be complex, inconsistent, slow, costly, encouraging a culture of defensiveness and secrecy which prevented organisational learning, and failing to provide patients with explanations and apologies (Chief Medical Officer 2003).

The report proposed the introduction of an NHS Redress Scheme, as a first-instance alternative to the court-based system. Through this scheme, the incident would be investigated, and the patient would be given an explanation of what had happened, an apology, and details of actions that would be taken to avoid a repeat incident. If the harm could have been avoided, the patient would be offered a package of care to provide remedial treatment and a compensation payment (up to a capped amount). The government agreed with the broad principles of the scheme. However, at the time of writing the scheme was still to be set up. In March 2009 the government told the House of Commons Health Committee that it planned to focus first on reforming the complaints system before considering a new scheme for financial redress.

Developments in health care regulation have also, necessarily, formed part of the approach to patient safety during this period. The Care Quality Commission continues to work to ensure basic standards of safety, among other indicators of quality. It is now introducing these requirements to a greater number of organisations, through a new registration system, more developed risk-profiling methods, and greater enforcement powers than its predecessors.

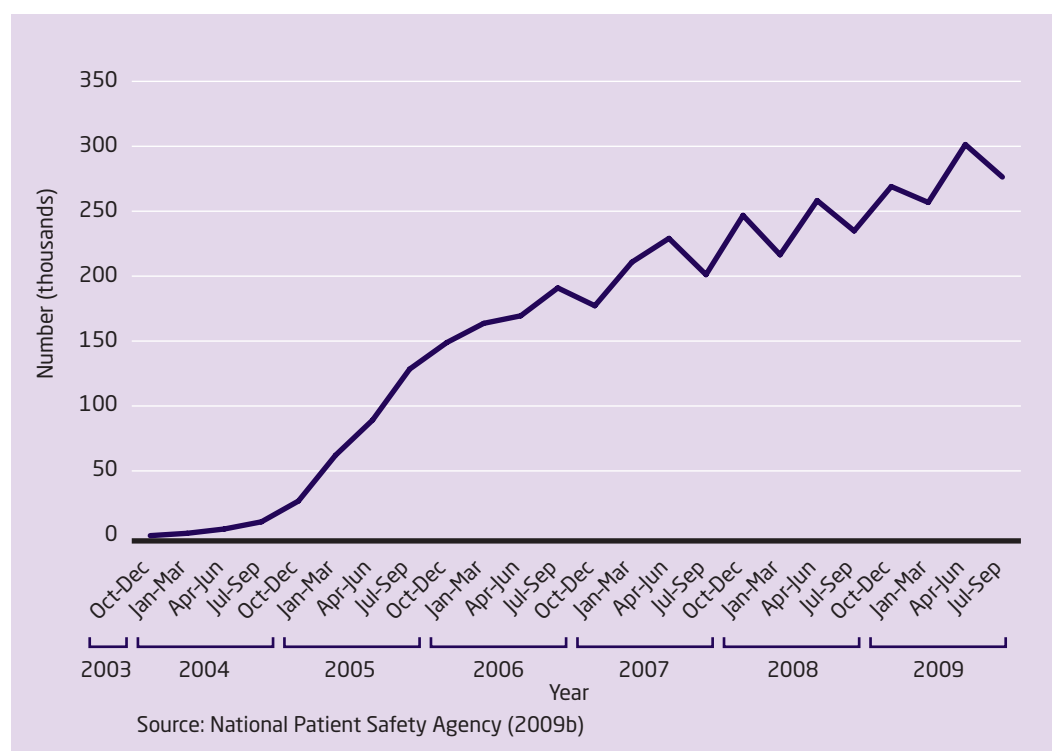
Lastly, in terms of national support, guidance has also been issued to commissioners to support them in commissioning for safety, in the form of the Never Events Framework (National Patient Safety Agency 2009a). This framework highlights eight incidents that should never happen, including inpatient suicide using non-collapsible rails, wrong site surgery (where surgery is performed on the wrong part of the body) and retained instrument post-operation (where instruments are left in the patient's body following surgery). From April 2009 PCTs have been asked to monitor and report all 'never events' that take place in the services they commission, with future plans to withhold payment from providers for those adverse events.

What the reporting and learning system tells us

So, how successful has this national patient safety system been? Certainly, reporting of patient safety incidents has increased – and this is seen primarily as a marker of improved surveillance rather than deteriorating standards. Figure 8, overleaf, shows how incidence reporting has increased dramatically since 2003.

At present, while safety reporting is still in its infancy, it is widely agreed that having a rising reporting trend demonstrates that an organisation has an improving safety culture (Hutchinson *et al* 2009). However, if reporting does eventually become truly

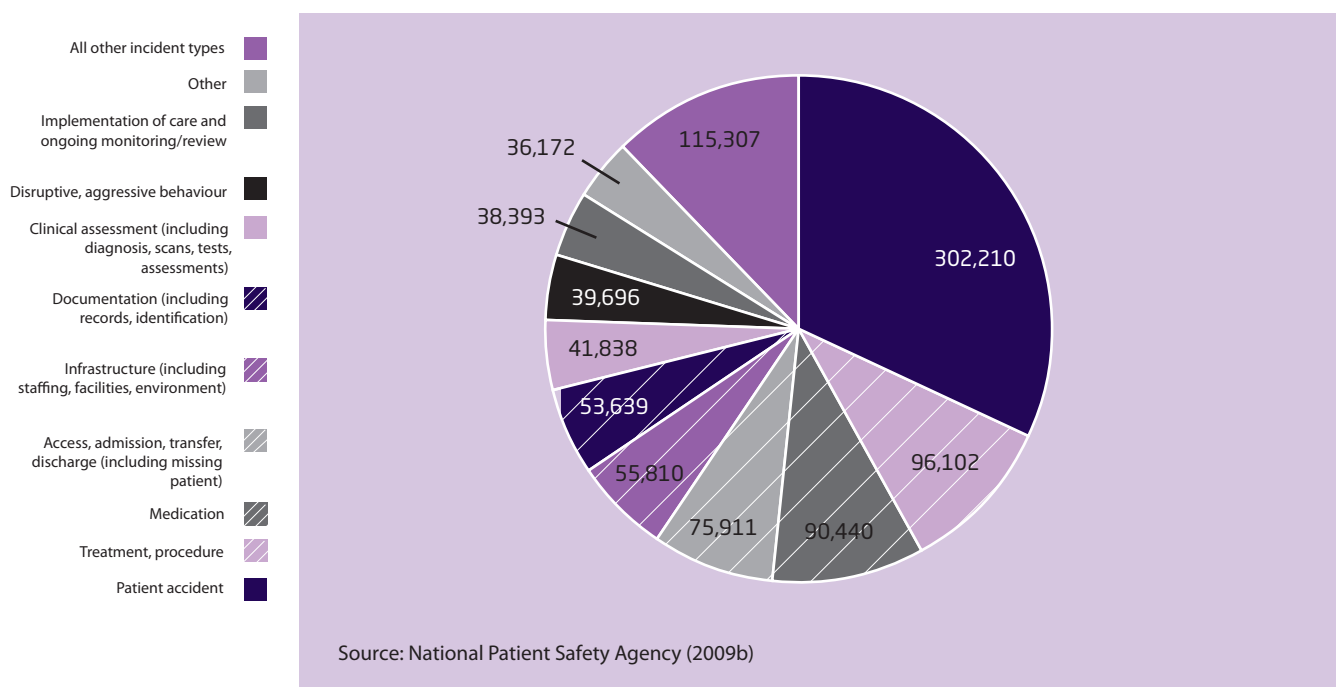
Figure 8 Number of patient safety incidents reported, by quarter, England, October 2003 to September 2009



comprehensive, an organisation's safety culture will be judged more on whether their reported incidents have begun to fall.

In terms of incidents currently reported through NPSA's National Reporting and Learning System, the most common type is patient accidents, such as falls (which accounted for 32 per cent of all incidents between July 2008 and June 2009), followed by

Figure 9 Patient safety incidents by type, England, 2008/9



errors in treatments and procedures or in medication (both approximately 10 per cent) (see Figure 9 on previous page).

The vast majority of reports (73 per cent) come from acute or general hospitals (see Table 2 below). However, as underreporting is still a major weakness of NRLS data – particularly in some sectors, such as primary care – there are limits to how much can be read from such figures. For example, one recent study found that reporting systems detected only approximately 6 per cent of the adverse events that were identified through a review of patient records (Sari *et al* 2007).

Table 2 Care setting of incident reports, England, 2008/9

Care settings	Number of incident reports
Acute/general hospital	693,700
Mental health service	131,459
Community nursing, medical and therapy service	86,388
Learning disabilities service	26,902
General practice	3,417
Ambulance service	2,546
Community pharmacy	728
Community and general dental service	366
Community optometry/optician service	14

Source: National Patient Safety Agency (2009b)

In terms of international comparisons, the 2008 Commonwealth Fund survey of chronically ill adults found that, when compared to Australia, Canada, Germany, New Zealand and the United States, the United Kingdom had the lowest rate of patients (12 per cent) who said they believed that a medical mistake had been made in their treatment (Commonwealth Fund 2008). The United Kingdom also had the second-lowest rate of patients (11 per cent) reporting that they had received incorrect test results or experienced delays in obtaining abnormal test results in the past two years.

Evidence on safety from routine data

In their review of patient safety in 2009, the House of Commons Health Committee recommended the regular review of patient case notes by hospitals and their collation by the NPSA (House of Commons Health Committee 2009b).

An alternative way of assessing patient safety is through analysing comprehensive routine data, such as Hospital Episode Statistics (Raleigh *et al* 2008). Some studies have shown the potential of using these data to pinpoint ‘outliers’ amongst individual surgeons, which might be suggestive of poor performance (Harley *et al* 2005). Other research suggests that care could be getting less safe for most of the patient safety indicators identified by the US Agency for Healthcare Research and Quality, although it is more likely that these trends in fact represent improvements in clinical coding and reporting (Vincent *et al* 2008). For the time being this data cannot provide definitive direct evidence about patient safety.

Patient safety in primary care

Many important patient safety initiatives have been introduced across the acute sector. However, safety in primary care has received comparatively less attention to date. Recent studies of patient records in areas such as diagnostic error (Kostopoulou *et al* 2008), child deaths (Harnden *et al* 2009) and suicide (Pearson *et al* 2009) suggest that there could be

significant safety problems. One review of studies of errors in primary care showed wide variations in error rates highlighted in different studies, ranging from five to 80 errors per 100,000 consultations, with errors related to diagnosis being the most common category (Sanders and Esmail 2001).

Meanwhile, levels of primary care reporting to the NRLS remain too low to build an accurate picture of the extent of safety incidents in these services (Care Quality Commission 2010). Between July 2008 and June 2009, less than 0.5 per cent of all safety incident reports came from general practice, despite that sector being responsible for the vast majority of NHS patient contact (National Patient Safety Agency 2009b). However, more efforts have been made recently to improve reporting in this area. For example, significant event audits are becoming more widely used in general practice, and Patient Safety Direct is rolling out new incident reporting systems for primary care (Department of Health 2009i).

While it is clear that significant improvement work is required in this area, it is worth noting that in two recent international surveys of primary care physicians, the United Kingdom has the highest proportion of respondents saying that they have in place processes for identifying adverse events and taking follow-up action (Commonwealth Fund 2006, 2009).

Tackling infections associated with health care

One of the elements of patient safety policy that has received considerable attention and seen substantial progress has been tackling health care associated infections (HCAIs) – specifically MRSA and *Clostridium difficile* (*C difficile*). In response to growing public concern about rising rates of infection, the government's approach to HCAIs has included:

- mandatory national surveillance
- challenging targets for infection reduction
- targeted initiatives on antibiotic prescribing
- information and support for staff, through improvement teams, the modern matron initiative and national campaigns such as the hospital 'deep clean' and the 'cleanyourhands' campaign.

(House of Commons Public Accounts Committee 2009)

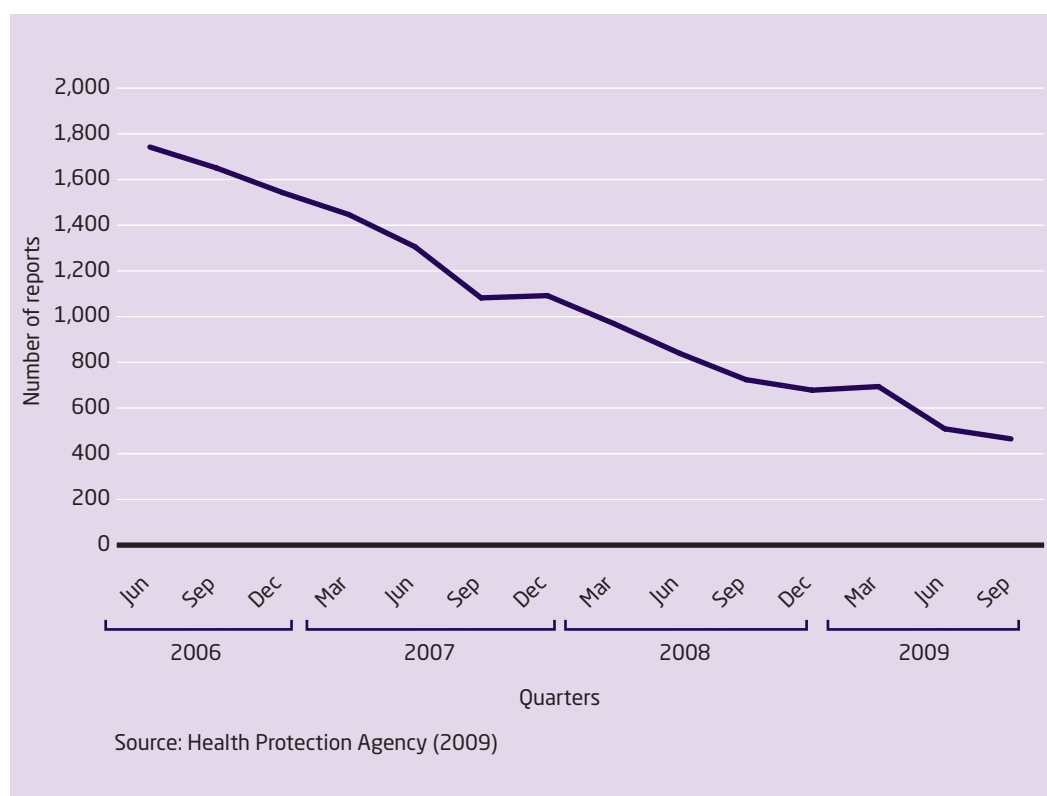
According to the Health Protection Agency (HPA 2009), in 2008/9 there were 36,097 *C difficile* infections in patients aged two years and over, representing a 35 per cent fall on the 55,499 total for 2007/8. Meanwhile, there were 2,933 cases of MRSA bloodstream infections, representing a 34 per cent fall on the 4,451 total for 2007/8 and a 54 per cent fall on 2006/7. As shown in Figure 10 opposite, the number of MRSA bloodstream infections has reduced rapidly, and continues to fall.

These achievements are considerable. However, the Public Accounts Committee recently criticised the government for failing to make equivalent progress against other HCAIs, such as other bloodstream infections, urinary tract infections and surgical site infections, and argued for mandatory reporting of all HCAIs (House of Commons Public Accounts Committee 2009).

Safety of medicines

Safety failures in relation to medicines include prescribing errors, dispensing errors, adverse drug reactions, and the increasing issue of counterfeit medicines. Medicines management in general has received policy attention from the government through the

Figure 10 Number of MRSA bloodstream infection reports, England, by quarter, June 2006 to September 2009



introduction of a set of standards and guidance for medicines management in hospitals (NHS Executive 1999a, Department of Health 2001b).

The Medicines and Healthcare products Regulatory Agency (MHRA) runs the Yellow Card Scheme, which collects reports on adverse drug reactions from health professionals, patients and the public (MHRA 2009). In 2007, to tackle counterfeit medicines, the government launched an anti-counterfeiting strategy, which combines public and professional education with monitoring and regulation of the supply chain (MHRA 2007).

At the same time, the NPSA reporting system captures medication incidents – showing, for example, that these incidents have comprised 10 per cent of all reported patient safety incidents in the past year. However, these reports provide only limited detail about the nature of these incidents. Pharmacists have been highlighted as a group who could play an important role in ensuring that medication incident reports are accurately categorised and at a sufficient level of detail to allow learning from them (Cavell 2006).

Creating a safety culture inside organisations

One clear message emerges from the research on safety (within health care and other sectors alike): the importance of a ‘safety culture’ in organisations. A major focus of government patient safety policy is the development of a more open learning culture, which is characterised by ‘shared passion for quality, by openness and respect, by support and by fairness. It is not a culture in which people are swift to blame, to find scapegoats, or seek retribution’ (Department of Health 2001a, ch 2, para 15).

This ambition has been most recently restated in the NHS Constitution, which emphasises the importance of openness with patients and families, and the need for NHS

staff to 'contribute to a climate where the truth can be heard and the reporting of, and learning from, errors is encouraged' (Department of Health 2009q, p11).

While there has been an increase in incident reporting, there remains a considerable way to go – particularly in some areas, such as primary care and medication errors (House of Commons Health Committee 2009b). The NAO found that staff were sometimes wary of apologising, or of being open about a safety incident, in case this risked a claim under the NHS clinical negligence scheme (NAO 2005). The review by the Chief Medical Officer in 2005 (Department of Health 2006d) found that staff felt they lacked the support they needed to admit their own mistakes, or to report mistakes they had witnessed. Several witnesses to the recent Health Committee inquiry into Patient Safety reported that in some areas an unhelpful blame culture persists (House of Commons Health Committee 2009b). The same inquiry also criticised the failure of senior managers and boards to take the monitoring of patient safety seriously enough in their roles.

Fear of criminal prosecution is a particular concern among pharmacists, since they are criminally liable for any errors in the dispensing of medicines. The Health Committee has called on the government to decriminalise dispensing errors (House of Commons Health Committee 2009b), and the government response said that the MHRA, the Department of Health, the Royal Pharmaceutical Society of Great Britain and the Crown Prosecution Service are working together to consider the issue (Department of Health 2009i).

In terms of communication with patients and families, the NPSA introduced new guidance, entitled *Being Open* (NPSA 2005), which was recently reviewed and updated. The government has also made a series of changes to NHS complaints and redress procedures (HM Government 2009b), although several reviews have found considerable weaknesses remain in complaints handling (NAO 2008b, Healthcare Commission 2007).

Table 3 NHS Staff Survey - measures of safety culture (%)

Survey responses	2005	2006	2007	2008
My trust encourages us to report errors, near misses or incidents	75	76	75	80
My trust blames or punishes people who are involved in errors, near misses or incidents	9	10	12	10
We are informed about errors, near misses and incidents that happen in the trust	30	32	31	31
We are given feedback about changes made in response to reported errors, near misses and incidents	33	34	33	34

Source: Care Quality Commission (2008b)

It is hard to measure the extent to which an organisation has a culture of safety (Pronovost and Sexton 2005). As shown in Table 3 above, the annual NHS Staff Survey does show some progress in the percentage of staff who feel that their trust encourages them to report incidents. However, overall, since 2005, most other questions in the staff survey relating to safety have shown no significant change, and percentages of staff

saying they have received feedback about changes made in response to incident reports remain low.

The statistics shown in Table 2 are for all NHS organisations. However, the 2008 survey showed that on the whole ambulance trusts performed notably worse than other types of organisation. For example, only 89 per cent of staff in ambulance trusts said they had reported the most recent error, near miss or incident they had witnessed (compared to an average 96 per cent), and only 17 per cent felt informed about changes made following reporting (compared to an average 32 per cent).

Looking forward

It is clear the NHS still has further to go before it fully realises its ambitions on patient safety set out in 2000. However, it is also evident that there is only a partial picture of how safe care is. It is important that rates of reporting continue to improve, through the Reporting and Learning System. However, it would also be valuable to continue testing and developing ways in which other more comprehensive and robust indicators – for example, information from routine data sources, such as Hospital Episode Statistics – could be used to monitor and study the safety of care.

Incident reporting has increased, but there is still significant under-reporting in some areas, including primary care, medication incidents, serious incidents, and reporting by doctors. In future, policy needs to focus on the greater involvement of patients, the public and frontline staff in reporting safety issues – something highlighted strongly by Dr Colin-Thomé's report into failures of care at Mid Staffordshire NHS Foundation Trust (Colin-Thomé 2009). The Care Quality Commission intends to gather more direct feedback of this sort in its regulatory activities, and local NHS organisations themselves need to find more effective ways to encourage and act on patient, family and staff feedback.

Safety in primary care remains a relatively under-developed area of policy interest, although some initiatives are under way. It is essential that greater attention is now given to safety in non-acute settings.

As identified by the Health Committee report in 2009, there is a whole raft of new technologies that represent important opportunities for innovation in patient safety (House of Commons Health Committee 2009b). These include the electronic patient record and the summary care record, electronic prescribing, automated dispensing, clinical decision support technologies, and virtual simulation training. Whatever the outcome of debates about the future of the major national IT initiatives such as Connecting for Health, it is important that work on issues such as e-prescribing endures.

Disseminating learning in patient safety remains an issue. Historically, the NHS has struggled to spread best practice across the service. The NPSA has improved both the analysis and feedback of its data and evidence, and local and national safety campaigns are yielding results, but spreading best practice remains challenging. The next government needs to continue to support the NHS to study and share lessons from serious incidents.

3 Promoting health and managing long-term conditions

Criterion 3: A high-performing health system supports individuals to make positive decisions about their own health and how to manage the negative effects of long-term conditions.

Key points

- Before 1997, the government had set a number of targets to reduce smoking, drinking and obesity, but had achieved only limited success. Work on chronic illness was similarly slow, although there was some success with screening and immunisation.
- Since 1997 policies on smoking have been the most successful. A combination of targets, legislation and an NHS-wide smoking cessation programme has contributed to sustained falls in smoking rates. Further gains in health are expected from the comprehensive ban on smoking in public places, passed in 2007, which represents a major step forward in public health policy.
- Government action on alcohol has been slow, and no targets have been set. Consumption has increased since 1998, accompanied by a rise in alcohol-related hospital admissions and rates of liver disease.
- Despite a number of targets in place, the prevalence of obesity is rising. Government action has focused on encouraging healthy choices, through information and advertising campaigns.
- Screening programmes have been increased in some disease areas, such as for breast and cervical cancer, with a positive impact on diagnoses, but progress is still needed in other areas.
- Action to support the management of long-term conditions has only recently been implemented, and needs to be a major focus for the next government.

Health promotion encompasses a wide range of issues and activities. According to the World Health Organization, health promotion is ‘the process of enabling people to increase control over, and to improve, their health’ (WHO 1998). In England, responsibility for action on some of the factors that influence public health lies outside the NHS. But there is much that the NHS can do, ranging from day-to-day prevention advice being offered by GPs, nurses and pharmacists to national programmes to protect the whole population from the risks of particular diseases. Other interventions include legislation to improve public health, such as the introduction of seatbelts and the smoking ban.

This section focuses on five key and overarching public health risk factors and themes:

- smoking
- alcohol
- obesity

- screening and immunisation
- self-care and chronic disease management.

The situation before 1997

This section considers smoking, alcohol abuse and obesity before 1997 and then looks separately at screening and immunisation, and at self-care and managing long-term conditions.

Smoking, alcohol and obesity

In the 1980s, the government's wariness of state interference in individual lifestyle choices or behaviours was transformed by the experience of the HIV/AIDS epidemic (Klein 2006). After this, major public health information campaigns became much more common (Klein 2006; Baggott 1994). The White Paper *The Health of the Nation* (HM Government 1992) signalled a further change in direction in public health policy, with a recognition that population health was influenced by a wide range of factors that required action by multiple government departments and non-government bodies, including local authorities and the voluntary sector (Klein 2006).

The Health of the Nation incorporated 27 targets, many related to ill-health prevention, intended to reduce:

- coronary heart disease (CHD) and stroke
- cancer
- mental illness
- HIV/AIDS and other sexually transmitted diseases
- unintentional injuries.

There were also a number of targets on smoking, alcohol and obesity, which were not met – other than for smoking, which was met only partially (*see* Table 4 below). Many of the targets were long term, with deadlines set after any election in the late 1990s.

Table 4 Health of the Nation targets on smoking, alcohol and obesity

Smoking	80% of public places to be covered by anti-smoking policies by 1994
	Smoking among 11-15 years to be reduced by one-third between 1994 and 2000
	Target not met*
	Smoking among pregnant women to be reduced by one-third between 1994 and 2000
	Target met*
	No more than 20% of adults to be smoking by 2000
	Target met**
Alcohol	Reduce the proportion of men and women drinking more than recommended weekly alcohol limits by 2005
	Target not met***
Obesity	Reduce prevalence of obesity among adults by 25% for men and 33% for women, by 2005
	Target not met****

* Harrison and New 1997

** NHS Information Centre 2009k

*** NHS Information Centre 2009h

**** NHS Information Centre 2009j

A government-commissioned review of *The Health of the Nation* in 1998 – entitled ‘A Policy Assessed’ – found that the policy had played a role in increasing activity on health promotion and prevention but did not ‘cause a major readjustment in spending priorities of health authorities’, while activities such as ‘waiting lists and balancing the books took precedence’ (Department of Health 1998b p1ff). It is difficult to assess the distinct impact of *The Health of the Nation* on mortality from heart disease and cancer, which had been declining steadily before 1992 and continued to do so thereafter (Klein 2006).

Screening and immunisation

In 1987, the White Paper *Promoting Better Health* introduced financial incentives for GPs to achieve target rates for child immunisation and cervical cancer screening (Department of Health 1987). In the early 1990s, immunisation coverage for all vaccines rose from around 70 to 90 per cent of the population (Freeman and Robbins 1994).

Screening programmes for cervical cancer and for breast cancer were also established on a national basis in the early 1990s. Meanwhile, other programmes, such as diabetic retinopathy, were introduced in some areas. The National Screening Committee was set up in 1996, to advise government on screening programmes across the UK.

Self-care and managing long-term conditions

The Health of the Nation emphasised the responsibility of individuals for improving their health, stating that ‘to seize the opportunity, people need information to help make the right choices’ (HM Government 1992, p 22). However, subsequent progress on developing policies to realise this ambition was slow. In 1996, the Patient Partnership scheme was implemented in order to promote relationships between patients and health care professionals, based on providing better information. However, by 1997 its impact was described as ‘minimal’ (Harrison 1998, p 237). By this time, still no steps had been taken to introduce any formal system of chronic disease management.

In summary, by 1997, the government had introduced national targets on obesity, alcohol and smoking but these did not translate into significant action at the front line. Immunisation rates had been increasing and a new National Screening Committee presented a promise of evidence-based policy. There had been very little policy attention given to managing long-term conditions.

Progress since 1997

This section addresses each of the five areas of focus (highlighted at the start of this section) in turn, examining the measures taken by the current government and evidence of changes in health behaviours and outcomes.

Smoking

Against a backdrop of steadily declining smoking rates among the adult population as a whole, the government set a series of targets aimed at reducing smoking in the general population and specific groups (*see* Table 5 overleaf). So far, these have all been met.

Table 5 Smoking reduction targets

Source of target	Population	Smoking rates in 1996 (%) [*]	Target rate for 2005 (%)	Target rate for 2010 (%)	Target for 2020 (%)
Smoking Kills (Department of Health 1998e)	Children (up to 15 years)	13	11 Target met***	9 Data not yet available	
Smoking Kills (1998e)	Pregnant women	23	18 Target met****	15 Data not yet available	
Smoking Kills (1998e)	Adults (16 years and over)	28	26 Target met**	24 Target met in 2005**	
Public Service Agreement (HM Treasury 2007)	Adults	28		21 Target met in 2007**	
Public Service Agreement (2007)	Adults - routine and manual socio economic groups			26 Target met in 2007**	
A Smokefree Future (HM Government 2010)	Young people (11-15 years)				Reducing 'inflow' of young people to smoking to 1% or less

^{*}From Health Survey for England 1996 (Department of Health 1998c)

^{**}NHS Information Centre (2009k)

^{***}NHS Information Centre (2009g)

^{****}HM Government (2010)

To support these activities, the government has used legislation to restrict the sale, promotion and consumption of smoking, and has set up a range of programmes to support smoking cessation (for full details, *see* Table 6 below).

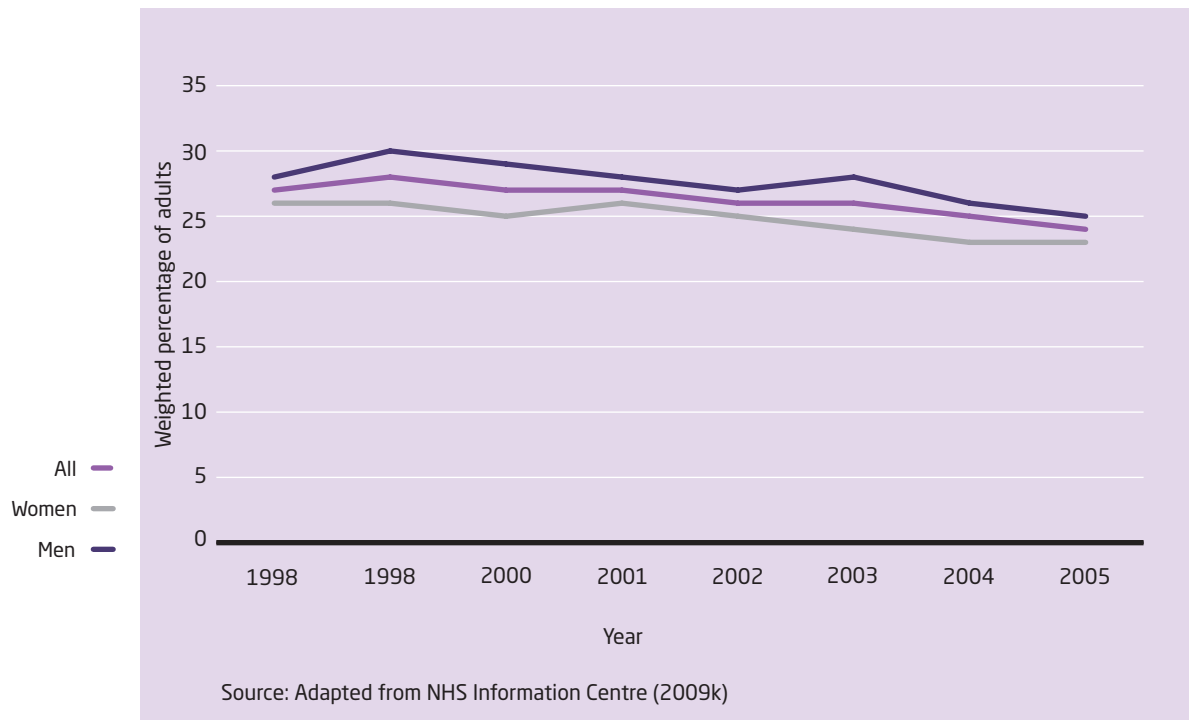
Table 6 Timeline of smoking reduction policies

2002	Legislation bans most remaining forms of tobacco advertising.
2004	The White Paper <i>Choosing Health: Making healthier choices easier</i> includes a strategy to tackle smoking and the effects of passive smoking, including improved smoking cessation support.
2006	The Health Act introduces a smoking ban in some work places.
2007	Legislation bans smoking in all enclosed public spaces, including pubs and clubs.
2007	The minimum age for buying tobacco is increased from 16 to 18 years following an order under the Health Act 2006.
2009	Displaying tobacco products at point of sale is prohibited, and sale of tobacco from vending machines is controlled under the Health Act 2009.
2010	A new strategy pledges to improve smoking cessation services, and to introduce new services at more convenient times, to promote new smoke-free places (such as cars), and to review whether the current legislation can be extended to include building entrances and doorways (HM Government 2010).

The rates of smoking among both men and women have fallen steadily since 1974 and the reductions have been sustained since 1998 (*see* Figure 11 overleaf).

A higher proportion of people in routine and manual occupations continue to smoke than people in managerial or professional occupations, although there have been declines in all social groups (NHS Information Centre 2009k). In 2007, 26 per cent of respondents

Figure 11 Prevalence of cigarette smoking among men and women (weighted), 1998-2007, England



to the General Household Survey from manual or routine groups were current smokers, down from 33 per cent in 2001 (Office for National Statistics 2007).

It is difficult to know the precise extent to which these declines are due to government policies, but legislation and NHS stop smoking services are likely to have made a significant impact. It is too soon for evidence to have emerged about the impact of the ban on smoking in public places in England, but some gains are to be expected in the future. In Scotland, where a ban has been in place since early 2006, a study found a 14 per cent reduction in admissions to hospital for acute coronary syndrome among smokers following the ban (Pell *et al* 2008). Meanwhile, in the Republic of Ireland (which introduced a workplace ban in 2004) studies have found significant declines in bar workers reporting respiratory symptoms (Allright *et al* 2005; Goodman *et al* 2007).

The NHS quitting service will have had some impact too. The Department of Health's *Priorities and Planning Framework 2003–2006* (Department of Health 2002) set targets for smoking cessation, including 800,000 people quitting successfully by 2006 (defined as abstaining from smoking tobacco four weeks after the quit date). A recent report on NHS cessation services found that at 2008/9, 671,259 people had set a quit date, and of those 337,054 self-reported as successful quitters, at an average cost of £219 per quitter (NHS Information Centre 2009i). However, critics have argued that the four-week quit date is an unreliable indication of long-term behaviour, and a national evaluation drawing on carbon monoxide test-validated data found that the quit rate fell from 53 per cent at four weeks to 15 per cent after one year (Bauld *et al* 2009).

Alcohol

In 1998 the government promised that it would develop a specific alcohol harm-reduction strategy, but it was not until six years later that the *Alcohol Harm Reduction Strategy for England* (Prime Minister's Strategy Unit 2004) was finally published. The

document aimed to encourage sensible drinking and reduce alcohol-related harm, but set no targets. Its four key strategies were:

- better education and communication
- improving health and treatment services
- combating alcohol-related crime and disorder
- working with the alcohol industry.

In 2007, the government issued the cross-department strategy *Safe. Sensible. Social. The next steps in the national alcohol strategy* (HM Government 2007b). This focused on awareness campaigns targeted at the general public, young people and pregnant women – but again, did not include measurable goals. In late 2008 a cross-departmental Public Service Agreement (PSA) was issued to reduce the harm caused by alcohol and drugs (HM Government 2009b). This aimed to bring about a reduction in the rate of alcohol-related hospital admissions, although a target figure was not set. The Department of Health launched a number of awareness campaigns that year.

Overall, since 1997, alcohol consumption has risen, as have alcohol-related hospital admissions and deaths. According to the most recent data, the mean number of units consumed per week was 18.9 for men and 9.2 for women (NHS Information Centre 2009h). However, this masks considerable variation. For example, in 2006 31 per cent of men exceeded the recommended 21 units of alcohol per week and 20 per cent of women exceeded the recommended 14 units.

Since 1998 there has been an overall increase in drinking that exceeds the recommended weekly limits. This change has been more marked among adult women, and is described as a ‘robust trend’, identified across different surveys and different measures of consumption, including the General Household Survey and the Health Survey for England (Smith and Foxcroft 2009).

In 2006, the method for calculating units was updated to take into account changes in the way drinks are served and the changing strength of drinks. So, in Figure 12 below, the

Figure 12 Percentage of men and women exceeding recommended units of alcohol per week, 1998-2006

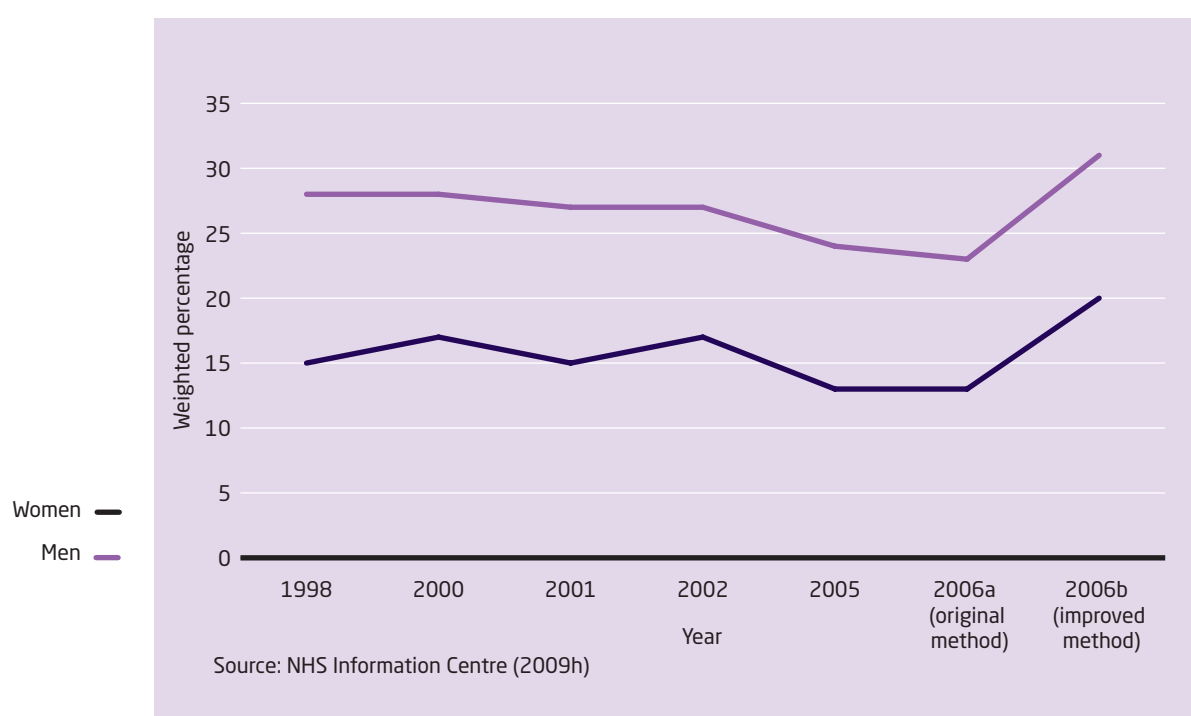
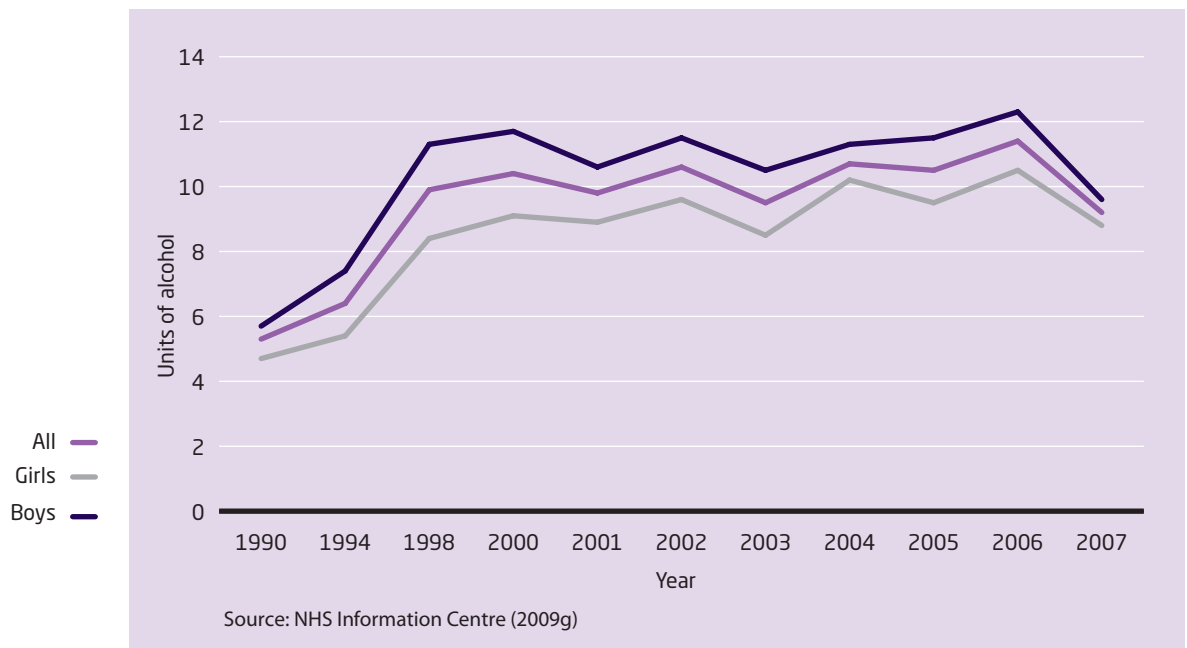


Figure 13 Mean alcohol consumption in the last week by pupils aged 11-15 years, 1990-2007

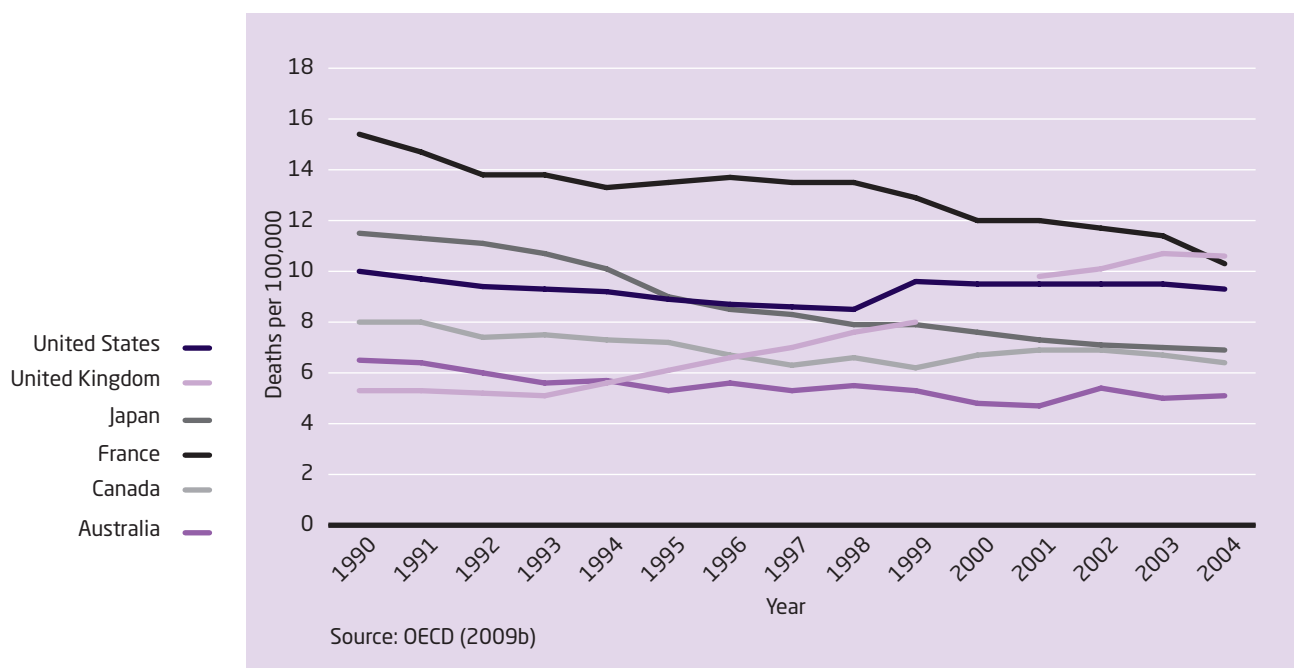


pattern of consumption from 1998 to 2006a reflects consumption according to the old method, while 2006b refers to the current level of consumption, according to the new method of unit calculation.

Meanwhile, between 1990 and 2007 overall consumption of units of alcohol also increased among 11–15 year olds, according to self-reported data (NHS Information Centre 2009g) (*see* Figure 13 above).

A key way of assessing the extent of harmful alcohol use is to look at the number of alcohol-related hospital admissions and deaths. In 2007/8, there were around 863,300

Figure 14 Deaths per 100,000 of the population from cirrhosis in selected OECD countries, 1990-2007



hospital admissions related to alcohol consumption – an increase of 69 per cent since 2002/3. There has also been an increase in alcohol-related deaths: in 2007 there were 6,541 deaths from causes directly related to alcohol use, compared to 5,476 in 2001 (NHS Information Centre 2009h). This trend appears to be country-specific: OECD data show that between 1990 and 2007 the rate of deaths per 100,000 of the population from liver disease had decreased in some countries, while increasing in England and Wales (see Figure 14 opposite).

Overall, there is no sign that the government's aims to reduce harmful alcohol consumption have been achieved. However, as the government has recently acknowledged, much of the potential improvement lies outside the NHS, including greater control of advertising, pricing strategies, and initiatives to limit the physical availability of alcohol.

Obesity

The White Paper *Saving Lives: Our healthier nation* (HM Government 1999) emphasised the need for physical exercise and a healthy diet as one of the ways to reduce the risk of mortality from cancer and coronary heart disease (CHD). Targets were set to reduce deaths from cancer, CHD and stroke, accidents, and mental illness by 2010, but not for reducing obesity *per se* (HM Government 1999).

Initially, it was envisaged that initiatives such as the Healthy Schools programme would promote healthy diets and appropriate body weights. Subsequently, National Service Frameworks (NSFs) were issued for CHD and diabetes, both of which emphasised the importance of maintaining a healthy body weight.

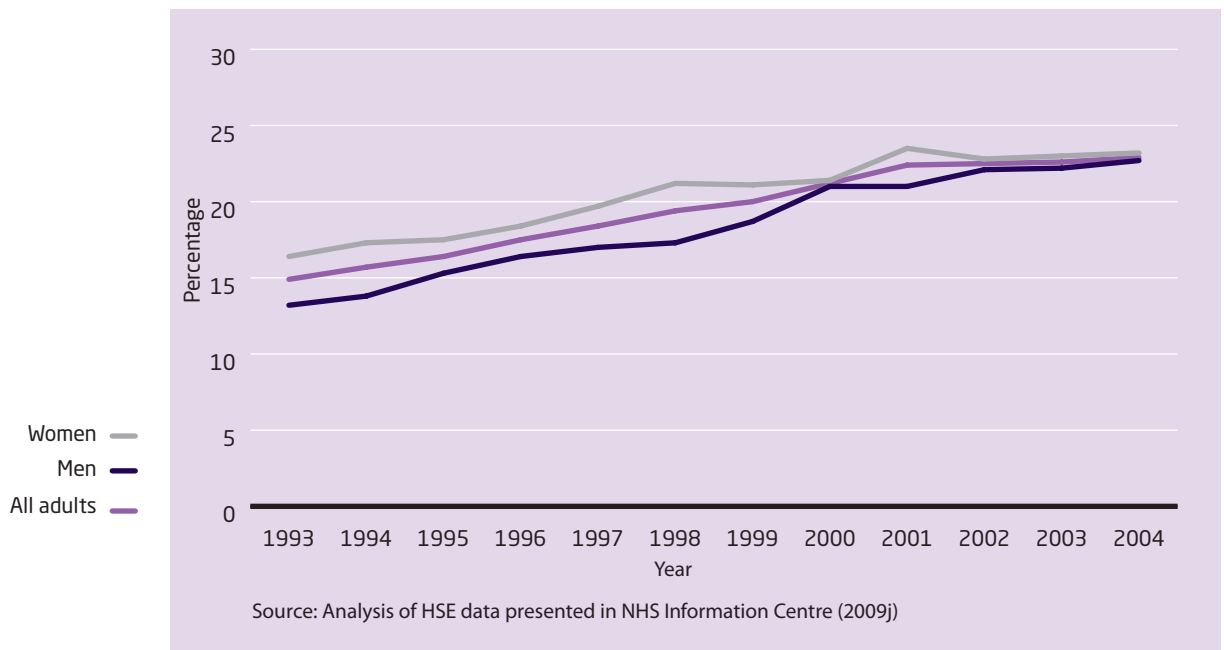
The 2004 Treasury Spending Review included a public service agreement to halt 'the year-on-year rise in obesity among children under 11 by 2010 in the context of a broader strategy to tackle obesity in the whole population' (HM Treasury 2004, p 13). Three departments, the Department of Health, the Department for Education and Skills and the Department for Culture, Media and Sport, were jointly responsible for meeting this target.

Approaches to reduce the rise in obesity have focused on prevention. Policies have included promoting healthy eating and physical activity (particularly in schools and through media campaigns) and improving antenatal nutrition. The 'Change4Life' social advertising programme, launched in early 2009, has sought to bring together many of these programmes to deliver a more effective and coherent obesity strategy, focused on encouraging the public to eat healthily and be physically active. Through these initiatives, the government has emphasised the responsibility of the individual for improving their own health.

In 2007, the UK government's Foresight programme – part of the Government Office for Science – produced a report that set out the scale of the obesity challenge facing the United Kingdom over the next 40 years. It predicted that without further action, by 2050 60 per cent of men and 50 per cent of women could be clinically obese (Foresight Programme 2007). The report recommended a 'substantial degree of intervention' (p 12) across different areas of government policy. Following this, in January 2008 the cross-government strategy *Healthy Weight, Healthy Lives* was launched (HM Government 2008). This aimed to make England 'the first major nation to reverse the rising tide of obesity and overweight in the population' (p v), focusing initially on children.

As far as adults are concerned, there is no sign of the tide turning. In 2007, 24 per cent of men and women were classified as obese, while 41 per cent of men and 32 per cent of women are classified as overweight. Data shows an increasing trend in the proportion of

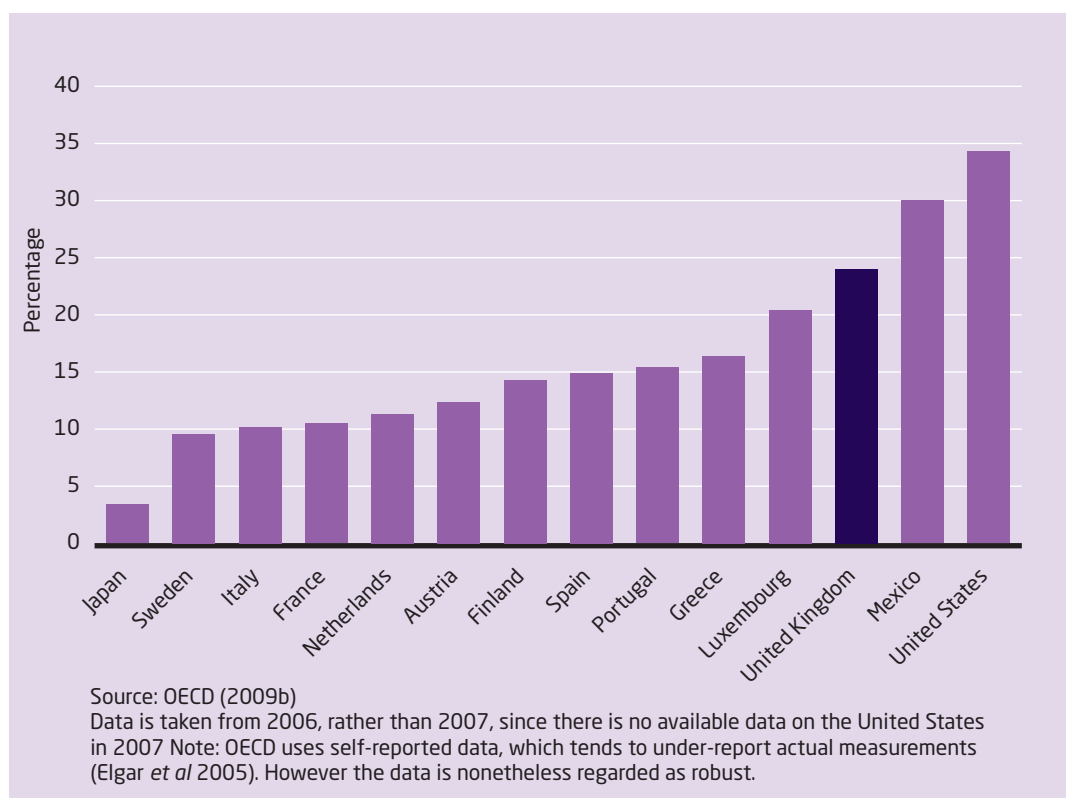
Figure 15 Prevalence of obese (including morbidly obese) adults in England, 1993-2007



obese adults in England (NHS Information Centre 2009j) (see Figure 15 above). (Note that data have been weighted for non-response since 2003.)

The proportion of obese adults is high relative to other developed countries, exceeded only by the United States and Mexico (see Figure 16 below).

Figure 16 Proportion of obesity among the total population in 14 OECD countries, 2006



A recent update of the modelling for the Foresight Programme report, based on more recent data, warned that the increase in obesity among adults in England shows no signs of levelling off. It predicted obesity rates in 2020 of 41 per cent of men and 36 per cent of women (aged 20–65) (Brown *et al* 2010). It also predicted rises in obesity-related diseases, including by 2050:

- a 23 per cent increase in the prevalence of obesity-related stroke
- a 34 per cent increase in obesity-related hypertension
- a 44 per cent increase in obesity-related CHD
- a 98 per cent rise in obesity-related diabetes.

At the same time, there have been significant increases in the proportion of children classed as obese. The proportion of obese boys increased from 10.9 per cent in 1995 to 16.8 per cent in 2007 (NHS Information Centre 2009j), and the proportion of obese girls increased from 12 per cent to 16.1 per cent over the same period. In terms of the PSA target issued in 2004 to halt the year-on-year increase in obesity among children under 11 (HM Treasury 2004, p 13), the data shows a slight improvement (McPherson *et al* 2009), but it remains to be seen whether this pattern will continue on this course.

These increases in weight have occurred despite an apparent rise in exercise. In 2006 the proportion of adults meeting the recommended minimum physical activity guidelines for adults (30 minutes of moderate exercise five days a week) was 40 per cent of men and 28 per cent of women – an increase from 32 per cent of men and 21 per cent of women in 1997 (NHS Information Centre 2009j). In 2007, 72 per cent of boys and 63 per cent of girls met the recommended minimum exercise guidelines for children of 60 minutes of moderate physical activity per day.

At the same time the government has made some progress in increasing healthy eating through its 5 a Day campaign. Between 2003 and 2007 there was a slight increase in the proportion of men and women consuming five portions of fruit and vegetables a day. During the same period there was a more promising increase among children eating 5 a Day (10 per cent of boys and 12 per cent of girls in 2003, rising to 21 per cent of boys and girls by 2007). However, not all adults and children can correctly identify what equates to a fruit or vegetable ‘portion’ (NHS Information Centre 2009j). This suggests that several years after the launch of the campaign, some people are still not clear what is being recommended.

Screening and immunisation

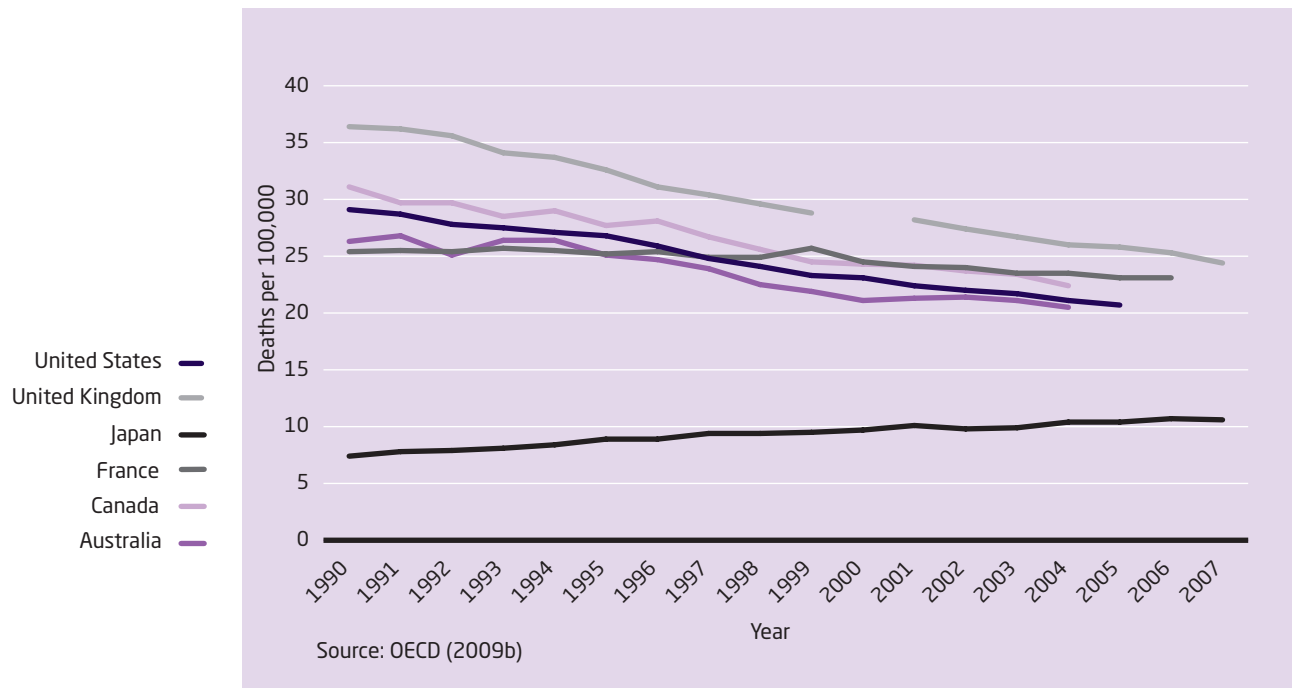
Since 1997 the government has maintained, and slightly expanded, the existing screening programmes for breast and cervical cancer, and this has shown a positive impact on diagnoses of breast cancer. The government has also introduced programmes for colorectal cancer, chlamydia and diabetic retinopathy, although some progress is still needed in these areas.

According to an international survey of primary care physicians, the United Kingdom has one of the most comprehensive systems in the developed world for routinely calling patients for vaccinations and screening appointments (Commonwealth Fund 2006).

We now consider in detail developments in screening in the following areas:

- breast cancer
- cervical cancer
- bowel cancer
- chlamydia
- diabetic retinopathy
- vascular risk checks.

Figure 17 Deaths per 100,000 females from breast cancer, selected OECD countries, 1990-2007



We then go on to look at immunisation.

Breast screening

Since 1997 more women have been screened, leading to a rise in the number of breast cancers detected among younger age groups. Women aged 50–70 years are routinely invited for breast cancer screening every three years. Before April 2001, this programme was only for women aged 50–64. Following its extension, in 2008/9 more than 2.2 million women aged 50–70 were invited for screening (NHS Information Centre 2010a). Numbers of cancers detected has increased for 50–70 year olds from 7.2 per 1,000 women screened in 2003 (when data first became available) to 8.1 in 2006, with a slight fall to 7.8 per 1,000 in 2009.

It is also of note that, among 50–64 year olds, invitations for screening increased by around 25 per cent and take-up increased by almost 20 per cent over a ten-year period up to 2008/9.

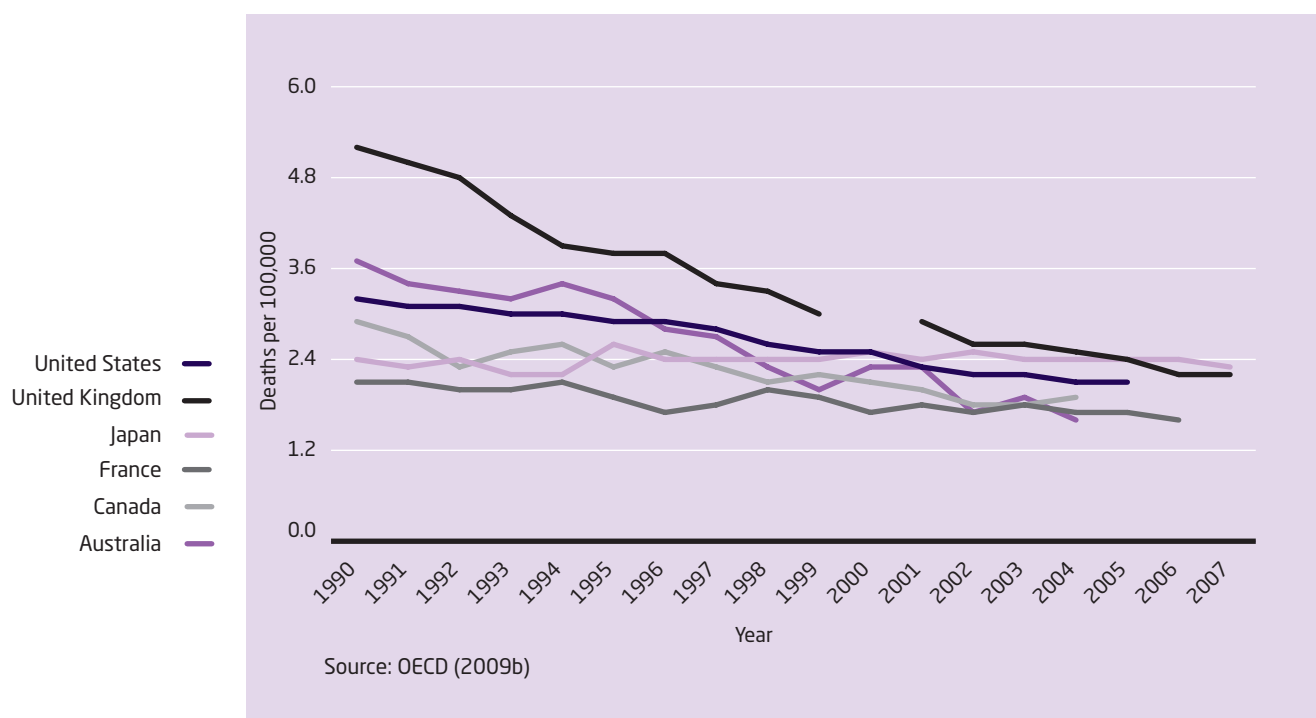
Although breast cancer mortality rates among women are higher for the United Kingdom than other selected OECD countries, there has been a declining trend since the 1990s (see Figure 17 above).

Cervical screening

Today, women aged 25–64 are routinely invited for cervical screening and, depending on their age, are screened every three or five years. The proportion of eligible women receiving cervical screening has improved between 2008 and 2009, rising from 78.6 per cent to 78.9 per cent, but is still lower than in 1999 when it was 82 per cent (NHS Information Centre 2009a).

The mortality rate from cervical cancer (for women of all ages) has fallen from 3.2 deaths per 100,000 in 1999 to 2.3 deaths per 100,000 in 2008 (NHS Information Centre 2009a). The United Kingdom still has a higher mortality rate for cervical cancer compared to

Figure 18 Deaths per 100,000 females from cervical cancer, selected OECD countries, 1990-2007



other selected OECD countries; however, this too has been declining since 1990 (see Figure 18 above).

Bowel cancer screening

Bowel screening for people aged 60 to 69 years was introduced in April 2006, and was rolled out nationwide by December 2009 (Department of Health 2009g). Data is not yet available to show how many people have been screened since the implementation of the programme.

Chlamydia screening

A national programme for chlamydia screening was launched in 2003, aimed at young people under 25. In 2007/8, 4.9 per cent of 15–24 year olds were reported to have been tested, against a target of 15 per cent. The Department of Health then introduced a requirement for primary care trusts (PCTs) to test 17 per cent of their 15–17-year-old populations, which increased testing rates to 16 per cent in 2008/9 (House of Commons Public Accounts Committee 2010). However, this is far short of the level of activity needed to significantly reduce the prevalence of chlamydia in the community (which requires annual testing of 26–43 per cent of young people) and to demonstrate value for money (National Audit Office 2009).

Diabetic retinopathy

The National Service Framework for diabetes set a target that by 2006 80 per cent of people with diabetes should be offered screening for diabetic retinopathy and 100 per cent by the end of 2007 (Department of Health 2001c). The most recent data (for 2007/8) show that this target has not been reached (NHS Information Centre 2008).

Vascular risk checks

In 2008, the government published a programme for more general physical health screening entitled *Putting Prevention First* (Department of Health 2008g). This proposed an NHS Health Check for all people aged 40–74, to identify their risk of CHD, stroke, kidney disease and diabetes. The implementation of the programme began in 2009, with checks being offered by GPs and pharmacists.

Immunisation

The government maintained the existing programme of childhood immunisation, which covered diphtheria; measles, mumps and rubella (MMR); *Haemophilus influenzae* Type B (Hib) and tuberculosis (Department of Health 1996a). Other vaccines have since been added, and at present childhood immunisations are offered routinely to children aged between two months and 18 years against 10 diseases (Department of Health 2009u). Influenza and pneumococcal vaccines are also offered to older people and other vulnerable groups.

Recent figures show a high proportion of children and elderly people being immunised (NHS Information Centre 2009e). For example, in 2008/9, by their 5th birthday, 93 per cent of children had received vaccination against diphtheria, tetanus and polio; 91 per cent received their Hib vaccination; and 74 per cent of people over 65 years received their seasonal 'flu vaccine (which is close to the WHO target of 75 per cent).

The exception is MMR. The decrease in children receiving the MMR vaccine by their second birthday is usually attributed to concerns over a potential link to autism claimed by a research article published in 1998. The Department of Health launched a 'catch-up' campaign in 2008, following a series of measles and mumps outbreaks. The WHO recommends that 95 per cent of children should be immunised to prevent MMR outbreaks: this has not yet been attained. In 2008/9, the figure stood at 78 per cent (the highest level since 1999/2000, when it was 76 per cent) (NHS Information Centre 2009e), compared to 92 per cent in 1995/6 (Harrison and New 1997).

In 2008, the government launched a routine national human papillomavirus vaccination (HPV) programme for girls aged 12–13 years, to protect against cervical cancer. In 2008/9 just over four-fifths of girls (80.1 per cent) had received all three doses of the vaccine (Sheridan *et al* 2010).

Better care of long-term conditions

Early government policy documents on health focused on tackling some of the major problems in the NHS acute sector. It was only with the publication of the *NHS Improvement Plan* in 2004 (Department of Health 2004c) that the needs of those with long-term conditions were put squarely at the centre of the government's reform plans. The Improvement Plan set out the three levels of care needed for those with chronic conditions, adapted from the Kaiser Permanente 'pyramid of care' model in the United States. This envisaged help with self-management for those able to look after their conditions on their own; disease management for those people whose conditions could be looked after by regular contact with a nurse, doctor or other professional; and intensive case management for those with the most complex needs. This approach was later developed into the 'NHS and social care long-term conditions model' (Department of Health 2005c).

To support those who could effectively manage their own condition, the government committed to expanding the Expert Patients Programme (EPP) to all areas of the country by 2008. EPP was adapted from the Chronic Disease Self Management Program,

developed in the United States, and was originally launched on a pilot basis in England in 2003. It trains lay people with experience of chronic care to deliver self-management skills to patients. In 2007, responsibility for its implementation was handed over to a 'community interest company'.

While initial findings from the United States suggested self-management support might reduce use of acute care services, subsequent (and more systematic) research studies in the United Kingdom have shown limited impact (Griffiths *et al* 2007). The national evaluation of EPP found that although patients on the programme had improved confidence in looking after their health ('self-efficacy') compared to a waiting list control group, there were no significant differences in self-rated health measures or use of services (Kennedy *et al* 2007). An evaluation of one self-care programme for arthritis showed that it did reduce levels of anxiety but did not reduce the number of GP visits after 12 months – although this could be because patients felt more encouraged to seek advice about their condition after the intervention (Buszewicz *et al* 2006). Current enrolments fall far short of the target to increase training capacity from 12,000 to 100,000 patients a year by 2012 (Department of Health 2006c).

For those with specific chronic conditions, the government underlined the need for proper support in primary care, and looked to the new GP contract implemented in 2004 and, in particular, the Quality and Outcomes Framework (QOF) (Department of Health 2010f), to deliver improved outcomes for these patients.

QOF rewards practices for performance against 146 indicators relating to ten chronic care conditions. The indicators cover performance in clinical care, organisation within the practice and patient experience. Many of the measures are 'process' measures, requiring that GPs keep a record of data such as smoking status, cholesterol, blood pressure and body-mass index for patients in the relevant disease areas. However, there are also a number of treatment and outcome indicators, such as treatment of chronic heart disease with beta blockers, or achieving low levels of cholesterol or blood pressure.

Evaluation found that achievement of QOF indicators was high in the first year and remained so in subsequent years (Doran *et al* 2006). Outcomes for asthma and diabetes improved more quickly after the introduction of QOF but not heart disease (Campbell *et al* 2007). For certain non-incentivised conditions the rate of improvement has slowed down since the introduction of QOF (Campbell *et al* 2009). However, a 2008 international survey of adults with diabetes in eight countries still found that UK respondents were the most likely of all respondents to report having received four key services associated with high-quality management of the condition (Commonwealth Fund 2008).

Following recommendations from the NAO and the Health Committee that indicators should be based more on outcomes and better informed by cost-effectiveness analyses (NAO 2008c; House of Commons Health Committee 2009a), the government has instructed the National Institute for Health and Clinical Excellence (NICE) to take charge of developing proposals for the clinical and public health indicators in future, to ensure that they are informed by transparent cost-benefit analyses.

For those with complex needs who would benefit from case management, the government piloted the Evercare programme (developed in the United States) which used advanced primary care nurses to look after patients with very complex needs. Evaluation of the pilot found that the nurses were perceived as beneficial by patients and carers, particularly in co-ordinating care and facilitating access to community services, but no significant reductions were found in emergency admissions, bed days or mortality (Gravelle *et al* 2007). Following the pilots, the government committed to provide the support of 3,000 new specialist nurses – so-called 'community matrons' – across all PCTs by 2008, with the

aim of reducing emergency hospital admissions. A target was set to reduce emergency bed days by 5 per cent by 2008, through improved care in primary and community settings for people with long-term conditions (using the 2003/4 baseline).

The most recent data available suggests that by September 2008 there were still only 1,521 community matrons (1,422 full-time equivalent (FTE)) in post (NHS Information Centre 2009f). However, the government estimates that official workforce census data may be an under-count, with some community matrons being counted in other occupational categories, and points out that by 2007 there were also an estimated 1,725 case managers in post, who have the same competencies as community matrons (Hansard 2008). An international survey of adults with chronic conditions conducted in 2008 found UK respondents were more likely than those in any of the other seven countries surveyed to have had a nurse involved in the management of their condition (Commonwealth Fund 2008), indicating that these policy efforts are having an impact on patient care.

In England, the community matron approach has not been significantly associated with a reduction in hospital admissions (Roland *et al* 2005; Taylor *et al* 2005; Gravelle *et al* 2007). However, community matrons (or nurse-led chronic disease management (CDM) programmes) have been well received by patients (Brown *et al* 2008) and have improved service use (Singh 2005; Barnett *et al* 2006). In order to identify the patients who would benefit most from intensive case management The King's Fund, with other partners, developed a software tool to enable better identification of those patients at risk of re-hospitalisation (PARR). This has not yet been evaluated (Ham 2010).

The government has been successful in exceeding its target for a reduction in emergency bed days, with a fall of over 13 per cent between 2003/4 and 2007/8 (Department of Health 2009g).

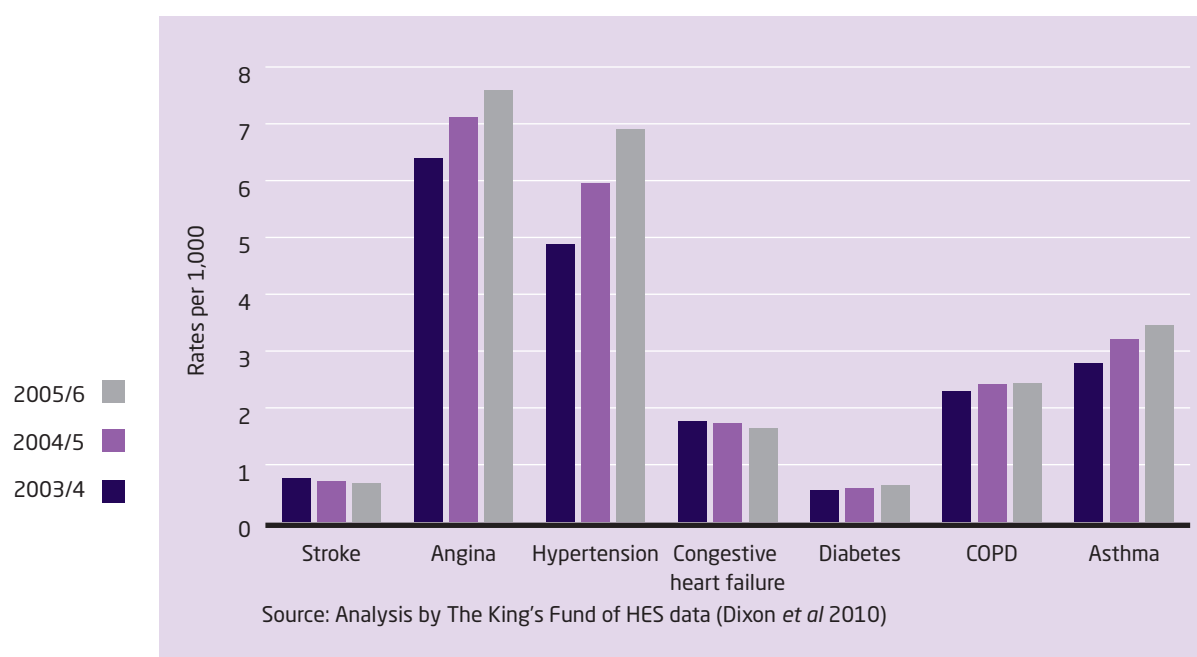
Nevertheless, the year-on-year increase in emergency admissions to hospital (defined as unpredictable admissions to hospital at short notice due to clinical need) more than doubled between 2007/8 and 2008/9 compared to the previous three years. A large proportion of these admissions were patients who were admitted and discharged on the same day or within 24 hours (Robinson 2010) – hence the parallel reduction in emergency bed days.

It is not clear what is driving this increase in emergency admissions. One hypothesis is that complications arising from long-term conditions could be a component. An analysis by The King's Fund of hospital data from 2003 to 2006 shows a rise in the rate of emergency admissions to hospital for patients with conditions such as asthma, hypertension and angina (*see* Figure 19 opposite). This could be a reflection of rapidly rising prevalence or could suggest that management of these conditions in primary care needs to be improved.

The NHS Improvement Plan (Department of Health 2004c) also emphasised the need for health and social care to work together, and for services to be more personalised, but did not set any firm commitments in these areas. The publication in 2006 of the White Paper *Our Health, Our Care, Our Say* (Department of Health 2006c) went further, committing that:

- everyone with a long-term condition or long-term need for support should routinely receive information about their condition, including details of where they can receive self-care support
- people with both health and social care needs would each have a care plan by 2008
- PCTs and local authorities should have in place joint teams to care for those with complex needs by 2008

Figure 19 Changes in emergency admission rates for selected chronic conditions (standardised for age and sex), England, 2003-6



- everyone with a long-term condition in 2010 – around 15 million people – should have a care plan by 2010 (a commitment reiterated in the NHS Next Stage Review (Department of Health 2008d).

Pilots for personal care plans for people with long-term conditions began in selected sites across England in March 2009, and a commitment was made to monitoring their impact in the period up to the end of 2010/11. However, the government is unlikely to meet its target in this area.

More recently, the government has sought to improve the co-ordination and personalisation of health and social care services through individual budgets and direct payments, based on a similar model to the personal budgets already used in social care (HM Government 2007a; Wise 2009; Ham 2010). The piloting of personal budgets in health only started in 2009 (Wise 2009), so it is not yet possible to determine their impact on the management of long-term conditions.

Recognising 'the potential benefits of information technology' has also been identified as a key characteristic of a high-performing chronic care system (Ham 2010). One example is enabling people to be supported at home through the use of 'telecare' (delivering care remotely or in the home using telecommunications and computer systems) and 'telehealth' (exchanging physiological data between a patient at home and staff in a health care setting to help with diagnosis and monitoring). Commitment to developing further assistive technologies that were already in place to support more people at home was outlined in *Our Health, Our Care, Our Say* (Department of Health 2006c). The government announced a Preventative Technology Grant in July 2004, to increase the number of people who could benefit from telecare services, and £80 million in grant finance was committed for two years from April 2006 (Department of Health 2005a). Finally, in May 2008 the Whole Systems Demonstrators programme was launched, to evaluate the piloting of telecare and telehealth in England. Its findings will be published in late 2010.

Looking forward

The government has introduced a range of new measures designed to protect individuals from ill health, and to encourage individuals to take care of their own health.

Reductions in smoking represent the biggest success. The government is on course to meet its targets for reducing smoking rates, and although there is not yet evidence of the health benefits of the ban on smoking in public places, early data from Scotland is promising. However, there is little evidence that existing policies on alcohol misuse and obesity are having any success. Long-term increases in deaths from liver disease, and significant increases in hospital admissions related to alcohol, are cause for major concern. On obesity, while rises among children show some sign of abating, the levels for children and adults alike indicate a huge future burden of ill health.

The question of whether policy should focus on strong state action (in a similar vein to the smoking ban) when it comes to the pricing and availability of alcohol and unhealthy foods, or on individual behaviour change, through information or incentive programmes, will in part depend on the political persuasion of the government in power. But given the scale of the challenge, there is a strong case for saying that a new government will probably need to draw on all available approaches where there is evidence of their effectiveness in comparable contexts.

The increase in screening and vaccination programmes – and the government's systematic approach in this area – is likely to have saved lives. However, the cost-effectiveness of these programmes needs to be assessed, and will depend greatly on the ability to maintain significant levels of take-up across the target groups.

In the area of long-term conditions, the government set out some clear policy ambitions to improve the health of those with chronic diseases. While there have been some successes, for example, high levels of achievement by GPs against the QOF indicators, new programmes of self-care support which are popular with patients, and new models of care for those with complex needs, their impact on health outcomes and service use has remained limited. There has not been a significant shift in resources from acute care to the support of those with chronic conditions and people continue to be admitted to hospital for conditions which could be effectively managed in the community. There remain barriers between primary and secondary care that hamper the delivery of more integrated care for the individual. Given the rising numbers of people with one or more chronic conditions, this is an area that must be given early priority by the next government.

The hope that the NHS and social care would work more closely together to deliver integrated and personalised care to those with complex needs has not been realised. It may be time for a more radical rethink of how health and social care work together to meet the rising needs of our ageing society.

4 Clinical effectiveness

Criterion 4: A high-performing health system delivers services to improve health outcomes in terms of successful treatment, the relief of pain and suffering, restoration of function, and, where these are not feasible, adequate care and support.

Key points

- In 1997, work to improve clinical effectiveness through national, evidence-based guidelines had already begun. After that time, the government extended this approach through the new National Service Frameworks and by setting up the National Institute for Clinical Excellence (now Health and Clinical Excellence) (NICE). Both represented a big step forward in setting evidence-based standards.
- There have been significant falls in mortality from cancer and circulatory disease since 1997. Deaths from suicide are at a record low.
- For cancer, there has been progress in improving the quality of surgery and access to drugs, but adherence to guidelines is variable, as is the timely use of radiotherapy. Mortality and survival rates have been improving but still lag behind other European countries.
- There have been improvements in access to cardiac surgery and recommended standards of stroke care, and these have contributed to falling mortality. However, as with cancer, variations in quality persist within England, and gaps still exist when compared with other comparable countries.
- In mental health services, access to specialist early intervention and crisis resolution teams for acute illness has improved. Progress is needed on care for common mental disorders and dementia.

This section looks at the clinical effectiveness of the NHS in treating sickness and ill health. Judging the clinical effectiveness of care is extremely complex, and measuring it involves using a wide range of indicators, all of which provide only a partial story. For example, survival rates for particular life-threatening conditions will be affected by factors outside the control of the health system, as well as by factors such as access times.

Meanwhile, measures of health care processes can offer some insights into the effectiveness of health care – for example, by looking at whether particular evidence-based procedures for treating particular conditions are followed – but they do not measure the actual clinical outcome. It is also hard to judge how much any improvements in these areas reflect the successful influence of government policy as opposed to independent trends, such as improving medical knowledge and technical capability.

For these reasons, this section presents a range of different types of measures and evidence, aiming to provide some indication of the clinical effectiveness of the NHS.

However, it cannot claim to give the whole picture or to make definitive judgements about the effect of government policy. It focuses solely on three particular groups of conditions: cancer, cardiovascular disease and mental health problems. These three groups of conditions were selected because each one affects between one in three and one in four people at some point in their lives. Together, they cause two out of every three deaths in England, and make up one-quarter of the total expenditure of the NHS (ONS 2009b; Department of Health 2009h). They have also been a major focus of government policy.

The situation before 1997

The focus on clinical effectiveness as a key objective of the health system has a long history. In the early 1970s the pioneering epidemiologist Archie Cochrane argued for more systematic use of evidence for effectiveness (Cochrane 1972). The emergence of clinical audit (Editorial 1974), and the growth of the ‘evidence-based medicine’ movement (Evidence Based Medicine Working Group 1992) were further significant developments.

In 1991, the Clinical Standards Advisory Group was established, to provide independent advice on standards of clinical care to UK health ministers (CSAG 1998). Soon after, in 1993, the government launched a ‘clinical effectiveness initiative’ to promote various sources of evidence, such as *Effective Health Care* bulletins and the work of the Cochrane Collaboration (NHS Management Executive 1993). In 1996 the document *Promoting Clinical Effectiveness* (NHS Executive 1996) set out the government’s vision of improvement through health technology assessments, clinical guidelines and better monitoring of national performance.

For cancer, 1995 saw the publication of a landmark report entitled *A Policy Framework for Commissioning Cancer Services*, by the then Chief Medical Officers in England and Wales, Kenneth Calman and Deidre Hine (Department of Health 1995). The report advocated a restructuring of cancer services, to increase specialisation through major cancer centres, where specialist surgery and other treatment could be provided. It also argued for greater co-ordination of cancer services, through cancer networks. While early implementation was patchy (Haward 2006), the report provided the basis from which the later cancer policy (Department of Health 2000b) would develop.

Though there was no equivalent to the Calman–Hine report in cardiovascular care, a number of studies in the 1990s demonstrated the potential for care to be dramatically improved – thrombolytic treatments, for example, known to reduce mortality from acute myocardial infarction, were routinely available in only just over one-third of accident and emergency (A&E) departments (Hood *et al* 1998), and only about one patient in three was taking a beta blocker after infarction (Bowker *et al* 1996). Estimates suggested that 30,000 deaths from coronary heart disease in the United Kingdom could be avoided if the most effective treatments were used (Capewell *et al* 1999).

Meanwhile, in mental health the trend had been a gradual move away from the large Victorian-era institutions, and towards community-based care. This process started in earnest from the mid-1980s, when the first of the asylums began to close. During the 1990s, a number of high-profile attacks involving people in contact with mental health services fuelled concern that community-based services were not effective. The 1990s also saw a growth in primary care-based counselling services for people with common mental health problems, such as depression and anxiety.

Progress since 1997

Clinical effectiveness has been an explicit aim of government health policy since 1997 (Department of Health 1997). Whether directly or indirectly, most of the major announcements of the White Paper *The New NHS* (Department of Health 1997) and the subsequent NHS Plan – more doctors, new hospitals, National Service Frameworks, regulation – sought to improve the clinical effectiveness of the NHS (Department of Health 2000c). Cancer, coronary heart disease and mental health were among the conditions singled out, with promises to improve services through National Service Frameworks (NSFs) (Department of Health 1999a, 2000a, 2000b). Several other NSFs were also developed for further conditions and patient groups (*see box below*).

National Service Frameworks

Cancer (2000)
 Children and Maternity (2004)
 COPD (in development)
 Coronary Heart Disease (2000)
 Diabetes (2001)
 Long term (neurological) conditions (2005)
 Mental Health (1999)
 Older People (2005)
 Renal (2004)
 Stroke (2007)

The NSFs varied in focus and delivery, but broadly all aimed to set national standards in order to improve quality and reduce unnecessary variations. They also established timetables for progress, and set up processes to measure and monitor performance. National clinical leadership for improvement in each of the NSF areas was then provided in the form of new national clinical directors (the ‘czars’).

As well as publishing the NSFs, the government established the National Institute for Clinical Excellence (now Health and Clinical Excellence) (NICE) to set guidelines for the NHS on clinically effective treatments and to appraise new health technologies for their clinical and cost-effectiveness (Department of Health 1998a).

More recently, clinical effectiveness has been reiterated as central to the policy agenda in the NHS Next Stage Review (Department of Health 2008d). The Review stressed a need for a range of actions to further improve quality, including clinical effectiveness, such as:

- NICE being given a new role to develop ‘Quality Standards’ for particular conditions, building on its existing programme of clinical guidelines
- the development of a central bank of Indicators for Quality Improvement for NHS organisations and clinical teams to use to measure quality
- the introduction of a new measure of clinical effectiveness, the patient-reported outcome measure (PROM), to measure how patients themselves report their quality of life changing as a result of clinical procedures
- commitments to publish more information on quality to the public, through Quality Accounts and on the NHS Choices website.

The impact of the initiatives announced in the NHS Next Stage Review is not yet clear.

We now go on to look at progress within the key areas of cancer, cardiovascular disease, mental health.

Our analysis here includes some international comparisons (usually relating to the United Kingdom as a whole, rather than England). It is important to interpret these with caution, as making such comparisons is by no means straightforward. Problems include differences in data, definitions, time lags and methodological issues, and often a dearth of evidence about what might cause perceived variation between countries and what to do about it.

(Nolte *et al* 2006).

Cancer

Cancer mortality has declined significantly, and is on track to meet the target for a 20 per cent fall in cancer death rates in people under 75 by 2010 (Department of Health 2009e). Decline in smoking among men is thought to be the main contributor to falling rates in male lung cancer, while the progress in declining mortality rates for breast and cervical cancer reflects improvements in screening and treatment (Cancer Research UK 2009b).

Cancer survival rates – in particular, five-year survival rates for some of the common cancers – have improved significantly, as shown in Table 6, below (Department of Health 2009e). However, improvements in survival vary significantly by cancer type. Whereas survival for testicular cancer and breast cancer has improved dramatically, survival for lung, oesophageal and pancreatic cancer has seen barely any improvement (Cancer Research UK 2009b).

Table 7 Age-standardised relative cancer survival, England

		2000	2003	2007
Colon	1 year (men)	69.5	69.9	73.0
	1 year (women)	67.6	67.9	70.4
	5 year (men)	47.6	48.9	53.4
	5 year (women)	47.6	49.2	52.7
Rectum	1 year (men)	76.4	77.1	79.3
	1 year (women)	75.6	75.8	77.7
	5 year (men)	49.6	51.9	54.3
	5 year (women)	51.2	53.6	56.0
Breast	1 year	95.1	96.0	96.6
	5 year	80.6	83.7	86.0
Prostate	1 year	92.5	94.4	95.8
	5 year	71.4	81.5	86.2

Source: Department of Health (2009e)

There is also notable variation in survival, by location. Looking at one-year survival rates, primary care trust (PCT)-level data for breast, colorectal and lung cancer reveals considerable variation across the country. For example, for lung cancer, figures range from 43.7 per cent survival in Kensington and Chelsea to 15.4 per cent in Herefordshire (Department of Health 2009e).

Comparisons between cancer survival rates in England and Europe are hampered by the unavoidable time lag associated with five-year survival rates and differences in the way countries collect data. The major source of data on cancer survival rates is the EUROCARE series of studies – the most recent of which (EUROCARE-4) cover patients diagnosed in 1995–99 (Berrino *et al* 2007) and 2000–02 (Verdecchia *et al* 2007). These show that for the period up to 2002:

- survival for the four most common cancers and ovarian cancer was lower in England than much of the rest of Europe, including the Nordic countries, France and Germany
- England had relatively lower overall survival rates compared to countries with similar expenditure of health
- the gap in survival rates between countries in Europe seem to be narrowing over time.

The time periods covered in these comparative studies mean that they cannot be used as evidence of the effectiveness or otherwise of government strategies for cancer during this period, since the patients in the study were all diagnosed either before, or in the very early days of, the NHS Cancer Plan (Wilkinson 2009).

The NHS Cancer Plan (Department of Health 2000b) contained the main initiatives to reform cancer services. It included:

- waiting times targets (see Section 1, pp 13–22)
- an expansion of the cancer workforce and screening
- reducing variations in the prescribing of cancer drugs
- greater specialisation of surgical treatment for cancer
- use of multi-disciplinary teams to co-ordinate the delivery of treatment and care.

Since 2002 NICE has published a range of cancer service guidance for different cancers (see NICE 2010). Broadly, the range in reported compliance correlates with the dates of publication of the guidelines, ranging from breast cancer at 94 per cent to testicular cancer (diagnosis and assessment) at 53 per cent (National Cancer Action Team 2008).

Clear progress can be seen towards the goal of increasing specialisation of surgery for cancer. This is an important process measure, since surgery carried out by specialist surgeons is thought to be an important contributor to good cancer outcomes (Richards 2009). For example, looking at surgery for prostate and bladder cancer, it is clear that:

- the overall number of prostatectomies and cystectomies has increased greatly, mostly due to the increasing incidence of prostate cancer
- the number of trusts undertaking prostatectomies and cystectomies has fallen from 145 to 119, with the number of trusts undertaking fewer than ten procedures per year (and so unlikely to have considerable specialist expertise) falling from 65 to 22
- the number of trusts undertaking at least 40 major procedures per annum has increased from 5 to 54, and the percentage of all such procedures undertaken in these high-volume trusts has increased from 12 per cent to 77 per cent.

(Source: Adapted from Department of Health 2008a)

A recent study of oesophago-gastric cancer services found that 11 of the 30 cancer networks have still to centralise surgery for these cancers (Palser *et al* 2009). Also, the National Lung Cancer Audit shows that only approximately 10 per cent of patients with non-small-cell lung cancer receive surgical resection, when evidence suggested a rate of around 20 per cent would be clinically appropriate (Department of Health 2009e). Meanwhile, although active anti-cancer treatment (surgery and chemotherapy) is offered to 54 per cent of patients with lung cancer, rates vary between trusts from less than 10 per cent to more than 80 per cent (NHS Information Centre 2009c).

Radiotherapy is another important area of cancer treatment – and one where more progress is needed. Overall, in England, by 2007 between 25 and 49 per cent of cancer patients were receiving radiotherapy as part of their treatment, depending on region. This means that while some areas provide radiotherapy very close to the generally accepted clinical need (around 50 per cent), other areas may be under-using this form of treatment – possibly as a result of later diagnosis (Williams and Drinkwater 2009).

A report from the National Radiotherapy Advisory Group in 2007 (NRAG 2007) estimated that by 2016 England would need approximately 90 new linear accelerator machines (LINACs) to meet clinical need, in addition to the 178 machines that would be needed to replace old machines. The government has recognised this shortfall, and has put a series of initiatives in place to increase radiotherapy capacity – not just by increasing equipment provision but also by developing the radiotherapy workforce and maximising the efficient use of existing machines (Department of Health 2009e).

Finally, cancer drugs have been a major focus of the NICE health technology appraisal programme. Media headlines have been dominated by several high-profile cases in which NICE decided not to approve certain cancer drugs for NHS use, and in these cases clinicians and patient groups have questioned the methodology used by NICE (BBC News Online 2009). Overall, however, the majority of NICE cancer drug appraisals have resulted in approving the drugs in question (*see* Section 1, pp 13–22), and successive studies of the uptake of NICE-approved cancer drugs have shown both that their use is increasing overall, and that variation in their use between areas, while not eliminated, is decreasing (Department of Health 2008a).

Following the near-achievement of the waiting times targets for cancer in 2006, cancer charities and others began calling for an update to the NHS Cancer Plan (Cancer Campaigning Group 2006; Rosen *et al* 2006). In 2007, following a year of consultation and development, the Department of Health published the *Cancer Reform Strategy* (Department of Health 2007a). This document recognised a need for a much greater focus on the beginning and the end of the cancer pathway: early diagnosis, and end-of-life care and support for cancer survivors. This emphasis on early diagnosis reflects evidence that one of the main reasons for England's poorer performance in cancer outcomes relative to other countries is failure to diagnose cancer early enough (Richards and Hiom 2009).

More evidence on the success of the various strategies contained in the NHS Cancer Plan and Cancer Reform Strategy since 2002 will be available next year, when EURO-CARE-5 data is published in 2011 alongside work on international comparisons being led by the Department of Health (Department of Health 2008a).

Cardiovascular disease

The overall target for reductions in mortality from cardiovascular disease was met five years early (Department of Health 2008b). This was a significant achievement. As with the cancer mortality target, the fall in mortality for cardiovascular conditions is thought to be due to a mixture of factors, including much greater prescribing of cholesterol-lowering drugs (statins), people stopping smoking, and improvements in access times for surgery – as well as some improvements in clinical effectiveness, such as more specialist stroke care (Department of Health 2008b; Royal College of Physicians 2009).

International comparisons of death rates from circulatory disease show that the United Kingdom as a whole has experienced a faster decline since 1990 than many other comparable countries. Death rates are now comparable to – and possibly slightly below – those of the United States and Sweden (*see* Figure 20 opposite).

A study ranking European national cardiovascular health care systems ranked the United Kingdom joint first with Norway for procedures. It drew on a mixture of indicators, some of which were not indicators of clinical effectiveness, for example, statin prescribing and ambulance response time. However, the United Kingdom ranked only 11th out of 29 countries for outcomes (Bjornberg and Yazbeck 2008).

Figure 20 Deaths per 100,000 population from diseases of the circulatory system 1990-2007, selected OECD countries



The main government strategies on cardiovascular disease since 1997 were the National Service Framework for coronary heart disease (Department of Health 2000a) and the National Stroke Strategy (Department of Health 2007c).

The National Service Framework for coronary heart disease covered prevention and risk reduction, access and treatment. Its major commitments included:

- rapid-access chest pain clinics across the country
- shorter waits for heart operations, including coronary artery bypass surgery and angioplasty
- improving use of effective medicines after heart attacks
- increased workforce (such as consultant cardiologists and cardiac surgeons).

The National Stroke Strategy was published seven years later. Its major commitments included:

- 20 quality markers and a ten-point action plan, published for commissioners and providers to use locally, to improve their stroke services
- national support for new stroke networks
- increased leadership training and support
- national co-ordination of public and professional awareness campaigns.

NICE's implementation database records evidence about how its guidance is implemented in practice, drawing on a range of sources and using a range of methodologies (NICE 2010). In terms of its guidance on cardiovascular disease, NICE has published 14 reports of guidelines implementation and 24 reports of technology appraisal implementation (some referring to secondary prevention activity). Overall, two of these showed that practice was not in line with guidance; 14 showed doubts about impact, or mixed impact, in practice; nine showed that practice was in line with guidance, and the remainder were either awaiting grading or not graded (NICE 2010).

Looking at one specific element of care – the management of heart attacks – the Myocardial Ischaemia National Audit Project (MINAP) collects and analyses data in this area. Its most recent report showed evidence of improvements against a range of quality indicators, as shown in Table 8, overleaf (MINAP 2009).

Table 8 Performance against quality indicators from the Myocardial Ischaemia National Audit Project, England

	2007/8	2008/9
Number of patients treated with primary angioplasty	4035	7351
Percentage of patients treated with primary angioplasty within 90 minutes of arrival at hospital	79	84
Percentage of patients receiving thrombolytic treatment within 60 minutes of calling for help	71	72
Percentage of patients prescribed aspirin following a heart attack	98	98

Source: MINAP (2009)

Overall, a recent study of access to cardiac care procedures in the United Kingdom commissioned by the British Cardiovascular Society, the British Heart Foundation and the Cardio and Vascular Coalition found that there was a ‘significant year-on-year increase in access to cardiac interventions (numbers and population rates) over the six year period from 2000 to 2006/07 for the UK as a whole and for each of the four countries’ (Oxford Healthcare Associates 2009, p 19).

In England, the increases included:

- revascularisation (angioplasty and coronary artery bypass grafts), by 71 per cent between 2000 and 2006 and valve surgery, by 47 per cent between 2000 and 2006
- new pacemaker implants, by an average of 5 per cent each year between 2002 and 2007
- new implantable cardioverter defibrillator implants, by an average of 8 per cent each year between 2002 and 2007.

Table 9 Compliance with quality indicators from the Sentinel Stroke Audit, England, 2004-8 (%)

Quality indicator	2004	2006	2008
Treated for 90% of stay in stroke unit	N/A	51	59
Screened for swallowing disorders within the first 24 hours of admission	64	67	74
Brain scan within 24 hours of stroke	Not comparable	43	57
Commenced aspirin by 48 hours after stroke	68	71	85
Physiotherapy assessment within first 72 hours of admission	65	72	85
Assessment by an occupational therapist within 4 working days of admission	N/A	50	68
Weighed at least once during admission	52	57	73
Mood assessed by discharge	46	54	66
Rehabilitation goals agreed by the multidisciplinary team	69	76	87
Average for the nine indicators	N/A	60	73

Source: Royal College of Physicians (2009)

In terms of stroke care, the Sentinel Stroke Audit reports performance against nine standards of care. The latest results, for 2008, show considerable overall improvements in the quality of care for stroke between 2004 and 2008 (*see* Table 9 above).

While this demonstrates some significant progress, there is much further to go before there is consistently high-quality stroke care for all patients. For example, the most recent audit found that at 69 sites, fewer than 5 per cent of patients accessed care that met all nine standards, and only three sites were consistently delivering high-quality care to all patients (Royal College of Physicians 2009).

Mental health

The National Service Framework for mental health (Department of Health 1999a) created three new specialist service models for people with severe mental health problems:

- crisis resolution and home treatment teams
- assertive outreach teams for community support
- early intervention teams for young people with first-time psychosis.

There was also a focus on improving the support offered to people with common mental health problems (who are supported largely in primary care). Graduate primary care mental health workers were introduced, to conduct assessments and deliver brief psychosocial treatments to people with less severe problems within general practice, while gateway workers provided specialist mental health input into primary care teams. An international survey of primary care physicians in 11 countries conducted in 2009 found that doctors from the United Kingdom were more likely than any others to report routinely using written treatment guidelines for the treatment of depression (Commonwealth Fund 2009).

The 2005 Labour manifesto contained a pledge to improve access to psychological therapy for common mental disorders (Labour Party 2005). Psychological therapies such as cognitive-behavioural therapy have been shown to be as effective as anti-depressant medication for mild-to-moderate depression, and are preferred by some patients, but availability of these therapies has been poor. The Improving Access to Psychological Therapies (IAPT) programme seeks to address this by training an additional 3,600 therapists by 2010/11, and establishing a new network of services closely linked to primary care (Department of Health 2008e).

As with other clinical areas, the creation of NICE has increased the amount of guidance available on the most effective and cost-effective ways of delivering mental health care. The effectiveness of a variety of new medications and psychosocial interventions has been reviewed, and clinical guidelines have been produced covering most diagnostic categories, including depression, anxiety, schizophrenia, bipolar disorder, obsessive compulsive disorders, eating disorders, and substance misuse.

A great many additional strategies have been implemented since the NHS Plan. A recent example is the National Dementia Strategy (Department of Health 2009l), which aims to increase awareness of dementia, promote early diagnosis, and improve the quality of care provided. Another is the Delivering Race Equality programme, which aims to tackle variations in the access to and experiences of mental health services by people from different ethnic groups (Department of Health 2005b).

Also during this period, the legal framework controlling when and how a person can be detained for compulsory treatment of mental illness has undergone a major overhaul, with the passage of the Mental Health Act 2007. Among other changes, this introduced community treatment orders, through which a person can be subject to compulsory treatment while living in the community.

Judging the effectiveness of mental health services is complicated by the fact that the mental health system serves multiple aims, which are often in tension with each other, and which different groups of people prioritise differently (Rogers and Pilgrim 2001). They include:

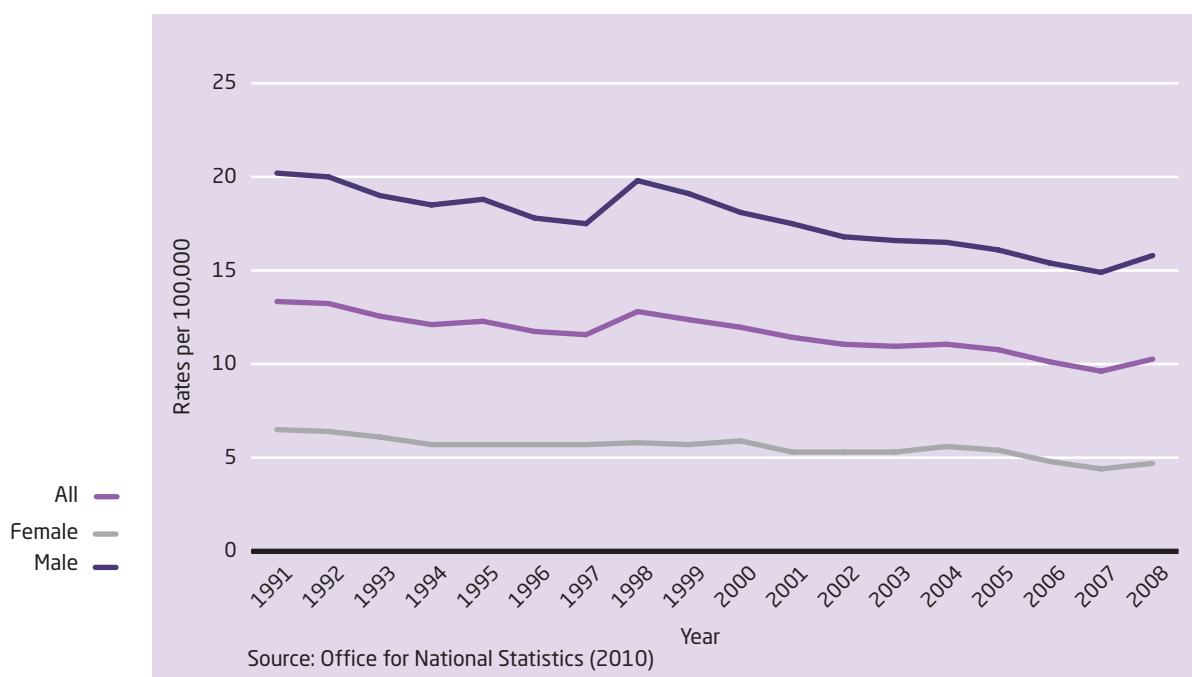
- curing or improving symptoms of mental illness
- improving the quality of life of people with mental health problems
- controlling risky behaviour and protecting the public.

Here, we focus on clinical effectiveness defined in terms of the first two of these aims – particularly the first (curing or improving symptoms of mental illness).

Evaluations of the three new specialist service models introduced by the NHS Plan suggest that these approaches have had some success in achieving their primary aims in relation to acute mental illness, as follows.

- **Crisis resolution and home treatment teams** have reduced admission to hospital during crisis by around 10 per cent, increasing to over 20 per cent in areas where a 24-hour service is available (Glover *et al* 2006; Johnson *et al* 2005a, 2005b).
- **Assertive outreach teams** have been more effective than standard community services in engaging hard-to-reach client groups, in terms of the quality and quantity of contact with staff (Killaspy *et al* 2006).
- **Early intervention in psychosis teams** appears to have reduced admissions and improved patient engagement relative to normal care (Craig *et al* 2004; Birchwood *et al* 2007).

Figure 21 Age-standardised suicide rates per 100,000 population for England, 1991-2008

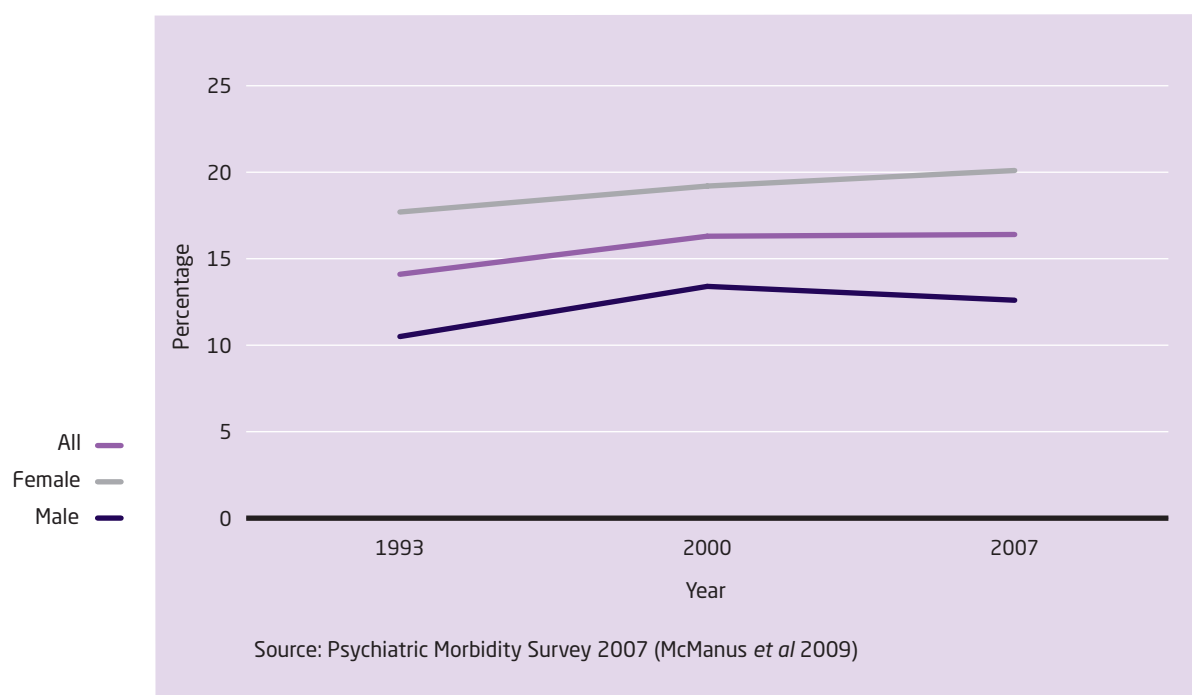


Nevertheless, there is no evidence to suggest that these improvements have translated into increased clinical effectiveness. The studies cited above found no differences between the new service models and standard community care in terms of clinical symptoms, social functioning or quality of life. In some cases, this is not surprising. For example, the relatively brief period of intensive support offered by crisis teams might not be expected to have a detectable effect on symptoms. It is also important to note that the new models have all been associated with higher levels of patient satisfaction.

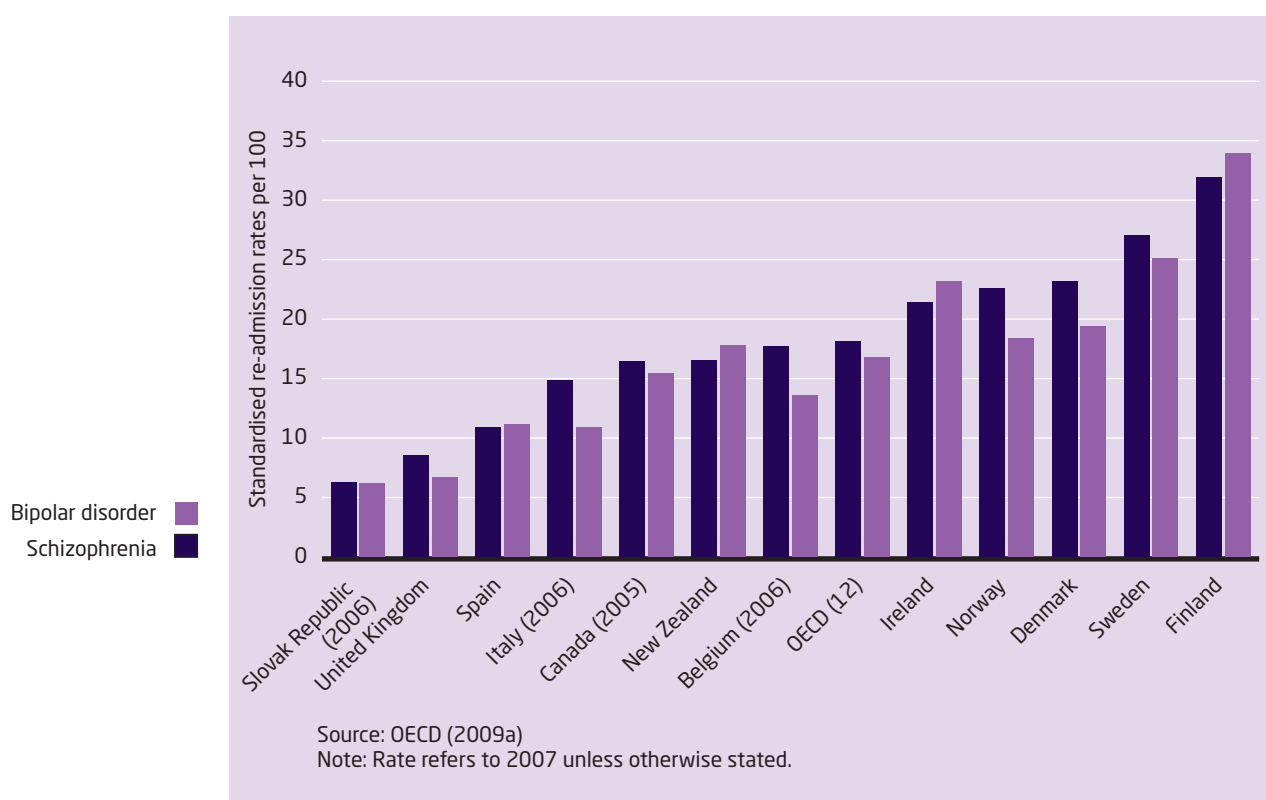
The impact of the introduction of graduate mental health workers into primary care has been limited by problems with training, supervision arrangements and retention (Harkness *et al* 2007). The only randomised controlled trial to date failed to find any effect on clinical symptoms, although this was only a small pilot study (McMahon *et al* 2007). In terms of its scale, the Improving Access to Psychological Therapies programme seems more likely to have an impact on the effectiveness of primary mental health care. Initial evidence suggests the new services established are offering effective treatments for anxiety and depression, although no trial data is available yet (Clark *et al* 2009). Given that in the past many of the patients seen by IAPT services would have received minimal treatment or none at all, this seems to be an advance.

It has been argued that although a number of new types of mental health services have been introduced since 1997, these new services 'have grown inside the old system' (Rankin 2005, p 48), and that beneath the high-profile changes, much core mental health practice remains relatively unchanged, and is not always based on evidence about what is effective. For example, there is little high-quality evidence on the effectiveness of acute inpatient wards (Gowers and Rowlands 2005). There is some evidence that residential alternatives to inpatient wards may be cheaper and more acceptable to some patients (Lloyd-Evans *et al* 2009). Further research on the clinical effectiveness of standard wards versus residential alternatives is needed.

There is evidence that the impact of NICE guidelines in mental health has been variable, with some guidelines having a profound impact on practice and others causing limited change (McAllister-Williams *et al* 2006). In some clinical areas, access to effective

Figure 22 Percentage of population in England meeting criteria for one or more common mental disorder

interventions recommended by NICE is limited. For example, research suggests that the majority of children and adolescents with diagnosable mental health problems are not provided with effective treatment (Meltzer *et al* 2003; British Medical Association's Board of Science 2006).

Figure 23 Psychiatric re-admission rates in OECD countries, 2007

Suicide rates have been used as a marker for the quality of mental health care. On this measure there has been success, with suicide levels falling to historically low levels (National Mental Health Development Unit 2009), as can be seen in Figure 21 above. This reflects the role of mental health services and the impact of specific measures to reduce suicide (for example, reducing access to lethal means).

Data from the national psychiatric morbidity survey suggests that the prevalence of most adult mental health problems have remained broadly static since 1997 (McManus *et al* 2009). However, in the case of common mental health problems (such as anxiety or depression) there is evidence of a rise between 1993 and 2000, but no change between 2000 and 2007 (*see* Figure 22 opposite).

This is encouraging. However, it is difficult to draw conclusions from such data on the effectiveness of mental health services, since the prevalence of mental health problems is influenced by many things in addition to mental health care. Meanwhile, there is some evidence that childhood mental health problems have become more common, although only as part of a long-term trend since the mid-1970s (Collishaw *et al* 2004).

Rates for most mental health problems are predicted to remain static for the foreseeable future. The one important exception to this is dementia, which is expected to increase by 61 per cent over the coming decades, from 58,000 in 2007 to 94,000 in 2026 (McCrone *et al* 2008). It is therefore of concern that the National Audit Office has concluded that the government's current strategy for dementia 'lacks the mechanisms needed to bring about large scale improvements' (NAO 2010).

In terms of international comparisons, it is difficult to compare the effectiveness of mental health care in England with that in other countries as there is so much disparity between the service structures of different countries. The OECD has used re-admission rates for schizophrenia and bipolar disorder as a comparative measure of the effectiveness of care for people with severe mental illnesses. On this measure, the UK performs very well, with lower rates of unplanned re-admissions than most OECD countries (*see* Figure 23 opposite).

This data tells us little about the effectiveness of services for people with common mental disorders such as depression and anxiety. However, England compared favourably to other European countries in a recent review by the World Health Organization (WHO 2008a), which highlighted the huge growth in community services in England over the past 10 years. It is one of the few countries in Europe with widespread specialist mental health input into primary care as well as a comprehensive network of assertive outreach, early intervention and crisis resolution services.

Looking forward

For all three groups of conditions considered in this section, mortality has declined and services have improved substantially over the period 1997–2010. The availability of many evidence-based treatments has risen, and clinical outcomes in some areas have undoubtedly improved, although in mental health there is limited evidence that services are more effective overall. However, there are many areas where performance, and more worryingly, outcomes vary around the country, and where England's performance remains below that of other comparable countries.

Since 1997 there has been a much greater policy focus on clinical standards and guidelines. It is not possible to obtain a full picture of how well this guidance is being implemented, but evidence from the national clinical audits, reviews by the Care Quality Commission, academic research, studies carried out by NICE, and other implementation studies tend to suggest that implementation can vary significantly. NICE has developed

a range of advice and tools to help PCTs and hospitals to implement their guidance, including detailed costing templates, commissioning guides, and implementation consultants. A future administration will need to continue to support the NHS in commissioning and delivering evidence-based high-quality care in line with national clinical guidance.

Alongside this, the NHS Next Stage Review has prioritised the greater use and publication of data on clinical effectiveness, both within clinical teams and at organisational level, to drive quality improvement.

Soon, there will be a new source of information on clinical effectiveness: patient-reported outcome measures (PROMs). Initially, these will provide information about patients' own assessment of the effectiveness of their treatments in four surgical procedures. However, the intention is to extend them to a wide range of services. It is hoped that they will form an important part of the information that clinicians and organisations use to judge the clinical effectiveness of their services and identify opportunities for improvement.

There is good evidence from areas such as cardiac surgery that professionally driven, rigorous reporting and benchmarking of clinical performance can enable and drive clinicians to improve their relative performance, and reduce unjustified variations in care. This is especially the case where the link between outcomes and clinical practices is well understood. For this reason it will be important for a new government to work closely with professional associations such as the royal colleges, and with frontline clinicians, to make sure the drive for greater measurement of clinical effectiveness receives sufficient investment, reaches clinicians and commissioners, and is actually used to improve care.

5 Patient experience

Criterion 5: A high-performing health system delivers a positive patient experience. This includes giving patients choices and involvement in decisions about their care, providing the information they need, and treating them with dignity and respect.

Key points

- In 1997, the importance of delivering a patient-centred service had been established, but there were no systematic attempts to measure progress. Since then, the NHS has transformed its ability to understand what patients think about services, by creating one of Europe's largest surveys of patient experience.
- Surveys have found that while overall patient ratings of care are positive for hospital, primary and community mental health services, there has been almost no change over time. Progress still needs to be made in relation to choice, involving patients with their care and some aspects of the hospital environment. Results are worse for users of inpatient mental health services, and there are systematic differences by age, self-rated health status, ethnic group and region.
- A future government will need to ensure that progress is made in improving experiences for all patients, and that local NHS trusts invest in surveys that improve care, particularly if resources are constrained.
- Overall public satisfaction with how the NHS is run has improved steadily in the past few years.

It is now common among health systems worldwide to judge the quality of care not only by measuring clinical quality, but also by collecting the views of the patients receiving treatment. For example, the World Health Organization defines a high-performing health system as one that should be 'responsive to people's needs and preferences, treating them with dignity and respect when they come in contact with the system' (WHO 2008b, p 2).

There is a potentially wide range of attributes contained within the idea of a 'positive patient experience', but all hinge on the capacity of the health system to treat a patient as a person (Goodrich and Cornwell 2008). Research has shown that patients who use the NHS value fast access to care, good clinical outcomes and safe services. Patients also value other qualities relating to the way care is delivered, many of them deriving from the personal interaction between staff and patients (Leatherman and Sutherland 2007; Richards and Coulter 2007).

We have chosen to explore progress in four main themes in relation to the way patients experience the NHS: being offered some choices and involvement with decisions about care; having access to valuable information; being treated with respect and dignity; and perceptions about cleanliness. We also review trends in overall patient experience and public satisfaction with the NHS.

The situation before 1997

Concern about whether the NHS delivered a responsive and patient-centred service took root in the 1980s, with the promotion of the idea of the patient as a consumer and the need for greater choice and responsiveness – not just in health, but across public services (Klein 2006). The Patient's Charter (HM Government 1991) exemplified this focus on the patient as a customer, stating that 'You can expect the NHS to respect your privacy, dignity and religious and cultural beliefs at all times and in all places' (HM Government 1991, p 3).

Although the Conservative government had clearly articulated the values underpinning more patient-centred care, there was little progress in measuring whether they had been implemented – partly because in the 1990s the art of measuring patients' experiences was still in its infancy. There is evidence that local trusts had begun to conduct their own surveys (drawing on expertise from the United States, where consumer surveys were most developed), but in England there were few examples of large-scale surveys that systematically explored patients' experiences (in addition to general 'satisfaction' levels) that allowed robust comparisons between trusts (Bruster *et al* 1994).

Progress since 1997

In its 1997 White Paper *The New NHS: Modern, Dependable*, the government promised a new national survey to be carried out annually at health authority level, 'to enable the health service to measure itself against the aspirations and experience of its users, to compare performance across the country and to look at trends over time' (Department of Health 1997). The creation of this national survey programme is an achievement in its own right – particularly when compared with Europe, where surveys on a similar scale have come into existence only more recently (Delnoij 2009a; Garratt *et al* 2008).

The first national survey took place in 1998, and focused on patient perceptions of GP services (Department of Health 1999b). More surveys followed, covering patients with cancer and coronary heart disease (CHD). Meanwhile, the first trust-level national surveys were introduced and commissioned by the Department of Health (with some central funding to cover developmental costs) and conducted by the Picker Institute and the National Centre for Social Research (NatCen), with survey costs being met by trusts.

Responsibility for co-ordinating and publishing most of the national surveys subsequently passed to the regulator, which in its current form is the Care Quality Commission (CQC). The CQC publishes a full range of surveys covering inpatient, outpatient, emergency and mental health services, along with some surveys of specific services, such as maternity and diabetes. The Department of Health also organises and publishes a regular survey of GP patients.

The national surveys currently ask a wide range of questions (between 50 and 100) from a sample of about 850 patients at each trust across England who have recently used NHS services. The surveys ask about timely access, trust in health professionals, perceptions of cleanliness and involvement in decisions, as well as whether a patient was treated with an appropriate degree of respect and privacy. The results are published by the CQC and the Department of Health.

Overall trends in patient experience

There has been little change in overall measures of patient experience over time. As part of the public service agreement (PSA) targets, which were set in 2002 and renewed in 2004 and 2007, the Department of Health needed to deliver 'sustained national

improvements in NHS experience' (HM Treasury 2004). To monitor this target, the government has simplified the data from the surveys, combining results into one aggregate score. Four out of five service areas have registered slight improvements in the 'overall score' derived from the patient experience surveys over time (*see* Table 10 below). What is striking about these results is the comparative lack of change since 2002, with the only clearly rising trend (albeit modest) coming from community mental health services.

Table 10 Changes in national patient experience aggregate scores, 2002-2009

Survey	2002/3	2003/4	2004/5	2005/6	2006/7	2007/8	2008/9
Inpatient	-	75.7	-	76.2	75.7	75.3	76.0
Emergency	75.0	-	75.8	-	-	-	75.7
Primary care	77.1	76.9	77.4	77.0	-	77.5	-
Mental health (community)	-	74.2	74.7	74.5	75.2	75.6	-
Outpatient	76.9	-	76.7	-	-	-	-

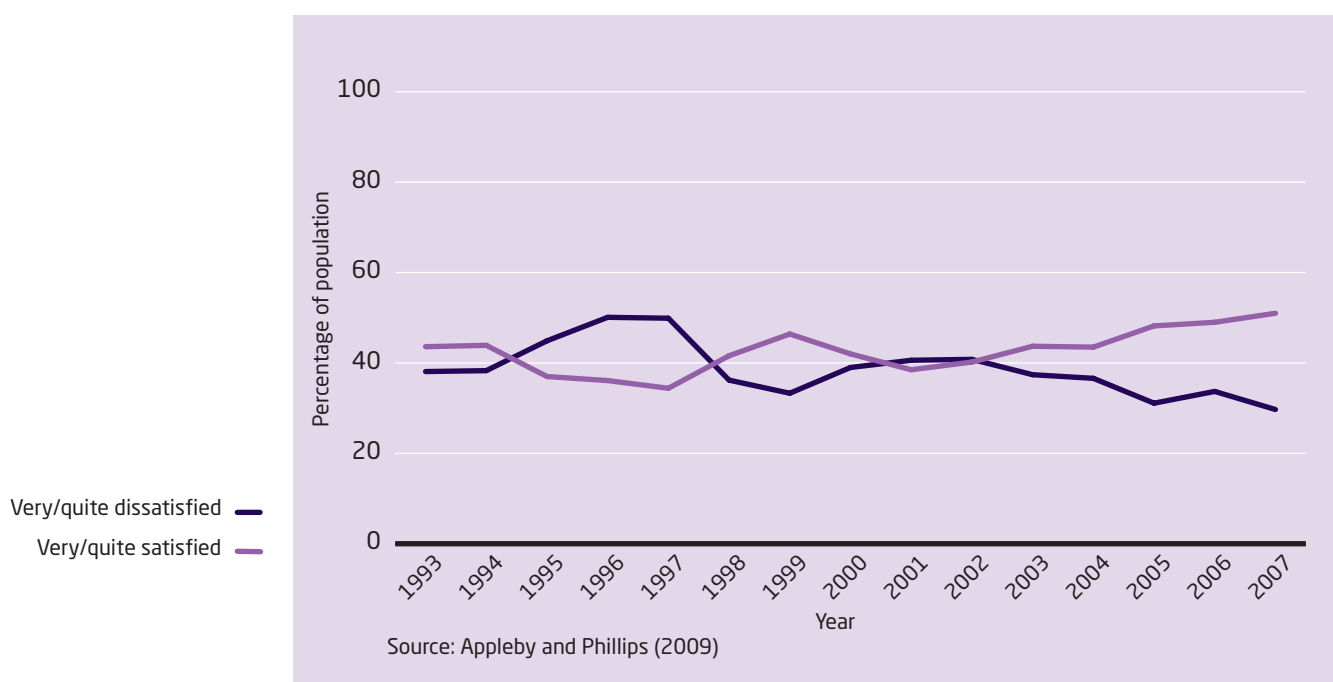
Sources: Department of Health (2009d, 2009r)

Overall trends in public satisfaction in the NHS

Although the government's focus has been on understanding patients' experiences of the NHS, it is worth reporting the findings of a long-running survey of public attitudes to the NHS, the British Social Attitudes Survey, conducted by the independent National Centre for Social Research. Since 1993 overall satisfaction with the NHS has improved: the proportion of those reporting that they are very or quite satisfied with how the NHS is run began to exceed those who are very or quite dissatisfied from 2002 (*see* Figure 24 below).

This represents the longest period of continuous increase in the proportion saying they were satisfied since the survey began in the early 1980s. For those surveyed who have had contact with the NHS, satisfaction rates tend to be higher: in 2007 56 per cent of people who had recent contact with the NHS said they were satisfied with inpatient services

Figure 24 Public satisfaction with the way the NHS is run, 1993-2007



compared with 47 per cent of people who had had no recent contact (Appleby and Phillips 2009).

Understanding the satisfaction data in relation to how well the NHS is performing is difficult, as satisfaction can be driven by many factors that are unrelated to health system performance, for example underlying expectations of public services or the way the NHS might have been portrayed in the media. An international comparison of public satisfaction with health systems conducted by the World Health Organization in different European countries found wide variations: over 70 per cent of people in Austria said that they were very satisfied with their health system, while at the other extreme only 10 per cent of people in Spain agreed (in the United Kingdom 35 per cent were very satisfied) (Bleich *et al* 2009). The researchers point out that there are wide variations even between countries that have very similar health systems and outcomes and they estimate that patient experience accounts for only 10 per cent of the variation (Bleich *et al* 2009).

Variations in experience

There are variations in experience both across countries and within England itself.

In terms of how patient experience in England compares with that of other countries outside the United Kingdom, a study of eight European countries published in 2005 sampled views from members of the public who had consulted a doctor in the past 12 months about the quality of their communication with doctors, involvement in treatment decisions and choice of provider (Coulter and Jenkinson 2005). The United Kingdom ranks among the top two or three countries for five of the seven questions, with lower-half rankings for patients' reported expectations of involvement with treatment opportunities, and reported opportunities for choices about health care.

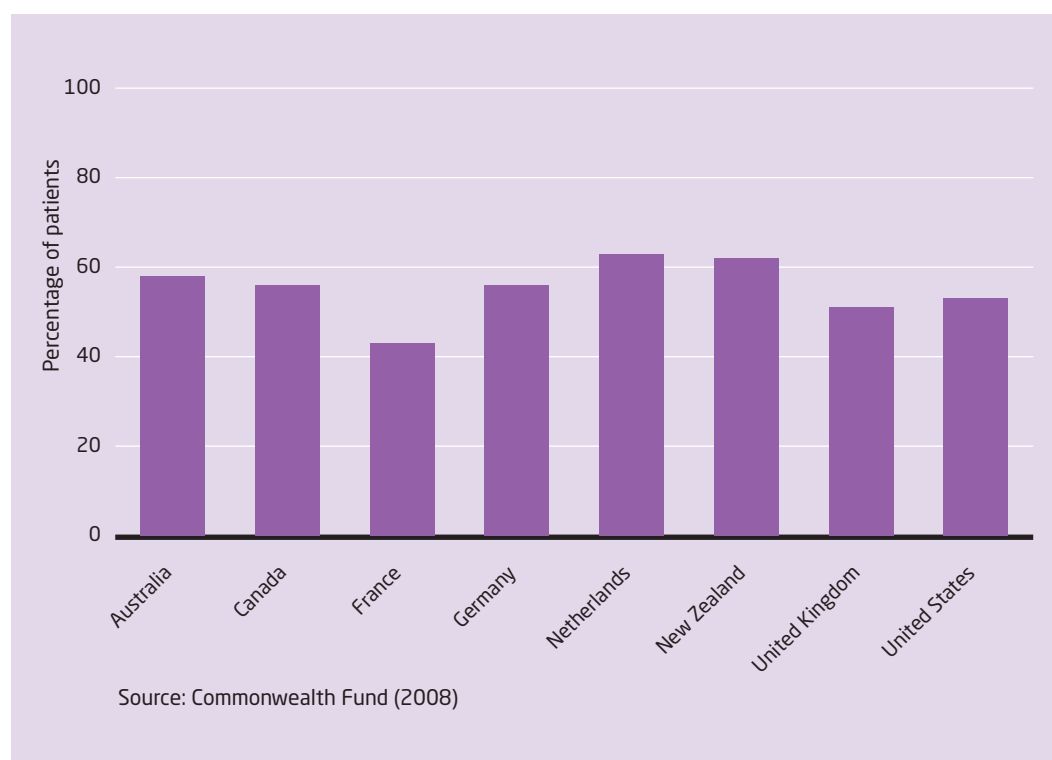
Another source of comparison is the US-based Commonwealth Fund, which has conducted a range of surveys, in a selection of developed countries, including the United Kingdom since 1998. In 2008 patients' views on the health system overall are broadly positive: patients from the United Kingdom were much less likely than patients from most other countries to say that the health system needed to be 'rebuilt completely' (only 12 per cent compared to 33 per cent of patients in the United States and 26 per cent in Germany) (Commonwealth Fund 2008).

However, a review of Commonwealth Fund surveys in 2004 and 2005 found that patients from the United Kingdom were less positive on many of the indicators of care exploring access and quality of communication than patients in other countries, although there were some exceptions. UK patients were more likely to have used telephone helplines and receive reminders for regular screening but less likely to have had access to information about the surgeon who carried out their operation and less satisfied with their choice of surgeon (Coulter 2006).

The most recent international survey of adults with chronic illness suggests that the United Kingdom is still outperformed by most countries in relation to involving patients in decisions and giving information (*see* Figure 25 opposite).

Within England, there are persistent differences in patient experience responses, by region. In London, patient experience is consistently poorer than in other areas of the country (Commission for Healthcare Improvement 2004). Research has shown that this 'London effect' also extends to some other surveys of public experience of other services, raising a concern that it is similar to the 'age effect', whereby older people consistently report better experiences than younger people, to a degree that has required the CQC to routinely adjust the results by age.

Figure 25 Proportion of patient reporting their doctor always involves them in treatment options and decisions



There is also evidence of persistent variations between groups. The former regulator, the Healthcare Commission, found in three consecutive analyses of national patient surveys between 2003 and 2006 that:

- younger patients were consistently more negative than older patients
- patients with a self-reported disability, or in poor health, were more likely to report a negative experience of health care services
- patients from black and minority ethnic groups were more likely than other patients to report negative experiences of some aspects of care – particularly around involvement with decisions, although in other areas, there were no differences and in some questions, black and minority ethnic patients were more positive.

The results at trust level reveal considerable variation. For example, in response to a question about patient involvement, in the best-performing trust only 26 per cent of patients reported insufficient involvement compared to 67 per cent of patients in the worst performing trust (Richards and Coulter 2007, p 20).

Questions have also been raised about the ability of patient surveys to pinpoint failures in quality in some trusts. In two recent cases of poor performance – the outbreak of *Clostridium difficile* in Maidstone and Tunbridge Wells NHS Trust, and the problems in the emergency department of Mid Staffordshire NHS Foundation Trust – the patient survey results showed these trusts in the bottom 20 per cent for some survey questions, but not all (Healthcare Commission 2009b, p 34; Healthcare Commission 2007, p 39). In the case of Maidstone and Tunbridge Wells, the Healthcare Commission's report notes that patients rated rooms and bathrooms as 'clean' while the Commission's own investigation found very poor hygiene (Healthcare Commission 2007, p.46).

Performance in specific domains

Choice and involvement with decisions

The promotion of greater choice for patients has been a priority for the government since 2001. Most effort has been focused on delivering greater choice in where to be treated. However, according to the Department of Health's survey of public opinion, other dimensions of choice, about whether to be treated at all, and, if so, how to be treated, are a higher order priority (*see* Table 11 below).

Table 11 Public's ranking of the importance of choice, involvement and other dimensions of NHS services

The NHS should:	Important (%)	Needs improvement (%)
Involve patients in decisions about their condition/illness or treatment	76	51
Treat patients with respect and dignity	59	39
Listen to the views and opinions of patients	47	46
Offer patients choice in the treatment they receive	46	36
Offer patients choice in their appointment date and time	42	38
Give clear information on what services are provided	38	41
Treat all people fairly	37	25
Offer patients choice in the services they can use	31	29
Offer patients choice of hospital	31	26
Offer patients choice of doctor	31	25
Focus on what patients want	24	28
Give clear information on the quality of services provided	21	27

Source: Department of Health (2003a)

Choice of where to be treated

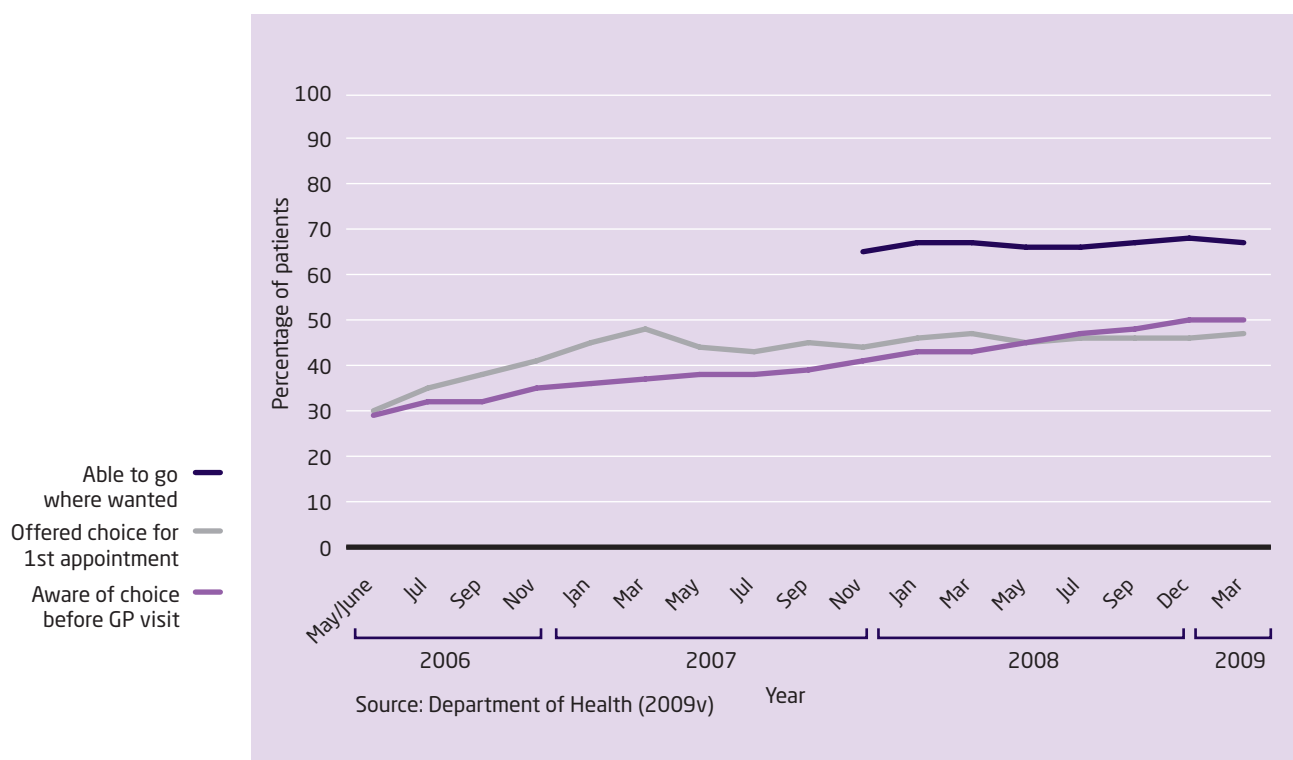
The available evidence suggests that a limited proportion of patients are exercising an active choice about where to have their hospital treatment.

Since January 2006, all patients referred by their GP for a non-urgent outpatient appointment should have been given a choice of hospital. To assess performance against the delivery of this target, the government ran a national survey of patients, between May 2006 and March 2009 (Department of Health 2009v). Patients who had recently attended hospital outpatient appointments were asked whether they remember being offered a choice of hospital, and whether they were aware that they had a choice.

In the most recent survey, run in March 2009, just under half (47 per cent) of patients surveyed remember being offered a choice – a rate that has remained static for two years (*see* Figure 26 opposite). There has been a gradual increase in the proportion of patients aware that they had a choice. Of those who had been offered a choice, 67 per cent were able to go where they wanted (Department of Health 2009v, p 6)

A question about choice of hospital is also included in the National Inpatient Survey (Picker Institute Europe 2009a). The most recent results shows a slight rise in the proportion of people saying that they had been offered a choice of provider in the past

Figure 26 Percentage of patients aware of choice, offered a choice of hospital and able to go where wanted for first appointment, 2006–9



two years – from 28 per cent to 33 per cent – with the rest (67 per cent) saying ‘no’ (Picker Institute Europe 2009a, p 4).

It should be noted that both surveys are administered several weeks after the discussion about choice might have taken place (either with a GP, other care professional or call centre), and there have been concerns that not everyone might remember a discussion about choice.

Choice of treatment

Choice about treatment mostly takes place at the level of the individual clinical encounter, and falls within the realm of clinical autonomy. It is up to clinicians to decide what treatments are appropriate for patients, and medical guidance makes clear that communication – rather than choice – is a core duty: ‘Respect patients’ right to reach decisions with you about their treatment’ (General Medical Council 2006).

For the most part, this interaction between patient and clinician has not been the subject of central policy initiatives to increase choice of treatments rather than adherence to nationally agreed standards. There are a few exceptions in which some degree of choice has been promoted – for example, in maternity services (over choice of pain relief), end-of-life services (treatment intensity) and mental health (the option to access talking therapies). However, progress has been slow, and most initiatives to actively increase treatment choices are relatively recent.

More choice in maternity services was a Labour manifesto promise in 2005. In 2007, the government set out plans to offer all women more choices, including choice of pain relief during childbirth (Department of Health 2007b). The government has only recently begun to monitor primary care trust (PCT) compliance, and the results are not yet published. However, in a survey conducted in 2007 the Healthcare Commission found that 64 per cent of women ‘definitely’ received the pain relief they wanted, and 28

per cent reported that they had the pain relief they wanted ‘to some extent’ (Healthcare Commission 2008, p 35)

Another 2005 manifesto promise was to increase choice at the end of life. The End of Life Strategy, released in 2008, promised more choice about the type and intensity of treatment leading up to death (Department of Health 2008c).

A review by the National Audit Office of end-of-life services in 2008 found that there had been some progress in recording the choices that patients make, according to a survey of PCTs conducted for the report (NAO 2008a) (*see* Table 12 below). However, it also found that there was some way to go in ensuring that these choices were honoured: 88 per cent of PCTs did not record whether patients’ wishes had been followed. Of the minority that did (17 PCTs), an average of 72 per cent of patients were able to die in the location of their choice (NAO 2008a). Details about treatment intensity are not recorded.

Table 12 Performance of PCTs on recording patients’ end-of-life choices

Type of choice	Recorded for ‘all patients’ (% of PCTs)	Recorded for ‘some patients’ (% of PCTs)
Treatment intensity at end of life	43	65
Choice of location of death	18	82

Source: NAO (2008a)

Another key area of choice is mental health. Increasing choice for users in treatment for anxiety and depression was one of the objectives of the Increasing Access to Psychological Therapies (IAPT) programme, launched nationally in 2008 following a series of pilots. The programme was intended to ensure that the NHS followed National Institute for Health and Clinical Excellence (NICE) guidelines on the treatment of depression and anxiety. These recommended greater use of a range of talking therapies, with a target that the programme should be rolled out across half of the country by 2011 (Johnson 2008), and active involvement of patients in choosing therapies.

Monitoring of the IAPT programme has only recently begun, and the progress to date is still modest: the proportion of people with depression and/or anxiety disorders who are offered psychological therapies had increased from 3.4 per cent in the fourth quarter of 2008/9 to 5.36 per cent in the first quarter of 2009/10 (Department of Health 2009d).

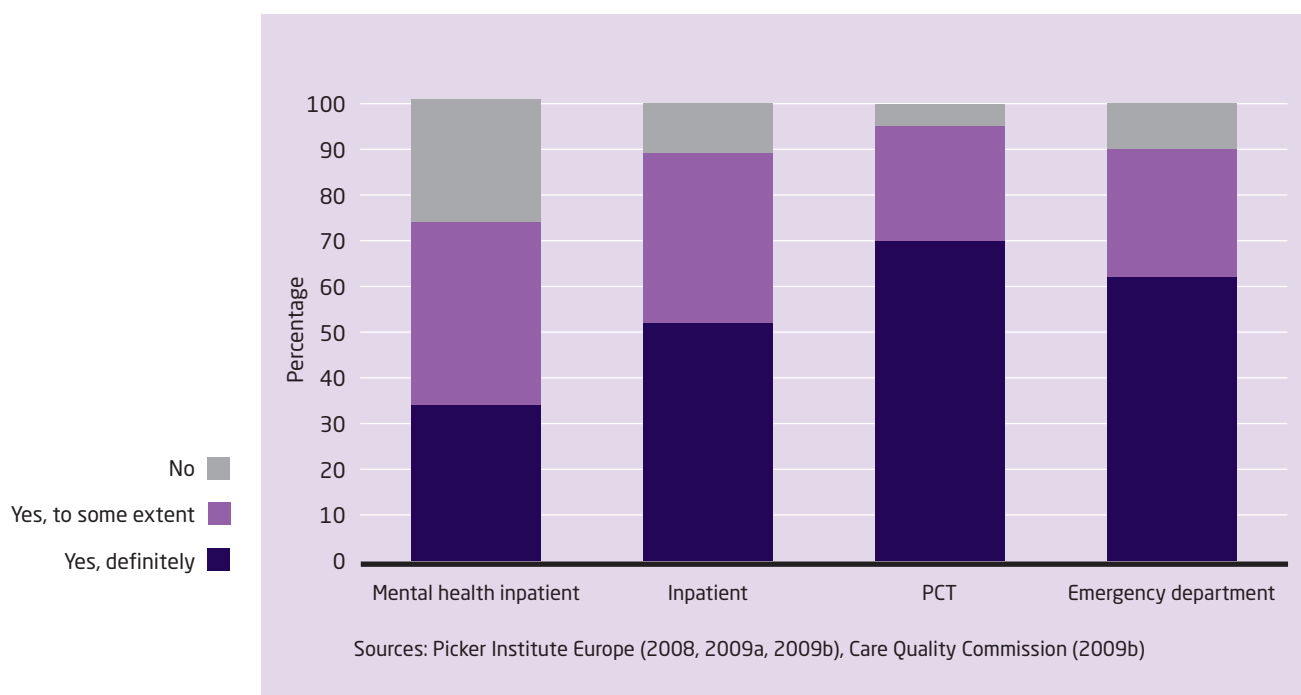
Involvement in decisions

Closely related to the idea of choice is the need to be involved in decisions about care. This dimension of the patient experience is routinely explored in all the national patient surveys, and the results suggest that there is still some progress to be made. While 70 per cent of patients using primary care services said they ‘definitely’ were involved as much as they wanted to be in decisions about their care, the proportion was much lower for inpatients – particularly inpatients at mental health trusts (Picker Institute Europe 2008; Care Quality Commission 2009b) (*see* Figure 27 opposite).

Access to information

Research with patients and the public has established that the provision of ‘clear, comprehensible information’ is a priority (Richards and Coulter 2007). This might include information on conditions and side-effects from drugs, as well as information about services. Since 1997 there has been a significant expansion in the range of patient information and the way it is delivered. The provision of information is now a ‘duty’ under the NHS Constitution (Department of Health 2009q).

Figure 27 Responses to the question 'Were you involved as much as you wanted to be in decisions about your care and treatment?', selected services, 2008



NHS Direct, launched in 1998, provides health information as a way of accessing health advice. NHS Direct's health information is now available on NHS Choices – a website launched in 2007 that provides additional information on the quality and location of GPs, hospitals and other care providers.

It is clear that there has been a rapid growth in the public's use of these resources, according to the annual reports of both NHS Direct and NHS Choices – particularly so after NHS Direct's online content was moved to NHS Choices in November 2008. Visits to NHS Choices grew by 242 per cent between April 2008 and March 2009 (NHS Choices 2009).

Assessments of how effective and useful this information has been for patients and the public are somewhat limited. Both NHS Direct and NHS Choices quote positive user feedback in their annual reports. There is currently no publicly available independent evaluation of how patients are using the information, and whether they find it useful. A patient survey conducted for The King's Fund found that only 4 per cent had used NHS Choices to make a choice about where they wanted to be treated – consistent with findings from the Department of Health's own research (Robertson and Dixon 2009).

At the same time, much health information is delivered to patients by health care professionals, and the effectiveness of this is measured through the national patient surveys. In the most recent inpatient survey, 21 per cent of patients said that 'not enough' information was given to them about their condition or treatment, compared to 15 per cent of emergency department patients (Picker Institute Europe 2009a, 2009b).

Meanwhile, users of primary care services are asked about the information they are given when receiving medicines. In 2008, 22 per cent of patients said they received some information about the side-effects of medicine 'but would have liked more' while a further 19 per cent of patients reported that 'I got no information but I wanted some' (Picker Institute Europe 2008). Nearly half (48 per cent) of mental health inpatients said they did not receive information about the possible side-effects of medication in a way they could understand (Care Quality Commission 2009b).

Problems with communication and information do form a significant proportion of patient complaints, suggesting that this is an area that may require more action (see Table 13 below).

Table 13 Ten leading causes of complaints about hospital and community services, England, 2008/9

Causes of complaint	Number of complaints
All aspects of clinical treatment	37149
Appointments, delay/cancellations	12102
Attitude of staff	11332
Communication/information to patients	8970
Admissions, discharge and transfer arrangements	4473
Other	3872
Aids and appliances, equipment premises	2055
Transport	1450
Patients' privacy and dignity	1351
Personal records	1047

Source: NHS Information Centre (2009b)

Respect, dignity and privacy

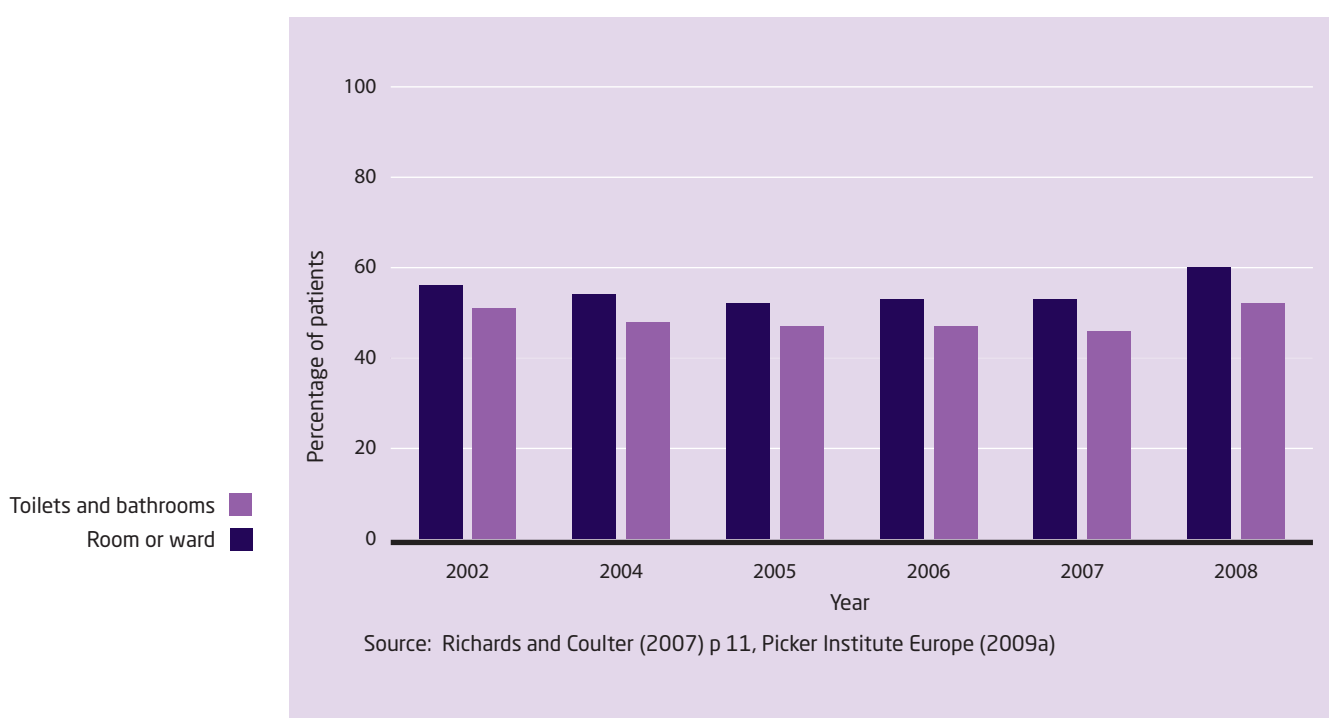
Patients using hospitals as outpatients and inpatients, and users of mental health inpatient and primary care services are all asked direct questions about being treated with respect and dignity (although the available responses are phrased slightly differently for each service). Inpatients are asked, 'Overall did you feel you were treated with respect and dignity?'. In 2008, 79 per cent said 'yes, always' and only 3 per cent said 'no'. Users of primary care services were even more positive: 93 per cent said their doctor treated them with dignity and respect 'all of the time' in 2008 while only 1 per cent said 'no' (Picker Institute Europe 2008, 2009a).

But there is a contrast with users of inpatient mental health services: only 56 per cent reported that the nurses 'always' treated them with respect and 69 per cent thought that psychiatrists always did so, while the proportions saying 'no' were much higher than for inpatient services (10 per cent and 9 per cent respectively) (Care Quality Commission 2009b; Picker Institute Europe 2009a).

Overall responses to questions on privacy for hospital inpatients were similarly positive, but some of the more detailed questions reveal a more nuanced picture. On the subject of mixed-sex wards (a long-running but currently unfulfilled Labour manifesto pledge), 24 per cent of inpatients in 2008 reported sharing a room with a member of the opposite sex (only 1 per cent improvement since 2006), which 32 per cent said bothered them. There was also an increase in the proportion of inpatients reporting being bothered by noise at night – from 37 per cent in 2005 to 39 per cent in 2008 (Picker Institute 2009a). The 2009 CQC census of people who use mental health services, *Count Me In*, states that overall, 67 per cent of respondents were not in a single-sex ward – similar proportions as in 2007 and 2008, while 19 per cent of men and 24 per cent of women did not have access to toilet or bathing facilities designated for single-sex use (Care Quality Commission 2010a, pp 28–30).

Cleanliness

There has been little change in the proportion of patients using general practices or health centres who report that the facilities are 'very clean' – a figure that in 2008 stood at 72 per

Figure 28 Proportion of inpatients who said facilities were 'very clean'

cent (Picker Institute Europe 2008). A lower proportion of inpatients rated their rooms, wards, bathrooms or toilets as 'very clean' (see Figure 28 above). However, as can be seen, last year's results do represent an improvement, particularly in relation to patient perceptions of clean bathrooms and toilets, which had been on a gradual decline since 2002.

Local impact of patient experience surveys

A central objective of the government's patient experience programme has been to encourage individual NHS organisations to use the data to improve services. The Commonwealth Fund's most recent survey of primary care doctors found that the United Kingdom substantially outperformed the other ten countries with 96 per cent of physicians reporting that the practice routinely receives and reviews data on patient satisfaction and experience (Commonwealth Fund 2009).

Many hospital trusts are conducting their own patient experience surveys. In the National Inpatient Survey (2008) there has been a slight increase in the proportion of patients who said they were asked for their views on the quality of their care while in hospital— from 6 per cent to 9 per cent between 2002 and 2008 (Picker Institute Europe 2009a, p 74).

A survey conducted by the regulator in 2007 explored the value and use of the national patient survey in 27 trusts in England (Reeves and Secombe 2008). The study found that nearly all trusts had used the survey results in 'action plans' for improving care, although not all of these had necessarily been translated into concrete improvement projects. Some trusts reported using the national surveys as templates for their own local questionnaires.

Among the perceived barriers to greater use of the patient experience surveys were low levels of clinical engagement and concerns that trust-level results were too general to be of use to improve quality at ward or specialty level (Reeves and Secombe 2008).

The Department of Health is encouraging NHS trusts to improve the quality and frequency of measuring patients' experiences, including using new technologies to collect 'real time' patients' experiences to feed directly back into practice (Coulter *et al* 2009).

Looking forward

This selective review of efforts to improve patients' experiences of the NHS has found a mixed picture. On the one hand, the government deserves credit for having set up a national programme of surveys that is among the first and most comprehensive of its kind in Europe. Overall patient experience scores are high and public satisfaction as a whole has been improving steadily since 2002. Patient experience has been built into regulation and many trusts are routinely monitoring survey results.

On the other hand, the surveys have revealed several weaknesses, including limited progress in delivering greater choice of treatments, information about care, involvement with decisions, problems with aspects of privacy for inpatients, and especially mental health inpatients.

A future government will have to address these weaknesses. At a national level, a decision needs to be made about whether current national targets to improve patient experiences are meaningful, given the absence of change in most indicators over time. It may be preferable to focus instead on improving the experiences of those with the most negative reports, or reducing the variations across England.

Some thought must also be given to the scope of the national surveys. The current framework may be too broad to yield answers that help trusts pinpoint areas that need improvement, while missing out altogether dimensions that are important to patients, such as the continuity of care as patients pass from one organisation to another.

The importance of using patients' experience to regulate and performance manage the quality of care has been firmly established since 1997. But there are concerns that patients' views are not gathered often enough to alert the regulator to incipient failures in quality. Equally, if targets are replaced by financial incentives that reward trusts for positive patient experiences, then the surveys that underpin these need to be detailed enough to reflect an accurate picture of what most patients are experiencing. However, it is not clear that it is either feasible or desirable to expand surveys to the degree needed.

It is clear that national surveys are being used at trust or GP level for local quality improvement but it is less clear whether they are being supplemented with other, more detailed surveys and methods of understanding how patients experience services. A future government will need to have better measures of whether trusts are looking at and responding to patient feedback. One immediate challenge for trusts will be to sustain investment in measuring patients' experience given the tougher financial climate. They will also need to ensure that all clinicians understand the value of patient feedback.

In summary, there is clearly more work needed on the two areas that have been identified as being particularly weak: the need for better information and for more involvement for patients – especially those who are more inclined to report negative experiences. The increase in the volume and methods of delivering new information is welcome, but it should not be confused with progress in making that information relevant and accessible to patients.

6 Equity

Criterion 6: A high-performing health system is equitably funded, allocates resources fairly, ensures that services meet the population's needs for health care, and contributes to reducing health inequalities.

Key points

- The government has put in place an overall policy goal of reducing inequalities in health outcomes. Life expectancy has improved for all social groups and infant mortality has also declined for all, but progress has been slower amongst the least well off. As a result, targets to reduce gaps in infant mortality and life expectancy between the most deprived and the average have not been met.
- The basic funding structure of the NHS – a tax-funded system with almost no financial barriers to accessing services – has remained unchanged, and is broadly equitable, especially when compared with most other health systems which have higher user charges.
- Continuing variations in the supply and use of services suggest that access to services is sometimes inequitable – for example, there are more GPs in the more affluent areas. There are gaps in our knowledge about whether all those who need treatment are getting equal access, as this is not routinely monitored in the NHS.
- New legal requirements on the NHS to ensure equitable access for all patients regardless of age, gender, disability, ethnicity, religion and sexual orientation, as well as deprivation, represent a big challenge, not least in terms of data collection and analysis.

The NHS was founded with an explicit aim of removing financial barriers to care, so that access depended on clinical need alone. As the public information leaflet explained in 1948, the NHS was designed ‘for rich or poor... there are no charges, except for a few small items. You are all paying for it, mainly as taxpayers and it will relieve your money worries in times of illness’ (Ministry of Health 1948).

When the NHS was conceived, inequality was chiefly understood as unfair differences between socio-economic groups. Since then, the state has recognised differences between people on the basis of gender, age, disability, ethnic group, religion and sexual orientation, and legislation exists to eliminate discrimination by public bodies such as the NHS. However, for reasons of brevity, this section takes a primarily socio-economic focus.

The NHS aims to ensure equal access for equal need. There are several distinct aspects to this equity.

- **Equity in health outcomes** Health outcomes may vary by socio-economic status, age, gender and ethnic group.

- **Equity in financing the NHS** Funding is judged to be fair if contributions are at least proportionate to income/wealth or progressive (ie, the wealthier bear a greater proportion). Fairness also depends on whether the funds raised are distributed across the NHS according to need.
- **Equity in access** Access to services is judged to be fair if those in equal need have equal access to care and services.

This section examines the government's policies and progress made on these various dimensions of equity.

The situation before 1997

Equity in health outcomes

Before 1997, government had taken no specific action to identify or reduce inequalities in health outcomes. In 1980, the government rejected the recommendations of the Black report on health inequalities (Department of Health 1980), and inequalities were absent from the government's flagship public health programme, Health of the Nation, launched in 1992 (HM Government 1992). Health of the Nation aimed to reduce overall mortality from cancer, heart disease and suicide, but devoted only one page to 'variations' in health among socio-economic groups, and did not establish any policies to address them (Davey Smith and Morris 1994).

Equity in financing

In the 1990s, despite occasional reports from pressure groups calling for a rethink on NHS funding (Warden 1994), there were no fundamental changes to the funding arrangements of the NHS, and it continued to be based on general taxation. However, there were some changes to the other (smaller) sources of NHS funding – namely, direct charges to patients for dentistry and prescriptions. Prescription charges had been rising annually since 1979, above the rate of inflation. Ophthalmic services were privatised in 1989, with vouchers for spectacles and free sight tests offered to the least well off.

NHS funds were allocated according to a formula designed to distribute NHS funds equitably. The formula, originally created in 1976, aimed to distribute resources across the country in proportion to need, rather than following historical patterns of spending (which tended to skew funding towards London and the South East, where there were more hospitals). The formula had been refined in 1995 to extend a better measurement of 'need' to community as well as hospital services (Harrison and New 1997).

Equity in access

Before 1997 there was no routine measurement of this dimension of health service performance, so it is unclear whether the efforts to make funding fairer led to a more equitable provision, or use, of services. However, a 1998 review of academic research into equitable access found evidence that people from poorer backgrounds and from some ethnic groups were not getting access to some specialist hospital services in proportion with their expected needs, or were not receiving adequate preventative services, such as immunisation or screening (Goddard and Smith 1998).

Progress since 1997

We now examine the three aspects of equity (health outcomes, financing and access) to consider the government's progress since 1997.

Equity in health outcomes

Since 1997, the government has put a significant focus on policies to reduce inequalities in health outcomes in sharp contrast with the policies of the previous administration. However, progress has been elusive.

On taking office, the new Secretary of State for Health commissioned a major independent review of health inequalities (Department of Health 1998d). The review recommended that the government prioritise the health of families with children, reduce income inequalities, and improve the living standards of poor households. At this time the NHS was involved in collaborating with Health Action Zones and other area-based local initiatives, such as Sure Start (which offered multi-agency support to families with young children).

The current health inequalities policy took shape from 2001, with the creation of national public service agreement (PSA) targets (*see* the box below). The detail of how these were to be delivered was published in 2003 (Department of Health 2003c). Much of the required action was cross-governmental – for example, improving employment opportunities and reducing teenage pregnancy – but the NHS was given responsibility for specific areas, such as delivering improved smoking cessation services and initiatives to prevent heart disease and other major diseases.

In 2004 the government refined its inequalities policy further, by identifying 70 local authorities and primary care trusts (PCTs) with the worst health and deprivation, which were termed 'spearheads'. In an effort to meet the national inequalities targets, the government gave these areas more intensive support and extra resources. It also set up a national support team at the Department of Health for spearhead PCTs, and created a tool for PCTs to quantify the scale of their local inequalities and estimate the impact of specific policies to reduce them – for example, better-targeted statin prescribing, or smoking cessation services (London Health Observatory 2009). It is not clear how successful the spearhead approach has been. Some additional funding was allocated to spearhead areas (equivalent to an additional £2.33 per head compared with non-PCTs between 2006 and 2008), but it is known that some of this was diverted to resolve the NHS deficit crisis in 2006/7 (Pears 2009). In some activities, spearhead PCTs were outperformed by non-spearhead PCTs – for example, in smoking cessation services (Care Quality Commission 2009a).

PSA inequalities targets

- By 2010, to reduce inequalities in health outcomes by 10 per cent, as measured by infant mortality and life expectancy at birth.
- Starting with children under one year, by 2010 to reduce by at least 10 per cent the gap in mortality between routine and manual groups and the population as a whole.
- Starting with local authorities, by 2010 to reduce by at least 10 per cent the gap between the fifth of areas with the lowest life expectancy at birth (the spearhead group) and the population as a whole.

Source: Adapted from Department of Health (2003b), p 7

The government has published regular updates on the progress against the inequalities targets. The most recent (published in 2008) shows that although life expectancy is improving for all groups, with significant improvements for the least well off, improvement is happening at a faster pace for the better off. This leaves a growing gap between the areas and groups with the best health and those with the worst health. The gap between the spearhead group and the rest of England has also widened both for men and women since 1997 (*see* Table 14 below).

Table 14 Change in gap between life expectancy between spearhead areas and England, men and women 1995/7-2006/8

Life expectancy target: to reduce the gap by 10%	Women	Men
Change in gap since baseline (2007 update)	+11%	+4%
Change in gap since baseline (2009 update)	+14%	+7%

Source: Department of Health (2007), Department of Health (2009n)

In relation to the infant mortality target, the gap has also widened between the groups classified as having 'routine and manual' occupations and the population as a whole since 1997 (*see* Table 15 below). The infant mortality target does not apply to the two groups with the highest infant mortality rates (sole registered mothers and 'other' groups, which includes the unemployed). These groups account for about 18.5 per cent of all infant deaths.

Table 15 Gap between infant mortality rate of routine/manual group and general population, three-year averages, 1997-2008

Year	Relative gap (%)
1997/98 (baseline)	13
2002-4	19
2003-5	18
2004-6	17
2005-7	16
2006-8	16

Source: Department of Health (2009m)

In 2009, the government published its own review of progress on inequalities in the past 10 years. In its own words, these wider inequalities have remained 'stubborn and persistent' (Department of Health 2009w, p 55).

The government has identified various problems in relation to implementing policies to reduce inequalities – including poor co-ordination between PCTs and other government agencies. For example, according to the government's own calculations, nearly 5 per cent of the potential 10 per cent reduction needed to meet the infant mortality target is likely to come from delivering better employment and less crowded housing, which is beyond the immediate control of health services (Department of Health 2009w).

The current targets expire in 2010, so in 2009 the government commissioned another expert report on health inequalities, to review current health inequalities policy and make recommendations about how it should develop in the future (The Marmot Review 2010). The review was briefed to reflect on the learning from past policy on inequalities. The main findings are summarised in the box below.

Marmot review: summary of learning from inequalities policy

- There has been a tendency to focus on lifestyle interventions rather than economic and psychosocial determinants of health.
- NHS funding and effort has been skewed towards treatment in the acute sector.
- There has been poor cross-departmental working at the local and national level.
- There has been poor targeting of interventions at those most in need.
- There has been a proliferation of short-term interventions, with pressure from government for ‘quick wins’.
- The spearhead approach has left out more than half of England’s deprived population.
- The inequalities workforce has been under developed – particularly frontline staff.

Source: The Marmot Review 2010, p 85ff

The Marmot review concluded that the targets have focused effort on the poorest when the ‘gradient’ in ill health affects all but the top group in society. It also found that the emphasis of current policy on mortality overlooked the importance of well-being across the life course, including years lived without disability. In addition, the area-based spearhead approach may have missed a large proportion of deprived people who do not live in areas of concentrated deprivation represented by the spearheads (Marmot Review 2010).

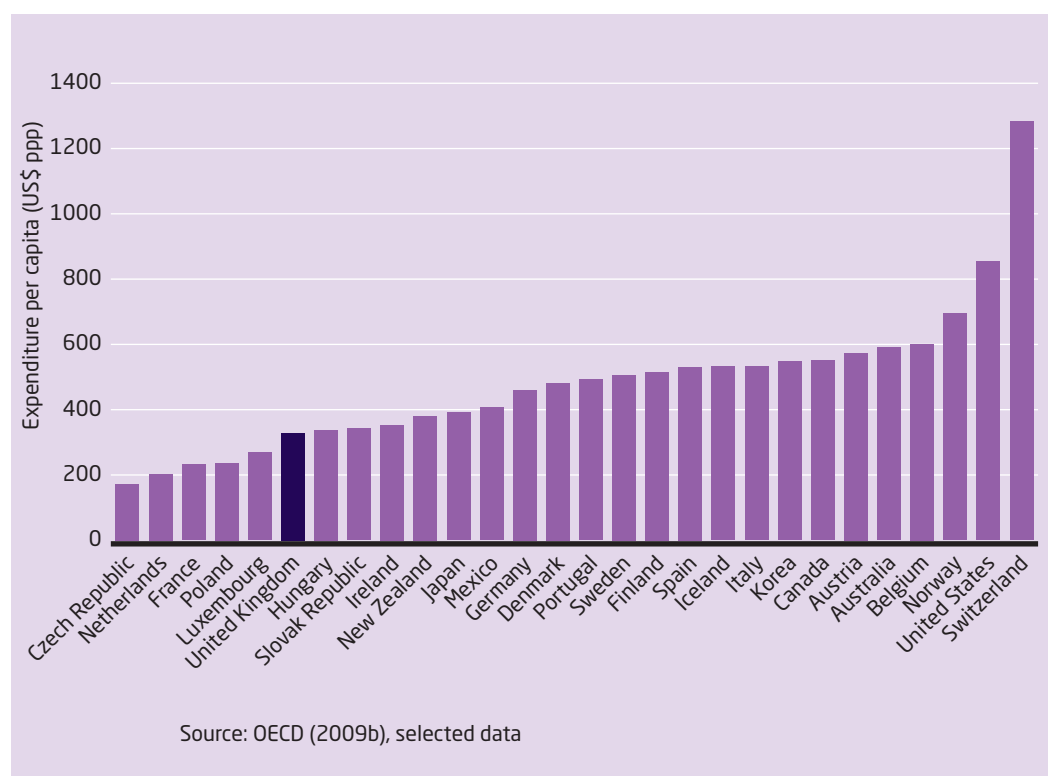
Finally, there is some evidence that despite the presence of targets and central government rhetoric on reducing health inequalities, NHS staff at local level viewed other priorities as much more important, for example, reducing waiting times or achieving financial balance in NHS trusts (Blackman *et al* 2009).

Equity in financing

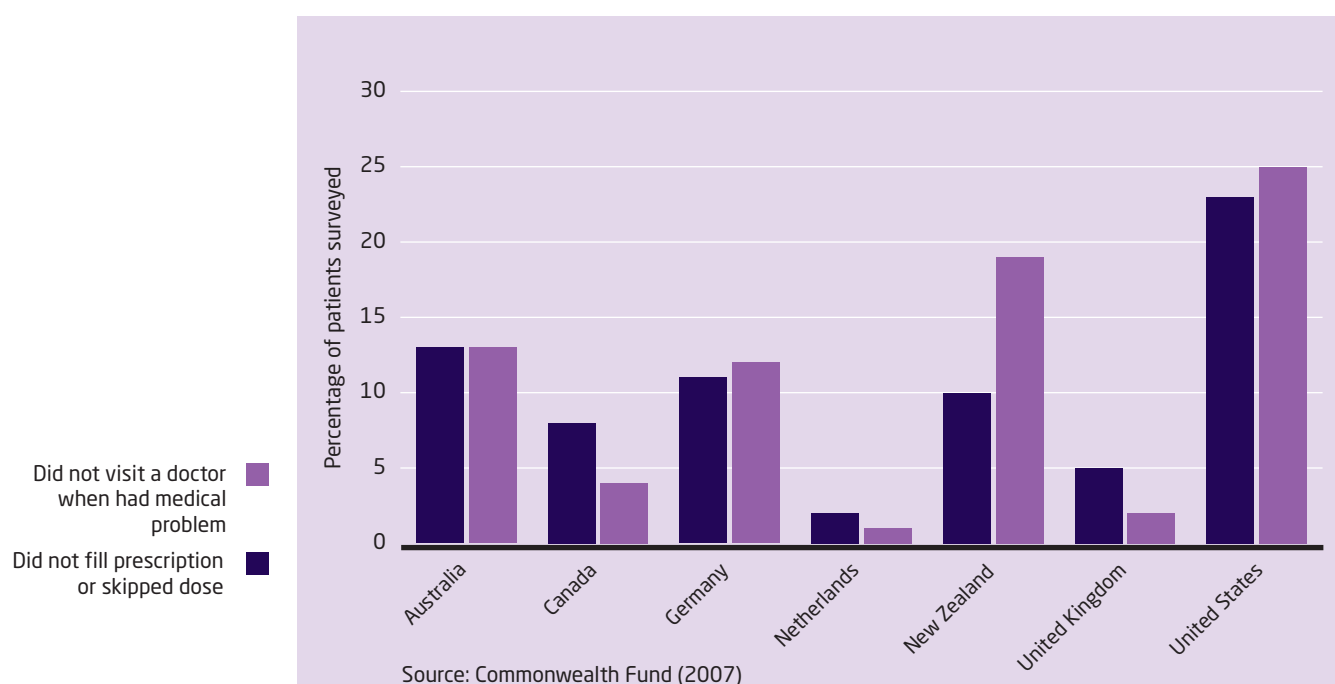
This section looks at two aspects of equity in financing: equity in raising funds, and equity in how funding is allocated.

Raising funds

Most NHS funding continues to come from taxation. Charges for prescriptions and other items contribute to a small proportion of the NHS budget (approximately 3 per cent). Compared with other industrialised nations, the United Kingdom as a whole still ranks as one of the countries with the lowest level of ‘out of pocket’ charges, that is, money spent directly by the patient on drugs and health care services. Figure 29 opposite shows the amount spent by households in ‘purchasing power parity’ US dollars that take account of variations in the price of goods and services.

Figure 29 Out-of-pocket expenditure, selected OECD countries, US\$ Purchasing Power Parity 2006

In England, nearly 80 per cent of prescriptions are exempt from charges, including those for children, the elderly people and people on low incomes and this means one of the lowest rates of financial barriers leading to problems with access: in a Commonwealth Fund survey, only 5 per cent of UK respondents reported having failed to collect a prescription or skipped doses because of costs (*see* Figure 30 below). This is low relative to

Figure 30 Patients reporting problems with prescription costs, selected countries, 2007

other countries, but concern within the United Kingdom over the impact of prescription charges for patients who fall outside the exemption categories has led to their abolition in Wales in 2007 and phased abolition in Scotland (Welsh Assembly 2007).

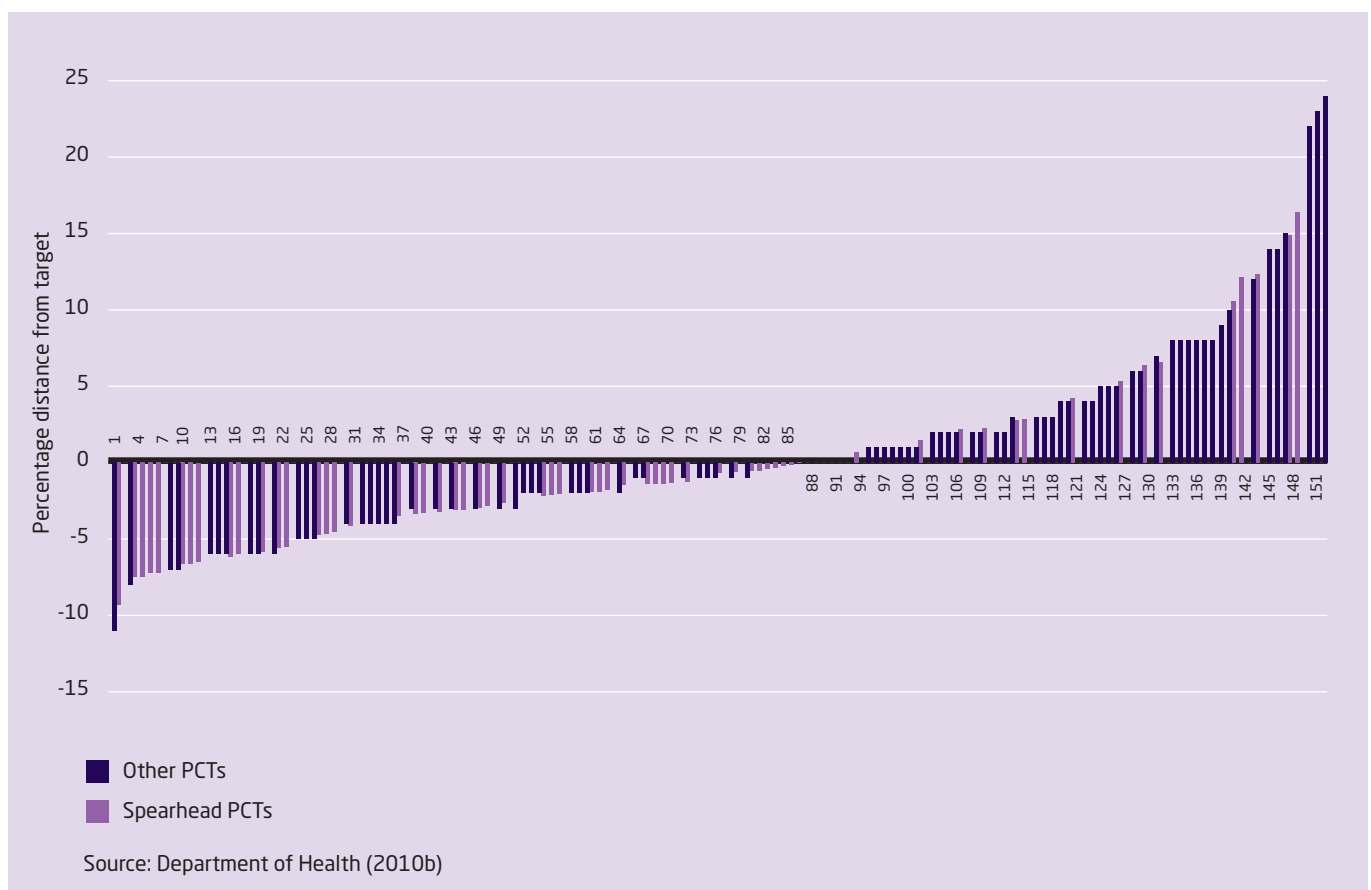
An inquiry in 2006 by the House of Commons Health Select Committee into prescription charges in England found that in addition to being overly complex, there was some evidence that some people struggle to meet prescription charges, despite the exemption system, although it also noted there was an absence of systematic evidence to support this (House of Commons Health Committee 2006b).

Allocation of funding

In 1997, the new administration inherited a funding formula that aimed to distribute funds around the NHS according to need. Since 1997, the formula has been adjusted to take account of unmet need and a health inequalities adjustment for those PCTs with the worst health outcomes (Department of Health 2009w).

One enduring problem with the allocation formula is that historically many PCTs have been receiving substantially more (or less) than the formula suggests. In order to spare local areas from the effects of sudden destabilising shifts in funding, ministers have traditionally dictated how quickly PCTs should be moved to their 'target allocations' (known as the 'pace of change policy'). In most years, including the 2009/10 financial year, funding has been increased by a minimum amount (for example, 5.5 per cent) for all PCTs, with only a small proportion of the overall budget being made available for redistribution between PCTs towards their target allocations.

Figure 31 Distribution of spearhead and non-spearhead PCTs' allocations as a percentage of their 'distance from target'



Research published in 2009 suggested that nearly 70 per cent of spearhead PCTs were below their target funding (Pears 2009). Analysis of the most recent data (*see* Figure 31 on previous page) suggests that a similar proportion (75 per cent) of spearheads were receiving allocations below their target allocation, although a minority are well above target.

Equity in access

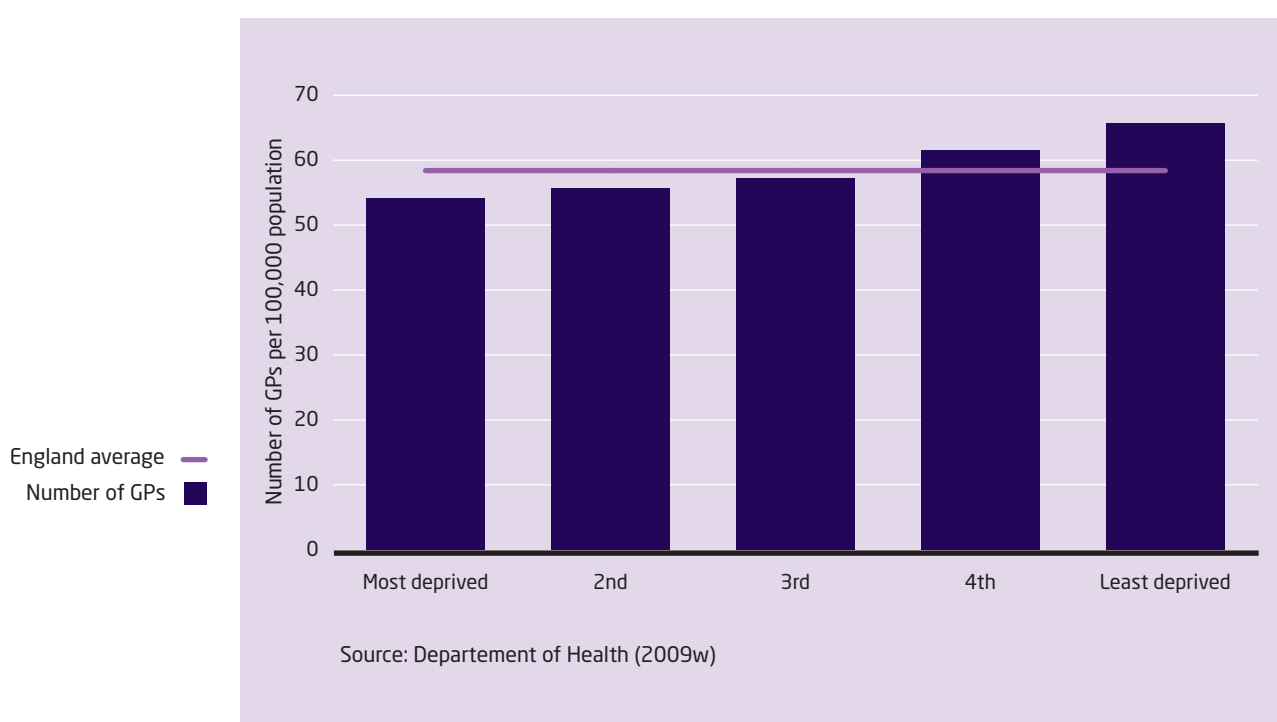
The allocation formula does not specify how resources should be spent locally. For this reason, it has been unable to reverse one of the defining features of the NHS: the unequal geographic distribution of services, that has sometimes seen more services in better-off areas. This inequality predates the creation of the NHS. It reflects the voluntary origins of many hospitals and other services, and has persisted despite numerous government initiatives. Because of the geographical disparities, higher rates of procedures in certain regions may partly reflect a higher concentration of services rather than higher rates of illness.

The NHS Plan (2000) promised action to tackle such ‘inequities in access’, describing how ‘there are 50% more GPs in Kingston and Richmond or Oxfordshire than there are in Barnsley or Sunderland after adjusting for the age and needs of their respective populations’ (Department of Health 2000c, p 107). It also proposed reforms to the funding formula, to include an inequalities element (realised with the health inequalities adjustment) and initiatives to increase the number of GPs in deprived areas.

A report by researchers from the University of York shows a gradually worsening inequality in the distribution of GPs between 1994 and 2006, when their analysis ends (Goddard *et al* 2009). This view is confirmed by the government’s own data for 2005 which shows fewer GPs in the more deprived areas (*see* Figure 32 below).

These figures predate the commitment made in the interim report of the NHS Next Stage Review, published in 2007, to provide 100 new GP surgeries in the 25 per cent of PCTs

Figure 32 Distribution of GPs per 100,000 population, by deprived area, England 2005



with the highest health needs and fewest primary care clinicians (Department of Health 2007d). The research team at York is in the process of evaluating these current policies.

The NHS Plan identified variations in certain types of surgery, by socio-economic group, stating that ‘many deprived communities are less likely than affluent ones to receive heart surgery, hip replacements and many other services including screening’ (Department of Health 2000c, p 107).

A recent review of research studies (some of which pre-date 1997) found some evidence of inequities in access to specialist treatment, although use of GPs seemed to be broadly equitable (Dixon 2007).

Similarly, a recent review of cancer treatment found that patients from more deprived backgrounds were less likely than their better-off counterparts to receive recommended types of surgery for breast and other common cancers (Raine and Wong 2010). This echoes the government’s conclusions in the 2007 Cancer Reform Strategy (Department of Health 2007a), which identified one of the key drivers of higher mortality rates as lower uptake of screening and preventative services, coupled with lower levels of knowledge, among more deprived groups.

The Chief Medical Officer’s 2005 annual report defined an equitable system as one where ‘variety is permissible, indeed essential, to guarantee access to appropriate care’ (Department of Health 2006d). The report recommended a national rate of 1,900 coronary revascularisation procedures – a procedure to unblock blood vessels to the heart – per million people each year as appropriate. Using estimates of coronary heart disease prevalence to define the local level of need, the report calculated that some areas, such as Greater Manchester, would need to increase their rates by more than 1,000 procedures per year, while a minority of regions in London and the South West would need to decrease their rates by several hundred per year for equity to be achieved.

The CQC adopted a similar approach in a review of how well the NHS provides two key prevention services: statins and smoking cessation (CQC 2009a). It found that more statins were being prescribed in deprived areas, suggesting that GPs were tackling those at risk of developing heart disease. On the other hand, smoking cessation rates declined with higher deprivation and higher smoking prevalence.

In 2003 the Department of Health encouraged local NHS commissioners to conduct ‘equity audits’ to ‘identify how fairly services or other resources are distributed in relation to the health needs of different groups and areas’ (Department of Health 2003b, p 2). It is not clear how many of these audits have been conducted locally, or how robust they are. A baseline survey of PCTs (Aspinall and Jacobson 2005) found that fewer than 20 per cent of PCTs had fully completed an equity audit to date. There is also no routine monitoring nationally of the uptake of NHS services from an equity perspective (although services are expected to monitor this locally to comply with equality legislation – *see below*).

As mentioned elsewhere in this review, much of the early NHS reform effort focused on increasing the overall volume of certain procedures (such as cataracts) as a means of reducing waiting times, rather than responding to unmet demand among specific groups or geographical areas. Some studies of data up until 1997 suggest that there were not only geographic variations in waiting times, but also that patients from more deprived backgrounds were more likely to wait longer than patients from better-off areas in some specialities (Pell *et al* 2000).

There is some evidence that inequalities in waiting times may have since reduced. In a retrospective study, Cooper *et al* (2009) analysed the time waited by patients from the most to the least deprived areas. They found that by 2007 there was very little variation in the days waited by patients from different socio-economic backgrounds.

In primary care, there have been improvements in care as measured by the Quality and Outcomes Framework (QOF). QOF financially rewards GPs for the successful management of patients with chronic conditions such as diabetes or heart disease. However, there is mixed evidence about whether the scheme has reduced inequalities. Some studies have shown a reduction in differences between practices in more deprived areas and affluent areas (Doran *et al* 2008), however the differences are small.

It is not clear how far this improved performance against QOF indicators, and any related better management of chronic conditions in poorer areas, has resulted in improved outcomes such as reduced mortality or disability.

Most of the research on inequities in access has focused on potential disadvantage experienced by people from more deprived backgrounds. However, since 1997 new legislation has been passed that aims to ensure that public bodies deliver equality in relation to gender, race and disability. In a new equality Bill currently passing through Parliament, these duties will be extended to include age, sexual orientation, religion or belief, and transgender. The Bill will also ask public bodies to consider how they can reduce socio-economic inequalities.

Compliance with the existing legislation has been patchy, and absence of data has hampered efforts to establish whether there are systematic inequities in the quality of care to specific groups. For example, small-scale research studies have suggested variations in the quality of diabetes care experienced by different ethnic groups in primary care (Millett *et al* 2007; Soljak *et al* 2007) but there is no systematic recording of the ethnicity of patients visiting GPs to investigate this at a national level. Evidence of inequalities for disabled, older people or people from ethnic minorities has come mainly from research literature or from periodic reviews by the regulator or other bodies. In relation to older people, for example, the Healthcare Commission has found that older patients were not getting access to the full range of mental health services available to younger people (Healthcare Commission 2009a) but that access to other services, such as hip replacements, had improved since 1999 (Commission for Healthcare Audit and Inspection 2006).

Looking forward

One of the biggest challenges for the new administration will be to decide on the future direction of the policies to reduce health inequalities and the role of the NHS within this. As the Marmot review has emphasised, many of the determinants of health are outside of NHS control, and require investment in education, employment and redistribution of income. However, the NHS clearly has some role to play. A major challenge is to realise the ambition of joint working between health and local government.

It will be important to find ways of making the case for local NHS organisations to invest in reducing health inequalities – particularly if concerns focus on the gap between the health of a relatively small group and a larger majority. The Marmot review attempted to frame the problem of health inequalities as something that affects the health of people across the social spectrum. A future government will have to decide whether to continue with an area-based approach which potentially omits poor people living outside of these areas.

The government will also need to make decisions about the future of the inequalities targets. The advantage of a high-level target is the focus it brings to action by central government and the NHS. But targets can also distort, and concerns have been raised that the inequalities targets have led to a disproportionate and excessive focus on secondary

preventions (such as the prescription of statins for heart disease) in the 50–60 age group, at the expense of other age groups and other types of risk prevention.

Another important area of work is to ensure equitable access to care once people have fallen ill. A formula exists to distribute resources within the NHS equitably but the redistribution of funds to areas of higher need is incomplete, and will become challenging – if not impossible – as NHS resources tighten up in the future.

It is also clear that the allocation of resources does not in itself guarantee adequate levels of service provision. From a national perspective it has not been easy to judge whether services are provided at the right volume and intensity in proportion to need: evidence has come from research studies or periodic inquiries by the regulator. PCTs need to understand whether services are being accessed according to need or whether variations are unwarranted and should be narrowed in the search for greater efficiency, (*see* Section 7, pp 89–100).

The final challenge concerns the ability of the NHS to respond to the multiple demands of the equality legislation in the future. Policies on equity have tended to centre on meeting the needs associated with socio-economic deprivation. In the future, the NHS will need to face up to the challenge of measuring, analysing and responding to inequalities by age, gender, ethnic group, religion and sexual orientation and disability, as well as deprivation, if it is to deliver a genuinely equitable service.

7 Efficiency

Criterion 7: A high-performing health system uses the available resources to maximum effect. This requires higher productivity in the delivery of care, supported by economy in the purchase of the goods and services that a health service needs to deliver that care.

Key points

- By 1997, the NHS had put in place a number of initiatives aimed at improving its use of resources, but there was no adequate measure of productivity.
- Since 1997, the measurement of productivity has improved but is still imperfect. According to the current measure the overall productivity of the NHS has declined: its activity has increased more slowly than the resources it has used. Although productivity has risen recently, it is still not back to 1997 levels.
- Higher pay costs have absorbed more than half of the increase in the financial resources that became available to the NHS since 1997. However, substantial savings have been made in the cost of medicines and other goods and services used.
- There is substantial scope for further savings through more efficient delivery of hospital and other services, such as reducing lengths of stay in hospitals, increasing the rate of day case surgery, and using lower-cost drugs.

The terms 'productivity' and 'efficiency' are often used interchangeably. Here, we use the term 'productivity' to refer to the ratio between the resources available to the NHS and the volume of activities it carries out. For example, if a hospital increases the number of operations it carries out, without any increases in the resources available to it, then its productivity will have increased.

Effective purchasing which reduces the cost of the inputs (staff, medicines, supplies and so on) required to provide care – subject to quality and safety issues – can improve productivity, enabling increased activity for the same level of financial resources.

A health care system may be very productive but not highly effective if some of the activities it carries out are of low value because they provide few patient benefits (such as provision of ineffective medicines). Efficiency therefore requires that each service is delivered in a way that minimises its cost, at the chosen level of quality, access and safety.

The situation before 1997

Before 1997 there were a range of policies and initiatives designed to promote better use of resources. These included reforms of the way supplies were purchased, regular reviews of the cost of pharmaceutical products, annual cost-improvement targets covering the

NHS as a whole, competitive tendering for hospital ancillary services, and sales of land and buildings that were no longer needed to provide care.

The NHS was becoming more effectively, rather than nominally, accountable for its use of resources (*see* Section 8, pp 101–111), and was required to report on an array of performance indicators. Annual negotiations between the Department of Health and the Treasury over funding typically assumed an annual rate of improvement in productivity. A simple measure was in use – the cost-weighted activity index, devised originally in the 1970s. This showed a slow but steady rise during the early part of the 1990s, but it applied only to hospital activity, and made no allowance for quality of care.

To support improvement in performance, the Audit Commission (originally established to monitor the performance of local authorities) was given a similar remit with respect to the NHS.

The introduction of general management in the 1980s, and of the internal market in the 1990s, were intended to facilitate and promote better use of resources. Similarly, the introduction of an explicit purchasing function at health authority or GP level was intended to reduce hospital provider power. However, by 1997 there was little sign that purchasers were having a significant impact on provider performance.

Progress since 1997

The need to ensure improvements in the use of NHS resources formed a fundamental assumption underpinning recommendations made by Sir Derek Wanless in his review of the future of UK NHS funding (Wanless 2002), carried out soon after the publication of the NHS Plan in 2000.

Wanless's estimates of the level of funding the NHS would need over the next 20 years were based on the assumption that about half of the extra resources deemed necessary for

Figure 33 Impact of productivity assumptions on the 2002 review's final spending recommendations, solid progress



a high-quality service would come from improvements in how resources were used (*see* Figure 33 opposite).

Wanless's efficiency assumptions of 2 to 3 per cent were in part based on judgements about what the NHS could feasibly achieve. In practice, the Department built in efficiency savings of between 1 and 3 per cent into tariff price for the services provided by NHS hospitals from 2003/4. In response to the new economic landscape the government has now set an even tougher target by freezing future tariff prices at 2009/10 levels – equivalent in 2010/11 of a need to make efficiency gains of 3.5 per cent per annum (with the strong suggestion that this would increase) (Department of Health 2009x).

This section considers the government's progress on efficiency by examining:

- headline measures of productivity
- unit costs
- measures to reduce input costs (such as staffing, goods and services, medicines and assets).

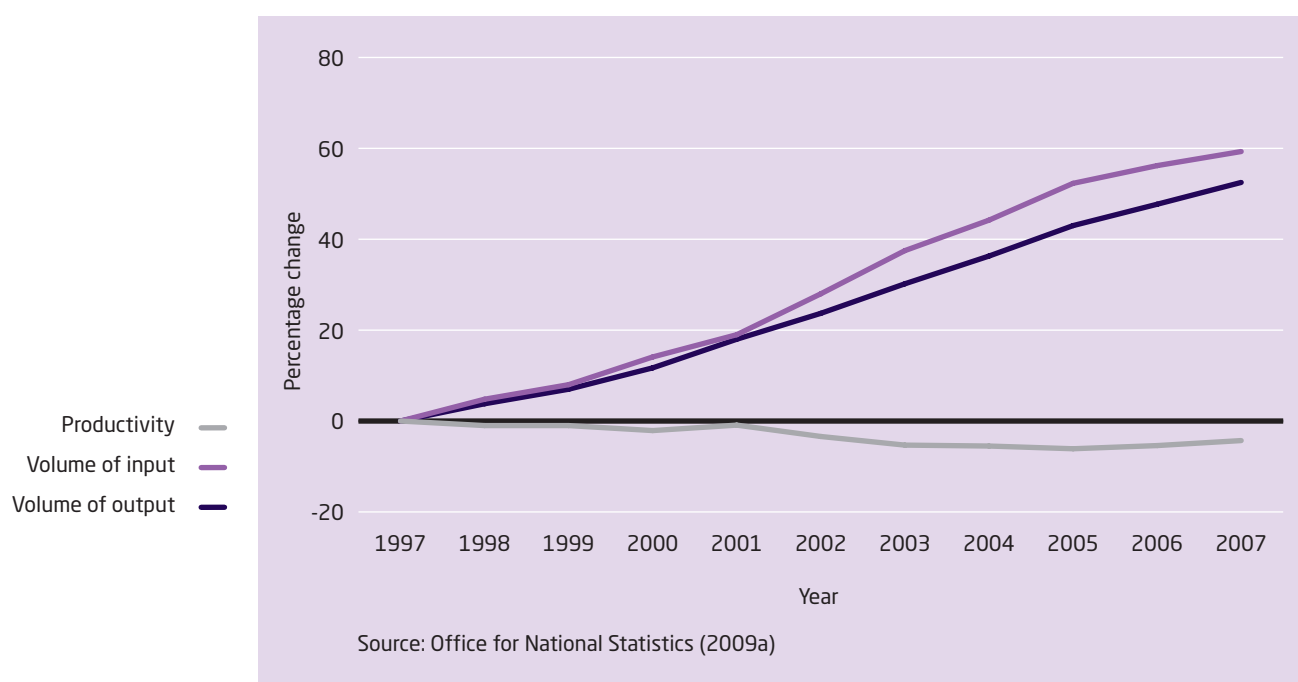
It then goes on to consider briefly some areas where resources could be used more effectively.

Headline measures of productivity

Wanless's assumed productivity improvements of around 2–3 per cent combined real reductions in unit costs with increases in the quality of care. However, the NHS failed to achieve these targets. Although NHS activity rose rapidly from 1997 onwards, at just over 4 per cent a year (reflecting the increases in finance that became available, and the resulting increases in human and physical resources that the NHS was able to deploy), it rose less rapidly than the increase in the resources required to produce them (*see* Figure 34 below).

As a result, the Office for National Statistics estimates that the productivity of the NHS as a whole, across the United Kingdom, declined slightly in the second half of the 1990s

Figure 34 Changes in inputs, outputs and quality-adjusted productivity, UK NHS



and then fell sharply between 2001 and 2004 – at which point the decline halted (Office for National Statistics 2009a). (These figures are quality adjusted: without adjustments for quality, productivity has fallen by an average of around 1 per cent each year between 1997 and 2007.) The most recent figures, for 2006 and 2007, suggest that productivity has now begun to rise but has still not returned to the 1997 figure.

As the Office for National Statistics notes, these estimates – which cover the vast bulk of NHS activity, both in and outside hospital – include a small allowance for improvements in the quality of care. However, the ONS are still developing their measures of public sector and more specifically, NHS, productivity to more properly account for improvements in quality (and not just activity). Nevertheless, at least on current measures, there has been a substantial shortfall in NHS performance, relative to that Wanless estimated would be required to keep actual cash funding increases for the NHS within affordable and sustainable limits.

Reducing input costs

The major inputs to the NHS include staffing (which accounts for around half the total NHS budget and about 70 per cent of hospital costs), goods and services, medicines, and assets, such as land and buildings. Each of these is discussed in turn.

Staffing

The NHS Plan committed the government to increasing the number of doctors, nurses and other professionals within the NHS (*see* Figure 35, below). In order to realise its plans to increase the number of people working in the NHS, the government decided that pay rises would be required. However, the scope for adjusting pay directly in 2000 was limited by existing agreements. In particular, the pay of nurses and medical staff was determined largely by their respective pay-review bodies. The government sought to renegotiate existing agreements, with the aim of making it easier to raise staff productivity. The revised consultant contract agreed in 2003 aimed to improve use of consultants' time,

Figure 35 Changes in number of staff in the NHS, England, 1998-2008

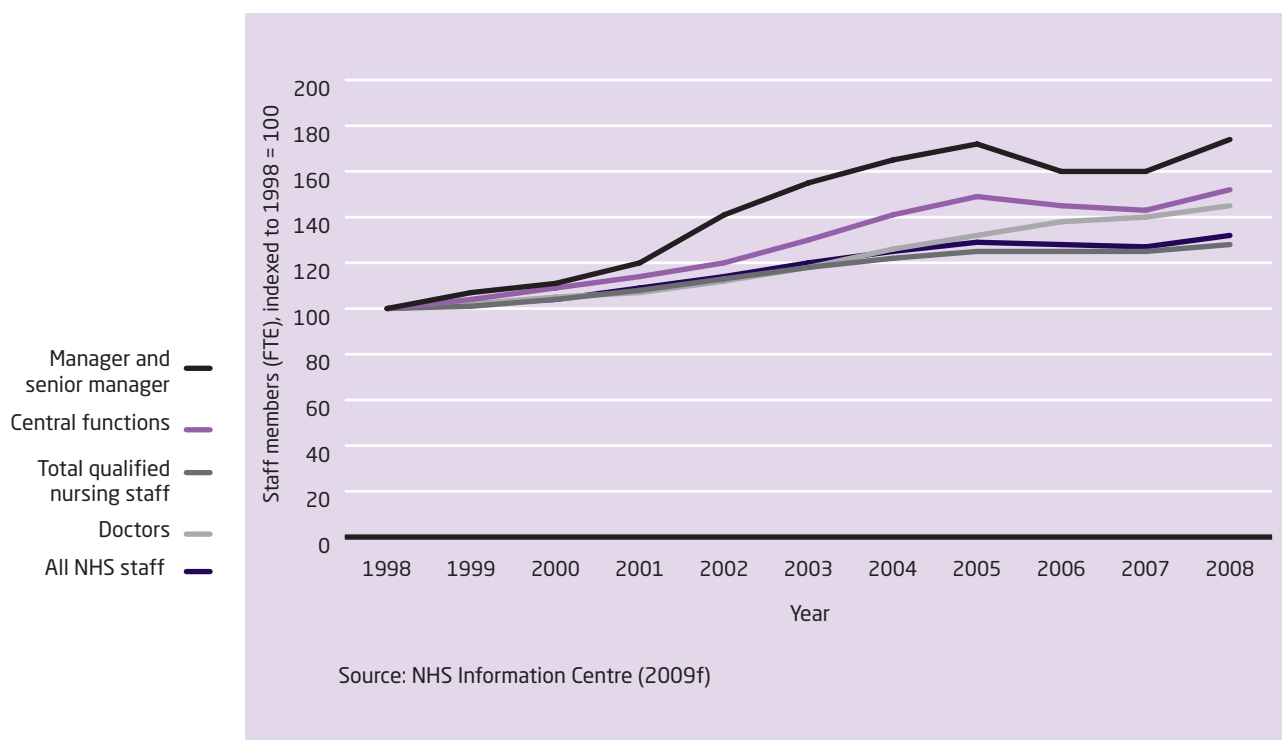
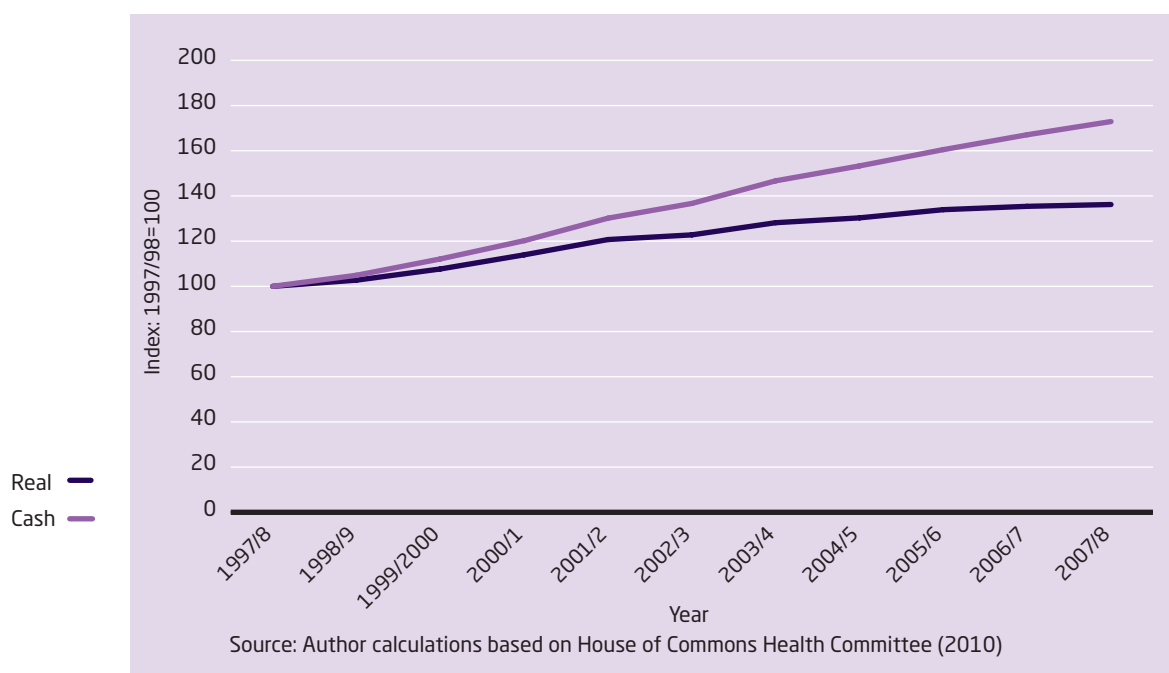


Figure 36 Index of cash and real (GDP-deflated) changes in average staff pay: 1997/8 to 2007/8 for hospital and community health services, United Kingdom



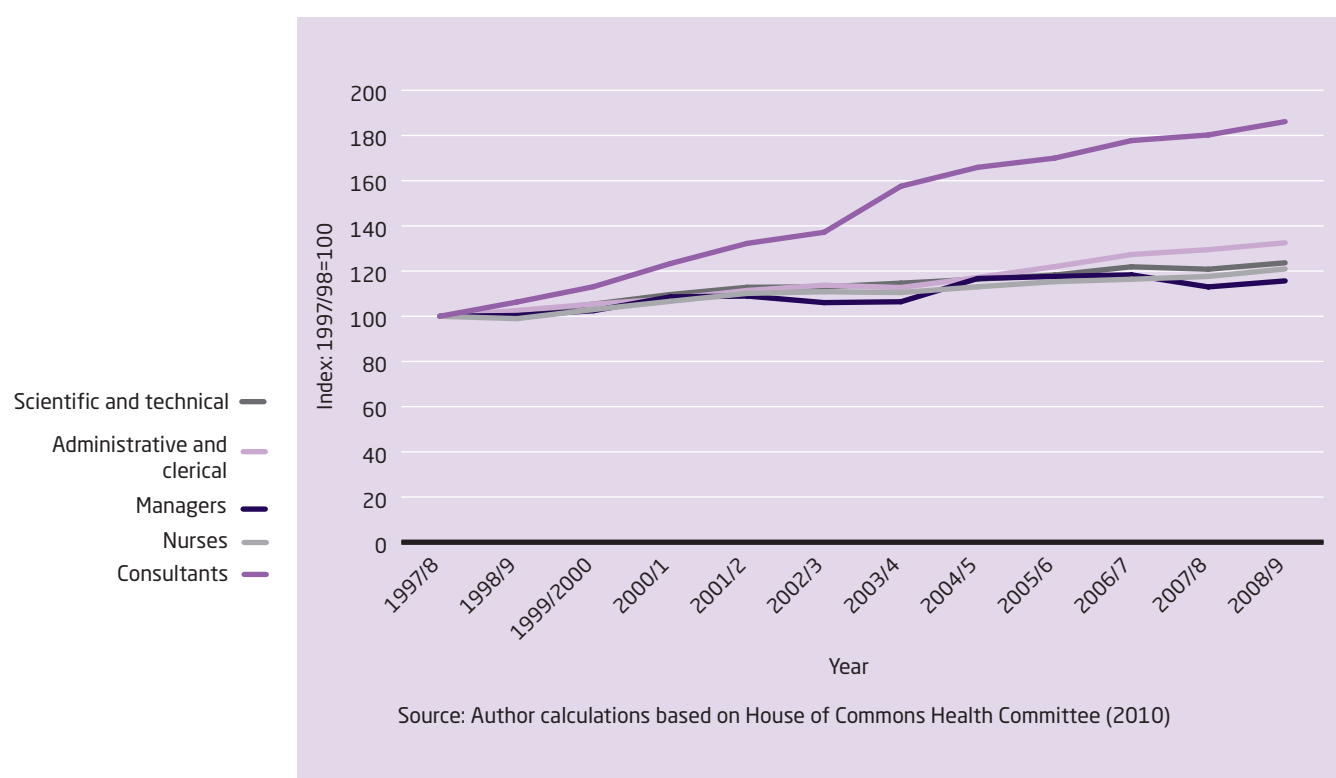
while the GP contract introduced in 2004 aimed to link activities leading to health improvements and remuneration more closely. For other NHS staff, a new pay framework – Agenda for Change – was rolled out nationally in 2004. This introduced new gradings and pay along with new systems to evaluate individuals' jobs.

As Figure 36, above, illustrates, average staff pay for those working in the hospital and community health services sector increased between 1997/8 and 2007/8 by nearly 75 per cent in cash terms, and by around 36 per cent in real terms (in other words, relative to general inflation in the economy): an average real increase each year of around 3.1 per cent.

Pay trends have varied for individual staff groups, but hospital consultants have received the largest increases. Figure 37 overleaf shows changes in real average earnings, per full-time employee, in a number of selected staff groups. GPs also received substantial pay increases over the same period. Their average net income (from NHS and private work combined) increased by 30 per cent between 2003/4 and 2004/5 following the introduction of the new contract, peaking at £110,000 in 2005/6 (NHS Information Centre 2010b). It has slowly decreased since then, to £106,000 in 2007/8.

The combination of higher staff numbers and higher pay meant that a significant proportion of the increase in NHS resources after 2000 was absorbed by pay costs (Wanless *et al* 2007).

Evaluation of the reformed contracts suggests they largely failed to deliver benefits commensurate with their cost. The introduction of the Quality and Outcomes Framework (QOF) – making a greater proportion of GP payments based on activities leading to health improvement – has generally been successful in encouraging high levels of performance. However, it remains arguable how cost effective this has been. The consultants' contract, however, appears to have had a negligible impact on the way that consultant times is used (Williams and Buchan 2006, National Audit Office 2007a). At the same time, the government has managed to claw back some of the 'excess' payments for GPs, by freezing the financial terms of the contract over the past two years.

Figure 37 Changes in average real earnings, selected NHS staff groups, England

For other staff, the reforms introduced by Agenda for Change (Department of Health 2004a) were expected to support the introduction of more efficient and effective working methods and lead to a 1.1–1.5 per cent annual increase in staff productivity. However, a report by The King's Fund found that the absence of consistent and detailed costing on the implementation of the programme means it is very difficult to evaluate its impact (Buchan and Evans 2007). In its report on the reforms, the NAO (2009a) could find no evidence of the intended productivity gains.

In principle, increases in pay can be offset by changes in the composition of the workforce – for example, by employing less expensive types of staff as substitutes for more expensive grades.

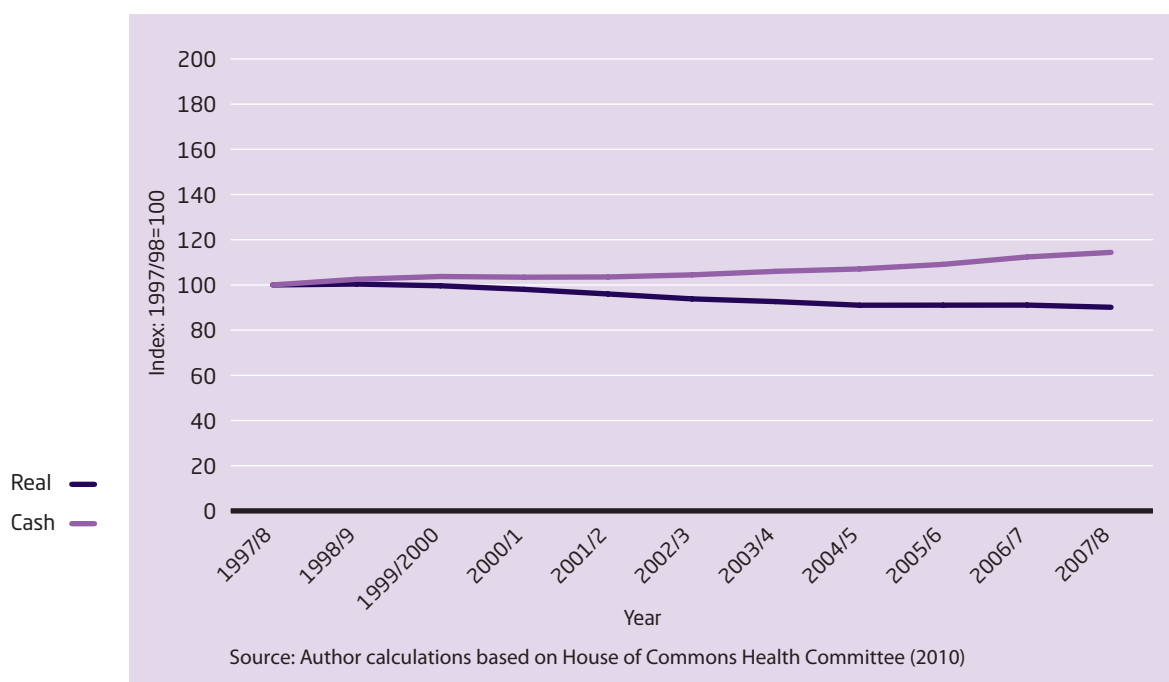
The Wanless review (2002), for example, suggested that nurses might take on around 20 per cent of the care provided by doctors, and that the resulting gaps in the nursing workforce could be met by health care assistants. The number of health care assistants more than doubled between 1998 and 2008 (offset by a fall in the number of nursing assistants or auxiliaries after 2004), and there was also a substantial increase in pharmacy support staff such as technicians (NHS Information Centre 2009f).

However, the impact on costs of service delivery of these changes cannot be identified, and there remains controversy over the extent to which this approach is acceptable on safety and quality grounds (Gainsbury 2009).

Goods and services

The prices paid overall for all goods and services consumed by hospital and community health services have increased by around 15 per cent since 1997/8 – an average increase of around 1.1 per cent per annum. However, relative to inflation across the economy as a whole (as measured by the GDP deflator), the real change has been negative, with real prices falling by 10 per cent (*see* Figure 38 opposite).

Figure 38 Index of cash and real (GDP deflated) changes in prices: 1997/8 to 2007/8 for hospital and community health services, England



The NHS is virtually the only purchaser of many of the goods and services it requires. So, in principle, it should be able to use its power within the market to achieve the lowest possible prices. In practice, however, it has not always found it easy to use its market power effectively.

A central purchasing function (NHS Supplies) was established in the 1980s, but trusts and other parts of the NHS preferred the flexibility and choice offered by purchasing for themselves.

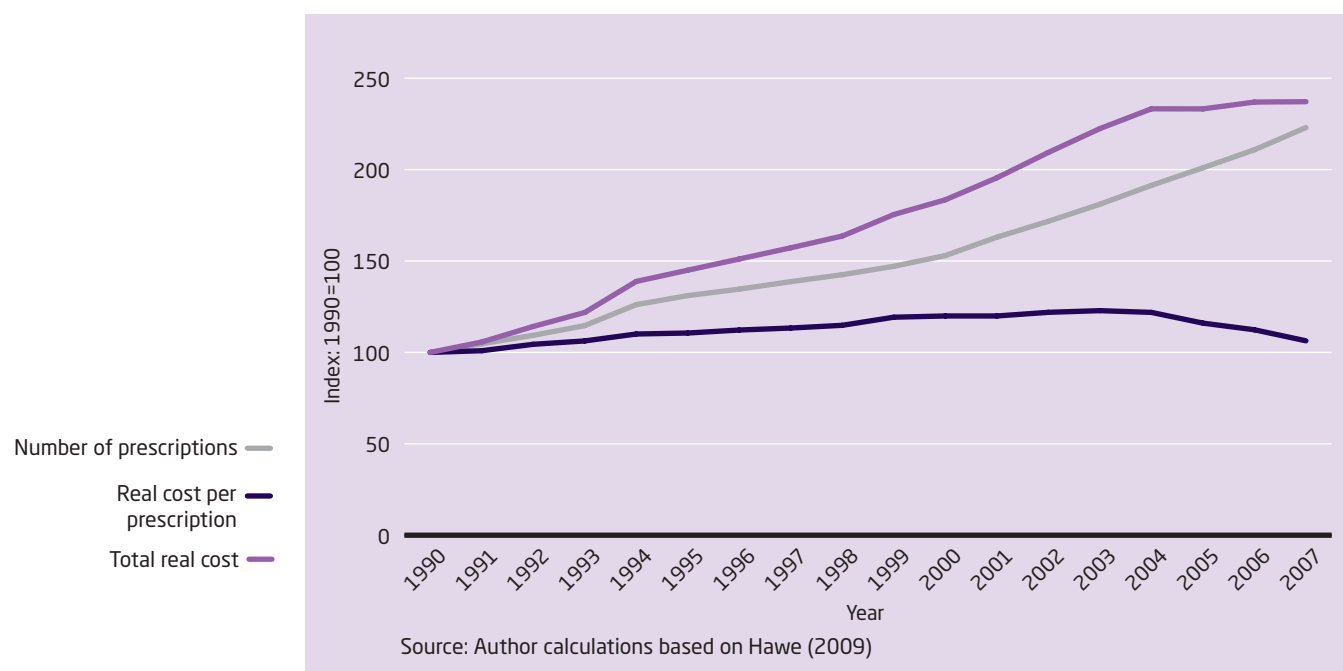
In 1999, a Cabinet Office team reviewed NHS procurement, and made a number of proposals for improvement. In response, the Department of Health required each trust to put in place a procurement strategy, and in 2000 established a national body – the NHS Purchasing and Supply Agency (PASA) – to support improved procurement at both national and local level (NHS Executive 1999b).

In 2006, the Office of Government Commerce launched a government-wide review of purchasing competence (Office of Government Commerce 2008). This concluded that while the Department of Health was strong in some areas (for example energy procurement), in many areas it required improvement.

In response, in May 2009 the Department issued a new *Commercial Strategy and Operating Model* (Department of Health 2009p) both for itself and for the NHS. The NHS Purchasing and Supply Agency (NHS PASA) was dissolved. Some of its functions, which involved national-level contracts, were transferred to Buying Solutions (part of the Office of Government Commerce – the central government purchasing agency), while other functions were transferred to new regional commercial support units.

Substantial savings have been claimed for the measures taken so far: before its dissolution, PASA claimed to have saved £599 million in 2008/9, with regional procurement activities and trusts contributing a further £144 million (PASA 2009). Transfer of supply chain services to a private sector company (DHL) in 2006 was forecast at the time to save £1 billion over ten years. Whether these new arrangements lead to greater, but as yet

Figure 39 Trends in numbers of prescriptions, total spend and cost per prescription (at 1990 prices, GDP deflator), United Kingdom



unspecified, savings, depends largely on how many local purchasers take advantage of national or regional contracts.

Medicines

In the case of branded drugs, the current government, like its predecessor, has sought to reduce prices directly, through regular negotiations with the industry, as part of the Pharmaceutical Price Regulation Scheme (PPRS). Such agreements, which are reached on a voluntary basis with the pharmaceutical industry, have been in place since the 1950s.

Successive renegotiations have reported that the price of drugs has been reduced. As Figure 39, above, shows, while the total number of prescribed items has continued to rise, from 2005 the real total spend on prescription drugs (around 80 per cent of the total NHS spend on pharmaceuticals) has levelled off, and the real cost per prescription has fallen back to early 1990 levels.

Recent international comparisons suggest that the prices the NHS pays are low relative to most OECD countries – though the lower value of the pound accounts for some of this difference (Department of Health 2009t). However, the Department of Health has always balanced the interests of the industry against those of the NHS, by making an explicit allowance for high levels of industry expenditure on research and development. It therefore has not sought to achieve the lowest possible prices that its purchasing power might have been able to extract.

An investigation by the Office of Fair Trading (2007) into the price of medicines suggested that costs to the NHS could be reduced further than the level achieved by the 2005 PPRS, and that the basis of the agreement should be modified so that prices paid reflected the value of new drugs to the NHS. The government responded by renegotiating the existing agreement.

The Department of Health has claimed that this will result in £350 million of savings in 2009, and £550 million in subsequent years. It is also hoping that following the Richards report (Richards 2008) (*see* Section 1, pp 13–22) it will be possible to reduce the cost of

drugs to the NHS through ad hoc deals over particular expensive drugs – through, for example, forms of value based pricing.

The PPRS applies only to branded drugs. When patents expire, these come in direct competition with generic drugs (non-branded drugs that have the same pharmaceutical content, which are always cheaper). Despite its support for the UK industry, the government has taken further the existing commitment to promote generic prescribing.

The rate of generic prescribing is now over 60 per cent as compared to around 40 per cent in 1997. However, there remains considerable variation between GP practices in their rate of generic prescribing. A report from the National Audit Office (2007b) into prescribing in primary care identified further potential savings of £200 million from this source. The Department is currently consulting on a proposal to allow pharmacists to substitute generics for branded medicines in GP-written prescriptions (Department of Health 2010e). A further £1.8 billion has been saved in the cost of generic drugs through renegotiation of the community pharmacy contract, after research (Oxera 2001) showed that excess profits were being made in the existing supply chain.

Assets

In 2000 the NHS Plan set a target of £600 million income from sales of its assets. This was met by end of 2003/4, alongside a further annual £60 million savings in running costs (Department of Health 2006a).

The Gershon report on efficiency across the public sector (Gershon 2004) identified scope for increasing sales further, as did the 2007 Comprehensive Spending Review. The Department of Health Value for Money Agreement 2007 (Department of Health 2007f) and the revised and updated version published in 2009 (HM Treasury 2009) also envisaged further savings from this source, including some £100 million savings in the costs of running the estate. A study carried out with NHS London suggested that trusts could deliver the current level of activity and quality with 18 per cent less space (HM Treasury 2009).

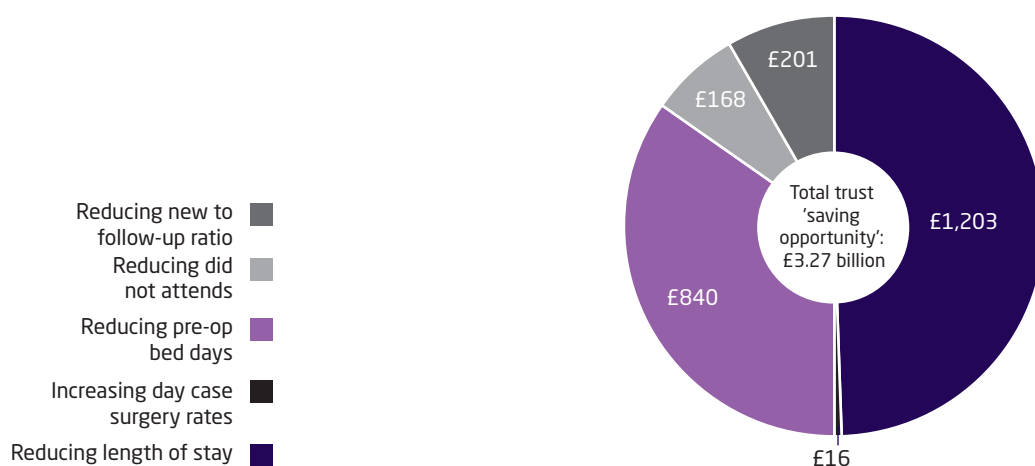
As a result of the sales that have already taken place, the total area occupied by the NHS estate fell by about 10 per cent between 1999/2000 and 2008/09 (NHS Information Centre 2010d). However, as a result of the massive hospital-building programme, launched in 1997, the value of the estate has risen rapidly from £16 billion in 2002/3 to £24 billion in 2008/9, suggesting that while the capital programme may have yielded benefits in terms of patient experience, it has not helped to reduce the cost of delivering services.

Using resources more effectively

Initially, the main drive to change the way that services were delivered came from the need to meet the waiting times targets set in the NHS Plan. From 1998 onwards, the government introduced a number of programmes (including the Action On series and Care Collaboratives) focused on particular operations or specialties. All of these were designed to promote and support new ways of delivering care – such as the wider use of day surgery, which had already been shown to lead to lower costs while maintaining quality and patient satisfaction.

To support local efforts, the NHS Plan announced the establishment of the Modernisation Agency (subsequently the NHS Institute for Innovation and Improvement) to provide support to trusts in making the required changes on the ground. The result has been a mass of advice on a wide range of operational issues, which has also demonstrated the scope for making better use of resources.

Figure 40 Better care, better value 'opportunity savings', £ millions, as at second quarter 2009, trusts



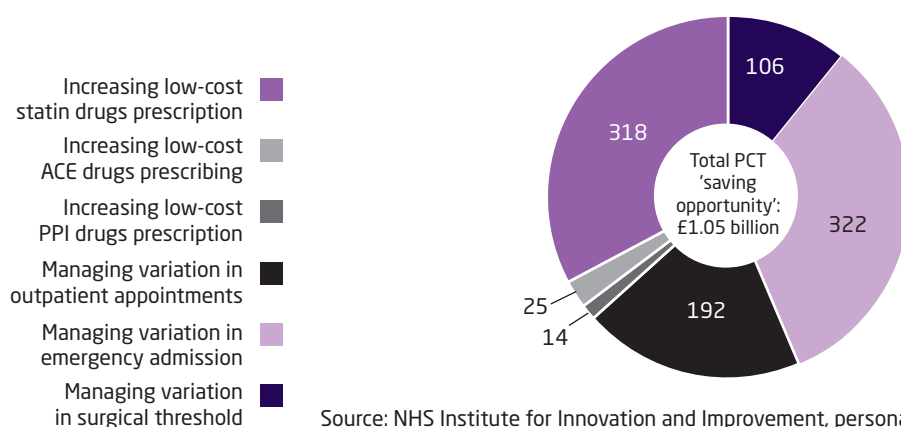
Source: NHS Institute for Innovation and Improvement, personal communication (2010)

According to the Department's 2009 value for money update (HM Treasury 2009), the NHS saved £500 million in the first nine months of 2008/9 by reducing the average length of hospital stay. Estimates based on work done by the NHS Institute suggests that there is considerable further potential for improvement from further reductions in lengths of stay and other operational changes (see Figures 40, above, and 41, below). However, there are wide variations in performance between trusts. Even after allowing for differences in case mix, average lengths of stay vary by over 50 per cent from the average.

Meanwhile, reductions in health care-acquired infections (see Section 2, 23–32) have been claimed to save £75 million (HM Treasury 2009).

Another area of potential savings is business services. The Gershon review concluded that substantial savings could be made if government organisations including NHS trusts outsourced back-office activities (Gershon 2004). By that time, the NHS had already established a shared services organisation – NHS SBS. In 2005 this was established as a joint venture with the private-sector company Steria. The forecast at the time was that

Figure 41 Better care, better value 'opportunity savings', £ millions, as at second quarter 2009, PCTs



Source: NHS Institute for Innovation and Improvement, personal communication (2010)

Note: ACE = angiotensin converting enzyme

PPI = proton pump inhibitor

this change would result in savings of £224 million over 10 years (Department of Health 2004b).

Other evidence suggests that there is substantial scope for making better use of medicines. The National Audit Office review of primary care prescribing (2007b) estimated that drug wastage alone costs some £100 million a year. There is also evidence of mis-prescribing in hospitals (General Medical Council 2009) and for residents of care homes (Department of Health 2010g), as well as overuse of antibiotics (Department of Health 2009c), despite campaigns to reduce their use.

A recent study (Garfield *et al* 2009), using research on each stage of the supply chain, estimated that only a small proportion of drugs (some 20 per cent or less) actually produced the desired effects – partly due to professional error, and partly due to poor patient compliance.

Raising productivity will require more than simply applying existing knowledge to existing services. The Next NHS Stage Review emphasised the need for more innovation, and in the following year a number of cross-sector clusters were announced, involving universities and the NHS in 2009 (Department of Health 2009y). Subsequently, a legal duty was placed on strategic health authorities to promote innovation, supported by the Innovation Fund, and regional commercial support units have been created to increase the uptake of new technologies.

Looking forward

Today, productivity in the NHS is better measured and understood than it was in 1997. However, even though the measurement of productivity is still imperfect and needs to be refined in order to properly capture changes in quality, it is clear that until recently, overall, productivity has fallen. The key task for the government given the pressure on public finances is now to reverse this trend, and improve the use of resources in the NHS.

The NHS has made considerable strides towards making better use of the resources at its disposal – particularly through reducing the cost of its supplies, and its significant efforts to dispose of its estates. Further savings from these sources appear to be available. Other areas for saving have been identified too, including avoiding ineffective procedures, and managing growth in emergency admissions.

Although the government has not set explicit targets for cost reduction in the way it did for waiting times, the year-on-year efficiency savings assumed in the tariff will require hospitals to confront future cost rises. The intended incentive in freezing the tariff is to encourage hospitals to absorb any increases in overall costs through reductions in unit costs.

One of the reasons for falling productivity since 1997 has been the growth in levels of NHS staff pay. The constrained financial climate and indications from the 2009 Pre-Budget Report means it is unlikely that staff pay will increase above inflation in the near future. This raises challenges for a future government in terms of retaining an engaged workforce and finding ways to improve productivity through better skill mix. Supporting innovation despite limited resources will be crucial.

In addition, work done by organisations such as the NHS Institute for Innovation and Improvement has shown that there is also potential for substantial savings to be made in other changes to clinical practice. For example, work carried out for the NHS Institute (NHS Institute for Innovation and Improvement 2009) by NHS nursing staff has suggested that adherence to basic good nursing practice, such as ensuring that patients are

properly fed and hydrated and free from pressure sores, could save over £9 billion a year while improving quality of care for patients in hospitals and nursing or care homes.

Also there is further scope for the better use of medicines through the guidance issued by the National Institute for Health and Clinical Excellence (NICE) whose twin aims are to determine which interventions should be available within the NHS, and to advise on how these interventions should be used in clinical practice. In 2009, NICE estimated that some £600 million could be saved if its recommendations on the use of medicines and other interventions were adopted universally (NICE 2009).

In summary, there is no shortage of opportunities for using NHS resources more effectively. The difficult part is to find the right blend of levers to realise them.

In the past, tighter budgets have been a key factor promoting greater productivity: whether this will be the consequence of the current squeeze on finances and whether improvements can be realised without sacrificing quality will in part depend on the engagement of the entire NHS workforce in understanding the scale of the challenge and the need to rethink the way services are delivered.

8 Accountability

Criterion 8: A high-performing health system can demonstrate that it is achieving high standards, takes into account the views of those who it serves, and has in place effective systems to remedy poor performance.

Key points

- By 1997, some efforts had been made to make the NHS more accountable to central government, and community health councils offered patients and citizens a voice in local services. However, there was still very little information or independent assurance available to politicians and the public on the quality of services.
- Since 1997, the government has introduced a plethora of targets and strong performance management, to make the service more accountable for its performance to central government, but successes came with costs.
- One of the government's most important contributions in this area has been to set up independent regulators of health care organisations to inspect and assure the quality of services. However, further work is needed to reduce the burden from different agencies on health care providers.
- The introduction of the foundation trust model has been one of the more significant experiments in enhancing the local accountability of services, but the available evidence casts doubt on the effectiveness of these arrangements in practice.

As a tax-funded system, the formal line of accountability in the NHS runs directly to the Secretary of State, who is accountable to Parliament for how public money is spent. However, it has long been recognised that control by central government of local NHS performance is seriously challenging in practice. Since the 1980s successive governments have adopted a range of different mechanisms in an effort to make the NHS more accountable both to the government, and to its users.

The situation before 1997

In the 1980s and early 1990s, the government sought to strengthen the upwards accountability of the health service to central government, through internal performance management. Following an emerging international trend for applying management approaches from the private sector to public services (known as 'New Public Management'), from the 1980s the government published national performance indicators for the health service, covering areas such as activity levels, ambulance response times, and expenditure on staff.

In 1991 the Audit Commission was made responsible for carrying out external financial audits of the service, and it continues to produce national reports on financial

management and value for money in the NHS. The 1990s also saw the introduction of a new management structure and ethos ('general management'), which was intended to make individual managers at all levels of the NHS personally responsible for the performance of the service.

Individual health professionals were subject to regulation by their respective professional councils, through a system of state-sanctioned self-regulation that remained relatively unchanged until reform in 2009. Before 1997 there was no independent regulation of health services as organisations, though useful data was collated by independent national inquiries into causes of death among particular patient groups.

An official channel for local public representation to the service had been established in 1974, in the form of community health councils (CHCs) – statutory bodies tasked with representing the views of local patients and citizens in the planning of local health services, and with legal powers to enter and inspect health care premises. These continued to operate into the early 2000s. A further move towards consumer power was introduced in 1991, in the form of the Patient's Charter (HM Government 1991), which included a list of basic rights to treatment and maximum waiting times for hospital appointments. The Patient's Charter was later credited with raising the awareness of patients' needs among staff, but very few patients themselves were aware of the charter or its contents (Farrell *et al* 1998).

So, when the current government came to power in 1997, it inherited a tradition of using a small number of public-facing service targets, the Patient's Charter (which codified rights, albeit with low levels of public engagement), and a long-established system for some citizen representation to the NHS at a local level. But some of the fundamental building blocks for securing strong accountability to the centre were not yet in place: there was very little information available on how the service was performing in clinical terms, along with few nationally determined standards for the delivery of care, and no external or independent regulation of health care organisations.

Progress since 1997

In 1997, the initial focus of the new government was on making the service more accountable to the Department of Health, through mechanisms such as targets and league tables, and central government exerted pressure on managers on a grander scale than before, and with renewed vigour. From 2002, the government also began to decentralise the management of the service to local commissioners, with the aim of making the service more responsive to local needs. However, in practice primary care trusts remain accountable upwards, to the Secretary of State, rather than outwards, to their local populations.

Throughout its second and third terms in office, the government continued to pursue policies intended to make the service more accountable to patients and local communities, with the introduction of new ways of governing provider organisations, in the form of foundation trust status, and reforms to existing structures for public involvement.

Since 2002, overlaying all three of these approaches to making the service more accountable (to the centre, to commissioners and to the community) has been a new system of quasi-independent regulation of health care.

Most recently, the government has introduced the NHS Constitution, setting out the rights of individual citizens to NHS treatment (Department of Health 2009q). In addition, at the time of writing, the government was seeking to enshrine in law the right to certain treatments within maximum time frames.

However, despite these successive shifts in the emphasis of policy rhetoric, in practice, strong central performance management of the service has continued in parallel to policies on decentralisation, external regulation and local accountability, and in many cases continued to dominate the attentions of health service managers.

We now examine the government's progress on making the NHS more accountable by considering activities in each of the following areas:

- accountability to central government
- holding providers to account through commissioning
- accountability to local communities
- external regulation.

Accountability to central government

A defining feature of the government's performance management regime (see Table 16 below) has been its collection of performance data and use of national targets as the basis on which to monitor, reward and punish performance.

Table 16 Key milestones in the development of the performance management regime

1997	Performance Assessment Framework The framework pulls together and publishes performance reporting by health authorities and (for some measures) acute trusts across six themes: health improvement, fair access, the effective delivery of appropriate health care, efficiency, patient/carer experience, and health outcomes.
1998	Public Service Agreements (PSAs) These were first introduced alongside the Comprehensive Spending Review. The first health PSAs included challenging, outcome-focused public health targets, together with a dozen others, including some on reducing waiting lists and waiting times.
2000	NHS Plan The document (Department of Health 2000c) includes more than 100 new targets, ranging from commitments to invest in equipment and infrastructure to increasing staff numbers and establishing maximum waiting times for treatments. The Department of Health puts hospital chief executives under strong pressure to meet these targets as part of the broader performance management system (Harrison and Appleby 2005; National Audit Office 2001).
2000	Star-ratings system Under this system, trusts are given a single summary score, between 0 and 3, according to their performance. Results are made public, and are intended to hold the system to account through a process of 'naming and shaming', under which chief executives of zero-rated trusts are at risk of losing their jobs (Bevan 2006). Full responsibility for collating and publishing these is shifted to the regulator in 2002, but the government continues to set the standards.
2000-04	Further targets More targets are introduced between 2000 and 2004, including targets on reducing socio-economic inequalities in life expectancy and infant mortality, establishing a maximum 18-week wait from referral to treatment for hospital care, and on halving rates of MRSA.
2007	Vital signs These are introduced in the NHS Operating Framework for 2008/09, dividing performance priorities for the service into three tiers: national 'must dos', national 'must dos' for which delivery is to be determined locally, and options for other issues from which local areas can select priorities.

There is no question that this approach has been successful in holding the service to account for its performance in the areas on which targets have been focused, and in improving that performance.

As described in other sections, the government has met nearly all of its own targets. However, its use of targets has been criticised for leading to damaging unintended consequences (House of Commons Public Administration Select Committee 2003; Gubb 2009), including:

- distortions in clinical priorities
- undermining professional autonomy and local leadership
- encouraging 'silo-based' rather than integrated approaches to providing care
- promoting a focus on process rather than outcomes.

In the government's second term in office – partly in recognition of the limitations of such a regime – policy rhetoric shifted away from a reliance on targets and centralised performance management.

Holding providers to account through commissioning

From the early 2000s, the government turned its attention to decentralising power within the service, and to introducing quasi-market reforms, in an effort to make organisations more 'outward facing', and the system as a whole self-improving.

One of the principal mechanisms for this has been to charge commissioners with holding providers to account for the services they deliver. The main vehicles for local commissioning are primary care trusts (PCTs), which spend 80 per cent of the NHS budget. The government's vision has been for PCTs to use their contracting power to hold local hospital providers to account for the quality of the services they provide. However, the ability of PCTs to achieve these objectives has been in part hampered by reorganisations at a local level.

Most PCTs only took shape in 2004, but within two years they were subject to further reorganisation and their numbers halved to 152, creating considerable disruption. The Department of Health launched its 'world class commissioning' programme in 2007, intent on improving PCT performance. However, it is still not clear whether PCTs have the power and resources to challenge powerful acute providers. In 2009, the world class commissioning assurance review found that fewer than 20 per cent of PCTs were eligible to be awarded 'green lights' across the three main competency areas of strategy, board governance and finance (Health Service Journal 2009).

Accountability to local communities

The new governance arrangements that accompanied the introduction of foundation trust status from 2004 represented one of the government's more significant experiments in increasing the accountability of services to local communities. This accompanied other reforms aimed at making the NHS more publicly accountable, including:

- increasing lay representation on national bodies such as the National Institute for Health and Clinical Excellence (NICE), the Independent Reconfiguration Panel, and regulators
- extending the overview and scrutiny powers of councils to cover the NHS
- successive reorganisations of local arrangements for representing the voices of patients and the public in local planning.

We now examine the following specific areas of activity intended to increase accountability to communities (including patients and the wider public):

- foundation trusts
- overview and scrutiny committees
- patient and public involvement forums and local involvement networks
- taking account of public views in commissioning decisions
- accountability to individual patients.

Foundation trusts

Foundation trusts (FTs) are hospital trusts that are run as not-for-profit public benefit corporations, enjoying greater freedoms to borrow capital, sell assets, retain surpluses, and develop their own incentive and reward packages for staff than their non-FT NHS counterparts. They are not performance managed by the Secretary of State for Health, but

are instead regulated by Monitor, a non-Departmental public body which is accountable directly to Parliament and are accountable to their 'members', who are drawn from the local public and from staff. FT members are responsible for electing a board of governors, which represents their views to the trust's board of directors. The trust has a duty to consult the governors in strategic planning, and the governors appoint the chair of the board of directors, who also serves as chair of the board of governors.

The government's policy had been for all NHS acute and mental health trusts to attain foundation status by 2010 (a postponement of the earlier target for acute trusts of 2008), though the latest iteration of this aim seems to be a softer claim that NHS trusts need to develop clear trajectories for reaching foundation status before 2014, with the possibility that for some trusts, 'other organisational forms' may be appropriate (Department of Health 2009o, p 59). At the time of writing, 88 out of a possible 168 acute trusts had foundation trust status, and 38 of 73 mental health trusts were FTs (Monitor 2010, NHS Choices 2010).

The evidence to date of the impact of FT governance arrangements on the accountability of trusts is based on relatively small-scale studies, and offers mixed conclusions. Most recently, a report on the government's reform programme for the NHS in general, by the Healthcare Commission and Audit Commission, identified confusion around the role of governors and found no significant evidence that the governors were impacting on how the trusts were developing (Healthcare Commission and Audit Commission 2008). Meanwhile, an independent report for the Department of Health concluded that the arrangements, while 'resource hungry', had 'made directors and staff more aware of the views of patients and the public' (Mutuo and University of Birmingham 2008, pp 16, 30).

There has been a marked decline in the number of people voting and standing for governing bodies of FTs. Average election turnouts among members have reduced by almost half from 48 per cent in 2004 to 27 per cent in 2009 (Santry 2009). FTs offer the potential for a more radically accountable model of service delivery than we have seen to date in the English NHS, but there is a real risk that this potential can go unrealised. Running these governance structures costs on average an estimated £200,000 per year for each trust (House of Commons Health Committee 2008) – a relatively small figure in the context of average trust incomes (around £220 million in 2008/9 (calculated using data from Audit Commission 2009)) but nonetheless one that might come under scrutiny in the context of intense financial pressures on hospital trusts in the near future.

Overview and scrutiny committees

Since 2003, there has been a requirement for NHS organisations to consult council overview and scrutiny committees (OSCs) on any 'substantial' plans for developing or changing local health services (Health and Social Care Act 2001). Where the OSCs think the consultation process or the plans themselves are flawed, they have the power to refer local planning decisions to the Secretary of State.

Early evidence on their effectiveness found that around 40 per cent of NHS organisations responding to a survey reported having made changes to their plans on the basis of recommendations by OSCs (Centre for Public Scrutiny 2005). The number of referrals to the Secretary of State has been relatively low in the context of the hundreds of local reorganisations taking place, although it has increased significantly from just 2 between 2002 and 2004, to 19 between 2006 and mid-2007 (House of Commons Health Committee 2006a; Hansard 2007b).

OSCs introduce a novel element of elected representation into the planning of local health services, but in practice they currently have few powers to enforce their

recommendations and limited resources to support their inquiries (Centre for Public Scrutiny 2007).

Patient and public involvement forums and local involvement networks

Patient and public involvement (PPI) forums replaced community health councils in 2003, and were intended to provide local representation to individual health organisations. However, within five years they too were abolished, on the grounds that they were unrepresentative of local communities, with membership averaging at just eight individuals (House of Commons Health Committee 2007). They were replaced by local involvement networks (LINKs), which are attached to local areas rather than specific organisations, and are intended to engage a wider range of community members by using existing community organisations as a resource to be drawn on by local 'host' organisations for the networks.

This move to broaden the resources and perspectives, which can then be taken into account when planning local services, seems sensible – but the frequency of reorganisations in local accountability arrangements is starting to take its toll. A survey of trusts in 2008 found that many were unsure of what was expected of them in relation to LINKs, and that uncertainty about the future direction of this policy made long-term planning difficult (The National Centre for Involvement 2008).

The other challenge presented by the new LINKs is that there is no central, publicly available account of their membership or activities. They are accountable locally, to their respective local authorities, and must provide annual reports to those authorities on their activities. However, the networks are funded centrally by the Department of Health – they received £84 million between 2008 and 2011 (Department of Health 2008f) and, although LINKs are obliged to report annually to the Secretary of State, when ministers have been asked in Parliament to assess the effectiveness of the new arrangements they have said that it is the responsibility of local authorities to manage contracts with these organisations (Hansard 2009b). So, it is not clear whether or how the government is assessing whether the arrangements are effective or providing good value for money.

Taking account of public views in commissioning decisions

The NHS Act 2006 has placed a legal duty on PCTs and SHAs to produce a report each year on what influence the public's views have had on commissioning decisions. The first reports are due to be produced by September 2010.

A survey of PCTs (Picker Institute Europe 2009c) found that following the introduction of involving patients and the public as a core competency for PCTs in the world class commissioning assurance process, public and patient engagement had been given a higher cultural and financial status in PCTs. However, it reported that activities were still focused on information gathering, with less evidence about how much weight these views were given in decision-making.

The new legal duty could provide the necessary pressure to prompt organisations to give a greater weight to the public's views when making decisions.

Accountability to individual patients

The terms of reference for the NHS Next Stage Review in 2007/8 included a commitment to shift the service in the coming decade to one that is 'based less on central direction and more on patient control, choice and local accountability, which ensures services are responsive to patients and local communities' (Hansard 2007a). The final report in 2008 (Department of Health 2008d) recommended a constitution to bring together

in one place the details of what staff, patients and the public could expect from the NHS, including 'rights' for patients. A constitution was published accordingly in 2009 (Department of Health 2009q).

Since the Health Act 2009, commissioners and providers of NHS services have had a legal duty to 'have regard to' the Constitution, which includes:

- general rights to access care
- access to treatments and drugs recommended by NICE (where clinically appropriate)
- choice of GP
- access to a patient's own health records
- and involvement – directly or through representatives – in the planning of services.

The constitution does not create new legal rights, but brings together existing rights into one place. As part of this policy, the government has begun consulting on enshrining into law the right to consultant-led treatment within 18 weeks of GP referral, the right to see a cancer specialist within two weeks of GP referral, and the right to NHS health checks every five years for people aged 40–74.

The constitution also commits the government to publishing and updating a clear 'statement of NHS accountability' (Department of Health 2009q, p 4). The current version of this document sets out the roles and responsibilities of NHS organisations and the Department of Health, and describes the regulatory landscape, local patient and public involvement mechanisms, and avenues for complaint and redress.

It is not yet clear whether the government has secured sufficient public interest in the constitution to protect it against the fate of its predecessor, the Patient's Charter. Baseline awareness research conducted for the Department in November 2009 found that just one-fifth of the general public surveyed were aware of the constitution to date (The State of Readiness Group 2009). However, the sample size for the survey was described as 'small', so it is difficult to assess how much weight to attach to these findings.

In general, informing patients of their rights seems to be a good thing, as long as the responsibility for ensuring that these rights are met does not fall solely onto the shoulders of individual patients.

External regulation

There are two aspects of external regulation to consider: regulation of organisations, and regulation of individual professionals. We discuss each in turn.

Regulating organisations

The need for a system of regulation on quality and safety was highlighted in the White Paper *The New NHS: Modern, dependable* (Department of Health 1997), which concluded that past performance on quality in the service had been 'variable' (para 1.1) and that the service had been slow to recognise and respond to 'serious lapses in quality' (para 3.3) – a reference to the Bristol Royal Infirmary case. Regulation of the private and public sectors in general had also been developing in the previous decade in line with policies to place public services at arm's length from the government (Walshe 2002).

Table 17 overleaf describes the different forms taken by the regulator over the ensuing years.

Table 17 Timeline of regulator bodies

1999	A new non-Departmental public body, the Commission for Health Improvement (CHI) is established, to assure local systems of clinical governance.
2002	CHI's role expands to include: <ul style="list-style-type: none"> ■ inspecting NHS organisations and services ■ publishing performance reports on trusts including 'star ratings' ■ providing annual reports to Parliament on the state of NHS services ■ recommending special measures where quality is poor.
2004	The Healthcare Commission brings together regulation of the private and public sectors. Its commissioners are appointed by the Appointments Commission rather than government. Its activities are focused on an Annual Health Check of health care organisations against core and improvement standards set by the Department of Health, based on inspections.
2005	The Healthcare Commission Annual Healthcheck process starts to be carried out through a system of self-certification, with inspections of only one-fifth of trusts.
2009	The Care Quality Commission is created by merging the Healthcare Commission, the Commission for Social Care Inspection and the Mental Health Act Commission (which monitors services and conditions for patients detained in hospital under the Mental Health Act 1983), in response to pressure for further reductions in the number of regulators (Office of Public Sector Reform 2003; Department of Health 2004d).

The table highlights in particular two major reorganisations of regulation: the introduction of the Healthcare Commission, and the merging of three bodies to create the Care Quality Commission. Both these have been characterised by attempts to increase the independence of the regulators, to reduce the cost of regulation, and to reduce the burden its activities place on frontline organisations.

The CQC has interpreted its mission as (Care Quality Commission 2008a): ensuring essential quality and safety standards, driving improvement, stamping out bad practice, and providing information to the public.

Although a version of the Annual Health Check (an assessment of healthcare organisations against government-set standards) will continue, the Commission's principal role will be to administer a new system of registration for all hospital and adult social care providers from 2010, with a view to extending the system to primary care providers from 2011/12 (subject to legislation). Its enforcement powers (effective from April 2010) are more wide ranging than those of its predecessor, and include imposing fines, placing conditions on or suspending registration, and prosecution for failure to register (which can result in imprisonment).

In 2004, an entirely separate regulator – Monitor – was established, to assess the suitability of individual trusts for foundation trust status, and to regulate all foundation trusts against their terms of authorisation, covering areas such as governance arrangements, financial management and business planning. Following the Healthcare Commission's investigation into failures in emergency services at Mid Staffordshire NHS Foundation Trust, Monitor has reviewed its approach to clinical governance and now also aims to undertake more systematic reviews of the clinical performance data of trusts (Monitor 2009). Monitor is a non-departmental public body that is accountable directly to Parliament. It has the power to require trusts to take actions within a specified time period, and to remove members of the trust board and even dissolve the trust entirely. Foundation trusts are also subject to the same inspection against national standards as non-foundation trusts, as carried out by the CQC, and can be subject to fines or de-registered.

All providers – FTs and non-FTs alike – are also subject to the requirements of a host of other regulatory and auditing agencies, including the National Audit Office, the National Patient Safety Agency, and specialist bodies such as the Human Fertilisation and Embryology Authority, the Human Tissues Authority and the Medicines and Healthcare Products Regulatory Agency. Non-FTs are also subject to reviews by the Audit

Commission. A recent report led by the NHS Confederation estimated that health care organisations are potentially subject to review by 35 different agencies, against more than 800 standards (NHS Confederation and Independent Healthcare Advisory Services 2009). In 2003 a survey of hospital executives in five countries asked about the ‘top two problems’ facing the respondents’ hospitals; 18 per cent of UK respondents included ‘regulations’ in their answer, while only 4–7 per cent of respondents from other countries mentioned this (Commonwealth Fund 2004).

Having introduced independent quality regulation to the service, the government has since sought to reduce the regulatory burden on organisations, and to streamline demands for information and reporting. However, there is still much work to be done to rationalise activities in this area. Meanwhile, with the post-Darzi quality agenda introducing a host of new requirements (such as Quality Accounts) and bodies (such as the National Quality Board), there remains a real risk of overlaps and confusion around the roles of different bodies. This could lead to problems being missed, as well as to unnecessary administrative burdens being placed on the service.

Regulating professionals

The existing system of professional regulation came under increasing pressure in the 1990s and early 2000s. This was partly due to criticisms that the professional councils lacked transparency and accountability. It was also a result of the findings of the inquiries into children’s heart surgery at Bristol Royal Infirmary, and the serial murders by GP Harold Shipman.

Following the report into Bristol, the government legislated in 2002 for a new Council for Healthcare Regulatory Excellence (CHRE) to scrutinise and oversee the work of the nine professional councils. The CHRE’s role includes conducting annual performance reviews of the councils and, where it believes that a regulator’s final-stage decision has failed to protect the public interest, referring individual cases to the courts.

In 2007, following various reviews, the government published the White Paper *Trust, Assurance and Safety* (Department of Health 2007e), which set out proposals for reform of professional regulation, including:

- a revalidation scheme that would be introduced for all health care professionals, to ensure their continued fitness to practise, comprising a relicensing process and an additional recertification process for GPs and specialists
- a new independent body, separate from the General Medical Council, to adjudicate fitness-to-practise cases
- reform of membership profiles of professional councils, to ensure an equal balance of lay and professional members or a lay majority
- the appointment, rather than election, of professional members.

These recommendations are currently being implemented by the professional councils.

Since the end of 2009, all doctors practising in the UK have been legally required to have a license to practice (based on appraisal, feedback and assurance by the relevant medical director). An additional process of recertification for GPs and specialist doctors every five years – details of which are still being established – is due to be introduced from 2011. Meanwhile, a series of principles have been established for the revalidation of non-medical health care professionals, and the government has committed to introducing that system, together with a new Office of the Healthcare Professions Adjudicator, by 2012 (Hansard 2009a).

These reforms represent a significant shift in the regulation of professionals, towards a system that is focused more on public than professional interests, and that increases the public accountability of professionals.

Looking forward

Since 1997, the accountability of the health service to central government has strengthened.

Much has been achieved through increased information reporting and national targets, but the regime of 'targets and terror' pursued in the late 1990s and early 2000s, and which continues to weigh heavily on managers today, has also brought its costs. Recently published consultancy reports conducted for the government as part of the Next Stage Review process in 2008 found that a culture of fear and blame was prevalent in the service, which stifled learning and distracted from a focus on patients and their families (Institute for Healthcare Improvement 2008, Joint Committee International 2008). Dr Colin-Thomé's report on failures in emergency services at Mid Staffordshire NHS Foundation Trust concluded in 2009 also concluded that an over-reliance on process measures and targets had come at the expense of focusing on the quality of services provided to patients (Colin-Thomé 2009).

Nevertheless, it is important to recognise that such unintended consequences may not be the inevitable result of targets in themselves, but rather of the particular way in which those targets were designed and enforced. Managers must be better supported to deliver targets in ways that do not undermine the ultimate purpose of service provision. Targets are undoubtedly a crude tool, which should be used only selectively, but the next government should be wary of abandoning them entirely given the scale of the benefits they have brought.

Accountability to the centre, and to the public, has also been strengthened by the introduction of external regulation of organisations. This has been a significant achievement. However, there are real concerns about the number of agencies involved in regulating health, and the potential overlaps in their roles. The risk is that health care organisations are overburdened with requirements for providing similar types of information to a host of different bodies, and that a lack of clarity over which agency is ultimately responsible for what leads to some issues falling between gaps. If the next government continues with the current policy for all acute and mental health trusts to gain foundation trust status, it will need to be clear about the distinctive responsibilities of Monitor and the Care Quality Commission, particularly in relation to regulating the quality of clinical services.

The quantity of data collected on NHS care has been described as the 'envy of the world' (Institute for Healthcare Improvement 2008), but it is essential that collected data is used to improve services, and that the burden of collection and processing on frontline organisations is not too onerous. Existing efforts to identify how single information sets might be shared effectively between different agencies need to be pursued with renewed vigour.

The foundation trust model has been a significant experiment in attempting to engage patients and the public in the planning of local service provision, as well as providing local staff with more independence from central control. Early studies on the impact of these arrangements have yielded mixed results. An extensive three-year research project to evaluate the impact of FT governance arrangements, funded by the National Institute for Health Research, is due to report later in 2010. The next government would do well to examine these findings carefully, in an effort to ensure that future efforts to increase

the engagement of patients and the public in provider services are informed by this experience.

The question of where, when and how to best engage patients and the public in commissioning decisions remains unanswered. This issue will require new thinking on the part of the next government, and may take on a new importance in the light of potential rationing decisions required by a tougher financial environment.

9 Looking forward

There is no doubt that the NHS today looks very different to how it looked in 1997. The government itself tells the now-familiar story of sustained investment, increases in staff numbers and new facilities. Other changes are shared with health systems around the world: an increasing focus on patient safety, the growth of evidence-based clinical guidelines, the emergence of a national body to decide about the effectiveness and cost-effectiveness of drugs and treatments, and a much stronger value placed on the perspective of the patient.

There are less obvious changes too, including a revolution in data collection and reporting, at a national and local level. There is now far more information about performance in the public domain, accessible to patients, carers and members of the public, than ever before.

Despite this wealth of information, it has not been possible in this review to provide a fully comprehensive account of the changes that have taken place; gaps remain in our understanding of the benefits that health care provides.

From the available data, we have uncovered a mix of achievements and disappointments.

Since 1997 there has been considerable progress in moving the NHS towards becoming a high-performing health system. The NHS has taken big strides forward in setting standards for high-quality, safe care based on the best available evidence and measuring improvements from patients' perspectives. Waiting times for hospital care have been transformed, and access to primary care has been improved. There has been progress in making the NHS more accountable and transparent to government and taxpayers.

The NHS has driven down rates of some hospital-acquired infections. Screening and legislative action to reduce smoking in public places are yielding improvements in health, while national standards are driving forward clinically effective treatments for the major causes of disease and ill health.

But the review has also found evidence that the NHS has some way to go before it can be considered comprehensively high performing. While access to hospital care has been improved – chiefly through enforcing targets for shorter waiting times – progress is still needed to ensure access to out-of-hours care and care outside of hospitals. In the future, clarity will be needed about the rationale for moving care closer to home and potential trade-offs between what is popular with patients and what constitutes safe and cost-effective care.

There are also important questions about the future of waiting times themselves, given that all three political parties have repudiated targets in favour of entitlements, rights, or guarantees of timely care for patients. Based on past experience, there is a real risk that if the NHS is no longer performance managed on maintaining waiting times, then those times will start to creep up – at least in some geographical areas, and for some conditions.

When it comes to issues of safety, there is further to go to create a fully open culture of reporting in the NHS, and under-reporting in primary care must also be tackled.

There will need to be continued investment in support for NHS organisations to implement guidelines and to successfully engage local clinicians in changing their own practice.

There is clearly further potential for government-wide action to reduce risks from smoking, obesity and alcohol misuse. Meanwhile the NHS must be supported to enable individuals to make healthier choices, using incentives and other behaviour-changing techniques. In particular, it is important to ensure that initiatives to drive healthier choices reach those who face the biggest challenges to their health.

One of the weakest areas of performance has been in the care of chronic conditions. Although there has been progress on individual components of chronic care policy, overall it has not been prioritised, either from the government or from local NHS organisations.

Responding to the needs of these patients in the community, rather than in hospital, in a way that recognises quality of life rather than absence of death, represents a huge challenge for the future. This means reversing the tendency, seen over some decades, for health policy to focus on improving acute hospital care in favour of a health system that can meet the needs of patients with chronic conditions who need to have seamless transitions between the boundaries of primary, community and hospital care.

Cutting across all of this is the need to maintain a focus on a positive patient experience. More work will be needed to ensure that NHS trusts collect and draw on patient experiences, collecting experiences at the 'point of care' more regularly, and in a more detailed way, to feed back to teams and departments within organisations.

The difficulties facing any government include not only the effort needed to complete the transformation of these individual components of the health system, but the inevitable trade-offs between them. These trade-offs exist in systems with finite resources, even at the best of times. However, in the medium term the NHS is facing the worst of times financially. This is likely to make the search for efficiency and productivity the pre-eminent concern within the eight dimensions of the health system identified in this review.

Without a focus on balancing these competing priorities some aspects of the health system could be damaged. For example, a relentless pursuit of efficiencies by reducing admissions without a clear understanding of need could result in greater inequities in access to care. Reducing lengths of stay in hospital or moving care outside hospital may sometimes save money, but must not come at the expense of safety and must be managed in a way that is sensitive to patients' perceptions of the quality of their care.

Where in the system should these priorities be set? The Labour government has attempted to devolve an increasing amount of decision-making locally – a process that would accelerate if national targets were no longer set and performance were not managed from the centre. But more local autonomy brings with it increased variation – which within the NHS system has often been considered undesirable.

Finally, even if the relative importance of the NHS goals could be resolved, the question of which levers and mechanisms work best has not yet been explored fully. Since 1997 the government has plotted a number of different courses in relation to harnessing market forces and competition within the NHS. Its first approach was to reject these principles in favour of targets and a regime of tight performance management. Next, it grafted on to this a set of reforms designed to drive improvements through a reformed hospital payment system, financial incentives for NHS organisations and GPs, consumer choice and competition. In the most recent phase, the market-style levers are still in place, but ministerial rhetoric has emphasised collaboration, clinical leadership and favouring

the NHS over potential independent competitors. These policies have yet to be fully evaluated, and there is little consistent evidence to guide policy-makers in the future.

All these approaches to reform were designed in a period of financial growth and had a strong focus on improving the quality of acute hospital care. Given the demographic challenges ahead, these reforms will need to be aligned to fit new priorities of prevention and chronic care.

In summary, there is no doubt that the NHS is closer to being a high-performing health system now than it was in 1997. It is capable of delivering high-quality care to some patients, in some areas, some of the time. We have identified a number of improvements that need to be made. Even though there are considerable financial challenges ahead the next government must aspire to create an NHS that can deliver quality to all patients, in all areas, all of the time – in a way that is demonstrably fair, efficient and accountable to the society that pays for it.

References

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- Allwright S, Paul G, Greiner B, Mullally BJ, Pursell L, Kelly A, Bonner B, D'Eath M, McConnell B, McLaughlin JP, O'Donovan D, O'Kane E, Perry IJ (2005). 'Legislation for smoke-free workplaces and health of bar workers in Ireland: before and after study'. *British Medical Journal*, vol 331, p 1117.
- Appleby J, Phillips M (2009). 'The NHS: Satisfied now?' in Park A, Curtice J, Thomson K, Phillips, M, Cleary M (eds), *British Social Attitudes: The 25th Report*, pp 25–54. London: National Centre for Social Research.
- Arah OQ, Klazinga NS, Delnoij DMJ, Custers T, Asbroek AHAT (2003). 'Conceptual Frameworks for Health Systems Performance: A quest for effectiveness, quality and improvement'. *International Journal for Quality in Healthcare*, vol 15, no 5, pp 377–8.
- Aspinall P, Jacobson B (2005). *Health Equity Audit: A baseline survey of primary care trusts in England*. London: Health Development Agency. Available at: www.nice.org.uk/niceMedia/documents/health_equity_audit.pdf (accessed on 4 March 2010).
- Audit Commission (2009). 'More for Less? Are productivity and efficiency improving in the NHS?' [online]. Audit Commission Website. Available at: www.audit-commission.gov.uk/SiteCollectionDocuments/AuditCommissionReports/NationalStudies/20091111moreforless.pdf (accessed on 5 March 2010).
- Audit Commission (2008). *Is the Treatment Working? Progress with the NHS system reform programme*. London: Audit Commission. Available at: www.audit-commission.gov.uk/health/nationalstudies/financialmanagement/Pages/isthetreatmentworking_copy.aspx (accessed on 30 March 2010).
- Audit Commission (2001). *Accident and Emergency Services*. London: Audit Commission.
- Baggott R (1994). *Health and Health Care in Britain*. London: Macmillan.
- Barnett N, Jenner C, Baker H (2006). 'Matron's mate'. *Health Service Journal*, vol 116(6032), pp 26–7.
- Bauld L, Bell K, McCullough L, Richardson L, Greaves L (2009). 'The effectiveness of NHS smoking cessation services: a systematic review'. *Journal of Public Health* (advance access online publication). Available at: <http://jpubhealth.oxfordjournals.org/cgi/content/abstract/fdp074> (accessed on 4 December 2009).
- BBC News Online (2009). 'Kidney cancer drug gets go-ahead'. 4 February. Available at: <http://news.bbc.co.uk/1/hi/health/7867817.stm> (accessed on 4 March 2010).
- Berrino F, De Angelis A, Sant M, Rosso S, Bielska-Lasota M, Coebergh JW, Santaquilani M, Eurocare Working Group (2007). 'Survival for eight major cancers and all cancers combined for European adults diagnosed 1995–99: results of the Eurocare-4 study'. *Lancet Oncology*, vol 8, pp 773–83.
- Bevan G (2006). 'Setting targets for health care performance: lessons from a case study of the English NHS'. *National Institute Economic Review*, vol 197, pp 67–79.

- Birchwood M, Bryan S, Jones-Morris N, Kaambwa B, Lester H, Richards J, Rogers H, Sirvastava N, Tzemou E (2007). *EDEN: Evaluating the development and impact of Early Intervention Services (EIS) in the West Midlands*. Report for the NHS Service Delivery and Organisational R&D. Manchester: National Primary Care Research and Development Centre. Available at: www.sdo.nihr.ac.uk/files/project/42-final-report.pdf (accessed on 24 March 2010).
- Bjornberg A, Yazbeck A (2008). *Euro Consumer Heart Index 2008* [online]. Health Consumer Powerhouse. Available at: www.ortivus.se/Documents/Pdf/euro-heart-index-2008.pdf (accessed on 26 November 2009).
- Blackman T, Elliot E, Greene A, Harrington BE, Hunter D, Marks L, McKee L, Smith KE, Williams, GH (2009). 'Tackling health inequalities in post-devolution Britain: do targets matter?' *Public Administration*, vol 87, no 4, pp 762–78.
- Bleich S, Ozaltin E, Murray C (2009). 'How does satisfaction with the health-care system relate to patient experience?' *Bulletin of the World Health Organization*, vol 87, no 4, pp 245–324.
- Bowker TJ, Clayton TC, Ingham J, McLennan NR, Hobson HL, Pyke SD, Schofield B, Wood DA (1996). 'A British Cardiac Society Survey of the Potential for the Secondary Prevention of Coronary Disease: ASPIRE (Action on Secondary Prevention through Intervention to Reduce Events)', *Heart*, vol 75, no 4, pp 334–42.
- Brennan TA, Leape LL, Laird NM, Hebert L, Localio AR, Lawthers AG, Newhouse JP, Weiler PC, Hiatt HH (1991). 'Incidence of adverse events and negligence in hospitalized patients. Results of the Harvard Medical Practice Study'. *New England Journal of Medicine*, vol 324, no 6, pp 370–6.
- British Medical Association's Board of Science (2006). *Child and Adolescent Mental Health: A Guide for Healthcare Professionals*. London: BMA.
- Brown K, Stainer K, Stewart J, Clacy R, Parker S (2008). 'Older people with complex long-term health conditions. Their views on the community matron service: a qualitative study'. *Quality in Primary Care*, vol 16, no 6, pp 409–17.
- Brown M, McPherson K, Marsh T, Byatt T (2010). *A Prediction of Obesity Trends for Adults and Their Associated Diseases*. London: National Heart Forum. Available at: www.heartforum.org.uk/Publications_NHFreports_ObesityTrends.aspx (accessed on 17 February 2010).
- Bruster S, Jarman B, Bosanquet N, Weston D, Erens B, Delbanco T (1994). 'National survey of hospital patients'. *British Medical Journal*, vol 309, pp 1542–9.
- Buchan J, Evans D (2007). *Realising the Benefits? Implementing Agenda for Change*. London: The King's Fund. Available at: www.kingsfund.org.uk/document.rm?id=7094 (accessed on 19 March 2010).
- Burnham A (2009). 'Speech by the Rt Hon Andy Burnham, Secretary of State for Health, 17 September 2009 to The Kings Fund' [online]. Available at: www.dh.gov.uk/en/News/Speeches/DH_105366 (accessed on 9 March 2010).
- Buszewicz M, Rait G, Griffin M, Nazareth I, Patel A, Atkinson A, Barlow J, Haines A (2006). 'Self Management of Arthritis in Primary Care: randomised controlled trial'. *British Medical Journal*, vol 333 (7574). BMJ website. Available at: www.bmj.com/cgi/content/short/333/7574/879 (accessed on 5 March 2010).

- Campbell SM, Reeves D, Kontopantelis E, Sibbald B, Roland M (2009). 'Effects of pay for performance on the quality of primary care in England'. *New England Journal of Medicine*, vol 361, no 4, pp 368–78.
- Campbell SM, Reeves D, Kontopantelis E, Middleton E, Sibbald B, Roland M (2007). 'Quality of primary care in England with the introduction of Pay for Performance'. *New England Journal of Medicine*, vol 357, no 2, pp 181–90.
- Cancer Campaigning Group (2006). *Preparing for a Second Plan. Maintaining the momentum in cancer policy* [online]. Available at: www.cancercampaigninggroup.org.uk/greenpaper.asp (accessed on 4 March).
- Cancer Research UK (2009). *Survival Statistics for the Most Common Cancers* [online]. Available at: <http://info.cancerresearchuk.org/cancerstats/survival/latestrates/index.htm#ten> (accessed on 2 December 2009).
- Capewell S, Pell JP, Morrison C, McMurray J (1999). 'Increasing the impact of cardiological treatments. How best to reduce deaths'. *European Heart Journal*, vol 20, no 19, pp 1386–92.
- Care Quality Commission (2010a). *Count me in 2009: Results of the 2009 national census of inpatients and patients on supervised community treatment in mental health and learning disability services in England and Wales* [online]. Available at: [www.cqc.org.uk/_db/_documents/Count_me_in_2009_\(FINAL_tagged\).pdf](http://www.cqc.org.uk/_db/_documents/Count_me_in_2009_(FINAL_tagged).pdf) (accessed on 30 March 2010).
- Care Quality Commission (2010b). *The State of Health Care and Adult Social Care in England*. London: Care Quality Commission.
- Care Quality Commission (2009a). *Closing the Gap: Tackling cardiovascular disease inequalities by prescribing statins and stop smoking services*. London: Care Quality Commission. Available at: www.cqc.org.uk/_db/_documents/Closing_the_gap.pdf (accessed on 4 March 2010).
- Care Quality Commission (2009b). 'Mental health acute inpatient service users survey 2009' [online]. Available at: www.cqc.org.uk/_db/_documents/2009_survey_of_mental_health_acute_inpatient_services_Full_national_results_tables.pdf (accessed on 8 March 2010).
- Care Quality Commission (2008a). *A Manifesto for the Care Quality Commission* [online]. Available at: www.cqc.org.uk/pdf/CQC%20manifesto%20final.pdf (accessed on 10 February 2010).
- Care Quality Commission (2008b). *National NHS Patient Survey Programme: Survey of adult inpatients* [online]. Available at: www.cqc.org.uk/_db/_documents/National_results_for_each_question_with_comparisons_to_previous_years_and_identifying_changes_that_are_statistically_significant.pdf (accessed on 4 March 2010).
- Cavell G (2006). 'Medication incident reporting – improving the quality of reporting'. *Hospital Pharmacist*, vol 13, pp 53–5.
- Centre for Public Scrutiny (2007). *The Anatomy of Accountability: How the NHS answers to the people*. London: CfPS. Available at: www.cfps.org.uk/what-we-do/publications/cfps-health/?id=37 (accessed on 10 February 2010).
- Centre for Public Scrutiny (2005). *Process, Progress and Making it Happen: Health overview and scrutiny in England*. London: CfPS. Available at: www.cfps.org.uk/what-we-do/publications/cfps-general/?id=66 (accessed on 10 February 2010).
- Chief Medical Officer (2003). *Making Amends. Clinical negligence reform*. Leeds: Department of Health. Available at: www.dh.gov.uk/en/Publicationsandstatistics/

Publications/PublicationsPolicyAndGuidance/DH_4010641 (accessed on 17 February 2009).

Clark DM, Layard R, Smithies R, Richards DA, Suckling R, Wright B (2009). 'Improving access to psychological therapy: initial evaluation of two UK demonstration sites'. *Behaviour Research and Therapy*, vol 47, pp 910–20.

Clinical Standards Advisory Group (1998). *Report on Clinical Effectiveness using Stroke Care as an Example*. London: The Stationery Office.

Cochrane AL (1972). *Effectiveness and Efficiency: Random reflections on health services*. London: Nuffield Provincial Hospitals Trust.

Colin-Thomé D (2009). *Mid Staffordshire NHS Foundation Trust: A review of lessons learnt for commissioners and performance managers following the Healthcare Commission investigation* [online]. Available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_098660 (accessed on 10 February 2010).

Colin-Thomé D, Field S (2010). *General Practice Out-of-Hours Services: project to consider and assess current arrangements*. London: Department of Health. Available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_111892 (accessed on 23 March 2010).

Collishaw S, Maughan B, Goodman R, Pickles A (2004). 'Time trends in adolescent mental health'. *Journal of Child Psychology and Psychiatry*, vol 45, pp 1350–62.

Commission for Healthcare Audit and Inspection (2006). *Living well in later life. A review of progress against the National Service Framework for Older People*. London: Commission for Healthcare Audit and Inspection. Available at: www.audit-commission.gov.uk/SiteCollectionDocuments/AuditCommissionReports/NationalStudies/HCC_olderPeopleREP.pdf (accessed on 10 March 2010).

Commission for Healthcare Improvement (2004). *Unpacking the Patient's Perspective: Variations in NHS patient experience in England*. London: Commission for Healthcare Improvement.

Commonwealth Fund (2009). '2009 Commonwealth Fund International Health Policy Survey' [online]. Commonwealth Fund Website. Available at: www.commonwealthfund.org/Content/Surveys/2009/Nov/2009-Commonwealth-Fund-International-Health-Policy-Survey.aspx (accessed on 23 March 2010).

Commonwealth Fund (2008). *International Health Policy Survey of Sicker Adults* [online]. Available at: www.commonwealthfund.org/Content/Surveys/2008/2008-Commonwealth-Fund-International-Health-Policy-Survey-of-Sicker-Adults.aspx (accessed on 17 February 2010).

Commonwealth Fund (2007). '2007 International Health Policy Survey in Seven Countries' [online]. Commonwealth Fund Website. Available at: www.commonwealthfund.org/Content/Surveys/2007/2007-International-Health-Policy-Survey-in-Seven-Countries.aspx (accessed on 23 March 2010).

Commonwealth Fund (2006). 'International Health Policy Survey of Primary Care Physicians' [online]. Commonwealth Fund Website. Available at: www.commonwealthfund.org/Content/Surveys/2006/2006-International-Health-Policy-Survey-of-Primary-Care-Physicians.aspx (accessed on 23 March 2010).

Commonwealth Fund (2004). '2003 International Health Policy Survey of Hospital Executives' [online]. Commonwealth Fund Website. Available at: www.commonwealthfund.org/Content/Surveys/2004/2003-International-Health-Policy-Survey-of-Hospital-Executives.aspx

- commonwealthfund.org/Content/Surveys/2003/2003-International-Health-Policy-Survey-of-Hospital-Executives.aspx (accessed on 23 March 2010).
- Commonwealth Fund Commission on a High Performance Health System (2008). *Why not the Best? Results from the National Scorecard on US Health System Performance, 2008*. Washington: Commonwealth Fund. Available at: www.commonwealthfund.org/Content/Publications/Fund-Reports/2008/Jul/Why-Not-the-Best--Results-from-the-National-Scorecard-on-U-S--Health-System-Performance--2008.aspx (accessed on 15 March 2010).
- Cooper Z, McGuire A, Jones S, Le Grand J (2009). 'Equity, waiting times, and NHS reforms: retrospective study'. *British Medical Journal*, vol 339, p b3264.
- Coulter A (2006). *Engaging Patients in their Healthcare: How is the UK doing relative to other countries?* Oxford: Picker Institute. Available at: www.pickereurope.org/Filestore/PIE_reports/project_reports/Six_country_study_with_ISBN_web.pdf (accessed on 23 March 2010).
- Coulter A, Fitzpatrick R, Cornwell J (2009). *The Point of Care: Measures of Patients' Experience in Hospital: Purpose, methods and uses*. London: The King's Fund. Available at: www.kingsfund.org.uk/publications/measures.html (accessed on 8 March 2010).
- Coulter A, Jenkinson C (2005). 'European patients' views on the responsiveness of health systems and healthcare providers'. *European Journal of Public Health* 2005, vol 15, pp 355–60.
- Craig TJK, Garety P, Power P, Rahaman N, Colbert S, Fornells-Ambrojo M, Dunn G (2004). 'The Lambeth Early Onset (LEO) Team: randomised controlled trial of the effectiveness of specialised care for early psychosis'. *British Medical Journal*, vol 329, pp 1067–72.
- Cullum N, Dawson D, Lanshear A, Lowson AJ, Mahon K, Raynor J, Wright, D, Wright, J (2004). 'The Evaluation of the Dissemination, Implementation and Impact of NICE Guidance: Final report' [online]. NIHR Health Technology Assessment programme Website. Available at: www.hta.ac.uk/nihrmethodology/briefs/1559.pdf (accessed on 19 March 2010).
- Davey Smith G, Morris J (1994). 'Increasing inequalities in the health of the nation'. *British Medical Journal*, vol 309, pp 1453–4. Available at: www.bmj.com/cgi/content/full/309/6967/1453 (accessed on 4 March 2010).
- Delnoij D (2006). 'Measuring patient experiences in Europe: what can we learn from the experiences in the USA and England?' *European Journal of Public Health*, vol 19, no 4, pp 354–6.
- Department of Health (2010a). '18 Weeks Referral to Treatment Statistics' (November 2009). Department of Health website. Available at: www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Perfomancedataandstatistics/18weeksReferraltoTreatmentstatistics/index.htm (accessed on 24 March 2010).
- Department of Health (2010b). *Exposition Book 2009–10 and 2010–11*. London: The Stationery Office. Available at: www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/Allocations/DH_091850 (accessed on 24 March 2010).
- Department of Health (2010c). 'Hospital Waiting Times and Waiting Lists' (Historical Time Series). Department of Health website. Available at: www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Perfomancedataandstatistics/HospitalWaitingTimesandListStatistics/index.htm (accessed on 24 March 2010).

Department of Health (2010d). 'Local data on pregnant women smoking at time of delivery'. Department of Health website. Available at: www.dh.gov.uk/en/Publichealth/Healthimprovement/Tobacco/Tobaccogeneralinformation/DH_4139682 (accessed on 23 March 2010).

Department of Health (2010e). *The Proposals to Implement 'generic substitution' in Primary Care, Further to the Pharmaceutical Price Regulation Scheme (PPRS) 2009*. Consultation document. London: Department of Health. Available at: www.dh.gov.uk/en/Consultations/Liveconsultations/DH_110517 (accessed on 23 March 2010).

Department of Health (2010f). 'Quality and Outcomes Framework'. Department of Health website. Available at: www.dh.gov.uk/en/Healthcare/Primarycare/Primarycarecontracting/QOF/DH_099079 (accessed on 5 March 2010).

Department of Health (2010g). *The Use of Medications in Care Homes* [online]. Available at: www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_110717 (accessed on 4 March 2010).

Department of Health (2009a). *The 2009 Pharmaceutical Price Regulating Scheme* [online]. Available at: www.dh.gov.uk/en/Healthcare/Medicinespharmacyandindustry/Pharmaceuticalpriceregulationscheme/2009PPRS/index.htm (accessed on 4 March 2010).

Department of Health (2009b). *AHP Data Collection: Dear Colleague letter, 19 November 2009* [online]. Available at: www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_108753.pdf (accessed on 15 March 2010).

Department of Health (2009c). *Antibiotic Resistance* [online]. Available at: www.dh.gov.uk/en/Publichealth/Patientsafety/Antibioticresistance/index.htm (accessed on 4 March 2010).

Department of Health (2009d). *Autumn Performance Report 2009*. Cm 7776. London: The Stationery Office. Available at: www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_109886.pdf (accessed on 4 March 2010).

Department of Health (2009e). *Cancer Reform Strategy. Achieving local implementation – second annual report*. London: Department of Health.

Department of Health (2009f). *A Consultation on Proposals for the Innovation Pass Pilot* [online]. Available at: www.dh.gov.uk/en/Consultations/Liveconsultations/DH_109236 (accessed on 4 March 2010).

Department of Health (2009g). *Departmental Report 2009. The Health and Personal Social Services Programme*. London: The Stationery Office.

Department of Health (2009h). *Estimated England Level Gross Expenditure by Programme Budget* [online]. Available at: www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/Programmebudgeting/DH_075743 (accessed on 26 November 2009).

Department of Health (2009i). *The Government Response to the Health Select Committee Report 'Patient Safety'*. London: Department of Health.

Department of Health (2009j). 'GP Extended Opening Hours'. Department of Health website. www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/PrimaryCare/DH_089459 (accessed on 24 March 2010).

Department of Health (2009k). *An Independent Review of NHS Dental Services in England* [online]. Available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_101137 (accessed on 4 March 2010).

- Department of Health (2009l). *Living Well with Dementia: A national strategy* [online]. Available at: www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/Olderpeople/NationalDementiaStrategy/index.htm (accessed on 4 March 2010).
- Department of Health (2009m). *Mortality Target Monitoring (Infant Mortality, inequalities). Update to include data for 2008* [online]. Available at: www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_109444.pdf (accessed on 24 March 2010).
- Department of Health (2009n). 'Mortality Target Monitoring. (Life expectancy and All-Age All-Cause Mortality, overall and inequalities). Update to include data for 2008' [online]. Department of Health website. Available at: www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_107912.pdf (accessed on 22 March 2010).
- Department of Health (2009o). *NHS 2010–2015: From good to great. Preventative, people-centred, productive*. Cm 7775. London: Department of Health. Available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_109876 (accessed on 4 March 2010).
- Department of Health (2009p). *Necessity – Not Nicety: A new commercial operating model for the NHS and the Department of Health*. London: Department of Health. Available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_098876 (accessed on 23 March 2010).
- Department of Health (2009q). *NHS Constitution: The NHS belongs to us* [online]. Available at: www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_093442.pdf (accessed on 4 March 2010).
- Department of Health (2009r). *Patient experience PSA scores update based on data up to and including 2008 patient surveys* [online]. Available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_100349 (accessed on 4 March 2010).
- Department of Health (2009s). 'PCT decisionmaking process on medicine'. Department of Health website. Available at: www.dh.gov.uk/en/Managingyourorganisation/Commissioning/DH_093414 (accessed on 23 March 2010).
- Department of Health (2009t). 'Pharmaceutical Price Regulation Scheme'. Department of Health website. Available at: www.dh.gov.uk/en/Healthcare/Medicinespharmacyandindustry/Pharmaceuticalpriceregulationscheme/2009PPRS/index.htm (accessed on 23 March 2010).
- Department of Health (2009u). *Report of the Director of Immunisation* [online]. Available at: www.immunisation.nhs.uk/Files/11678_ImmunisationReport_acc.pdf (accessed on 18 January 2010).
- Department of Health (2009v). *Report on the National Patient Choice Survey – March 2009, England* [online]. Available at: www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_103681.pdf (accessed 8 March 2010).
- Department of Health (2009w). *Tackling Health Inequalities: Ten years on* [online]. Available at: www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_098934.pdf (accessed on 4 March 2010).
- Department of Health (2009x). 'Tariff Information: Confirmation of Payment by Results (PbR) arrangements for 2009–10'. Department of Health website. Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_094091 (accessed on 23 March 2010).

Department of Health (2009y). *A Year of Progress towards High Quality Care for All* [online]. Available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_101670 (accessed on 4 March 2010).

Department of Health (2008a). *Cancer Reform Strategy. Maintaining momentum, building for the future – first annual report*. London: Department of Health.

Department of Health (2008b). *The Coronary Heart Disease National Service Framework, Building on excellence, maintaining progress. Progress report for 2008*. London: Department of Health. Available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_096555 (accessed on 4 March 2010).

Department of Health (2008c). *End of Life Care Strategy: Promoting quality of care for all adults at the end of life* [online]. Available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_086277 (accessed on 4 March 2010).

Department of Health (2008d). *High Quality Care For All: Final report of the NHS next stage review*. London: Department of Health.

Department of Health (2008e). *Improving Access to Psychological Therapies Implementation Plan: National guidelines for regional delivery*. London: Department of Health. Available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_083150 (accessed on 22 March 2010).

Department of Health (2008f). *Local Involvement Networks (LINKs)* [online]. Available at: www.dh.gov.uk/en/Managingyourorganisation/PatientAndPublicinvolvement/DH_076366 (accessed on 10 February 2010).

Department of Health (2008g). *Putting Prevention First. Vascular checks: Risk assessment and management* [online]. Available at: www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_083823.pdf (accessed on 4 December 2009).

Department of Health (2007a). *Cancer Reform Strategy* [online]. Available at: www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_081007.pdf (accessed on 4 March 2010).

Department of Health (2007b). *Maternity Matters. Choice, access and continuity of care in a safe service* [online]. Available at: www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_074199.pdf (accessed on 4 March 2010).

Department of Health (2007c). *National Stroke Strategy* [online]. Available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081062 (accessed on 4 March 2010).

Department of Health (2007d). *Our NHS Our Future: NHS Next stage review interim report*. London: Department of Health. Available at: www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_079087.pdf (accessed on 9 March 2010).

Department of Health (2007e). *Trust, Assurance and Safety. The regulation of health professionals*. Cm 7013. London: The Stationery Office. Available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_065946 (accessed on 22 February 2010).

Department of Health (2007f). *Value for Money Delivery Agreement* [online]. Available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081547 (accessed on 4 March 2010).

- Department of Health (2006a). *Gershon Efficiency Programme 2004–2008: High level delivery plan* [online]. Available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4131575 (accessed on 4 March 2010).
- Department of Health (2006b). *On the State of the Public Health: Annual report of the Chief Medical Officer 2005* [online]. Available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/AnnualReports/DH_4137366 (accessed on 4 March 2010).
- Department of Health (2006c). *Our Health, Our Care, Our Say: A new direction for community services*. London: Department of Health.
- Department of Health (2006d). *Report of the Chief Medical Officer 2005* [online]. Available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/AnnualReports/DH_4137366 (accessed on 4 March 2010).
- Department of Health (2006e). *Safety First: A report for patients, clinicians and healthcare managers*. London: Department of Health.
- Department of Health (2005a). *Building Telecare in England* [online]. Available at: www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4115644.pdf (accessed on 14 December 2009).
- Department of Health (2005b). *Delivering Race Equality in Mental Health Care: An action plan for reform inside and outside services and the Government's response to the Independent inquiry into the death of David Bennett*. London: Department of Health.
- Department of Health (2005c). *Supporting People with Long Term Conditions. An NHS and Social Care Model to support local innovation and integration. Improving care. Improving lives* [online]. Available at: www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4122574.pdf (accessed on 15 December 2009).
- Department of Health (2004a). 'Agenda for Change Final Agreement (December 2004)' [online]. Available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4095943 (accessed on 5 March 2010).
- Department of Health (2004b). 'Bureaucracy Busting Partnership will save NHS millions'. Press Release, 22 November. Available at: www.dh.gov.uk/en/Publicationsandstatistics/Pressreleases/DH_4095334 (accessed on 23 March 2010).
- Department of Health (2004c). *NHS Improvement Plan: Putting people at the heart of public services*. Cm 6268. London: The Stationery Office. Available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4084476 (accessed 15 March 2010).
- Department of Health (2004d). *Reconfiguring the Department of Health's Arm's Length Bodies* [online]. Available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4086081 (accessed on 10 February 2010).
- Department of Health (2003a). *Choice, Responsiveness and Equity National Consultation: Public survey* [online]. Available at: www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4078797.pdf (accessed on 30 March 2010).
- Department of Health (2003b). *Health Equity Audits: A guide for the NHS* [online]. Available at: www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4084139.pdf (accessed on 4 March 2010).

Department of Health (2003c). *Tackling Health Inequalities: A programme for action* [online]. Available at: www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4019362.pdf (accessed on 4 March 2010).

Department of Health (2002). *Improvement, Expansion and Reform – the next 3 years. Priorities and planning framework 2003–2006*. London: Department of Health. Available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4008430 (accessed on 5 March 2010).

Department of Health (2001a). *Building a Safer NHS for Patients. Improving medication safety*. London: The Stationery Office. Available at: www.dh.gov.uk/assetRoot/04/07/15/07/04071507.pdf (accessed on 17 February 2010).

Department of Health (2001b). *Medicines Management Framework*. London: Department of Health.

Department of Health (2001c). *National Service Framework for Diabetes: Standards*. Available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4002951 (accessed on 15 March 2010).

Department of Health (2000a). *A National Service Framework for Coronary Heart Disease*. London: Department of Health.

Department of Health (2000b). *The NHS Cancer Plan: A plan for investment, a plan for reform* [online]. Available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009609 (accessed on 4 March 2010).

Department of Health (2000c). *The NHS Plan. A plan for investment, a plan for reform*. London: Department of Health.

Department of Health (2000d). *An Organisation with a Memory. Report of an expert learning group on adverse events in the National Health Service*. London: The Stationery Office. Available at: www.dh.gov.uk/assetRoot/04/06/50/86/04065086.pdf (accessed on 17 February 2010).

Department of Health (1999a). *National Service Framework for Mental Health: Modern standards and service models*. London: Department of Health.

Department of Health (1999b). *National Surveys of NHS patients: General practice 1998* [online]. Available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_4010249 (accessed on 4 March).

Department of Health (1999c) *The NHS Performance Assessment Framework*. London: Department of Health. Available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009190 (accessed 15 March 2010).

Department of Health (1998a). *A First Class Service: Quality in the new NHS*. London: Department of Health.

Department of Health (1998b). 'The Health of the Nation. A policy assessed: executive summary' [online]. Available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4121577 (accessed on 8 March 2010)

Department of Health (1998c). *Health Survey for England 1996* [online]. Available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_4002768 (accessed on 2 December 2009).

Department of Health (1998d). *Independent Inquiry into Inequalities in Health Report*. London: Department of Health.

- Department of Health (1998e). *Smoking Kills: a White Paper on tobacco*. Cm 4177. London: The Stationery Office. Available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4006684 (accessed on 15 March 2010).
- Department of Health (1997). *The New NHS: Modern, dependable*. Cm 3807. London: The Stationery Office. Available at: www.archive.official-documents.co.uk/document/doh/newnhs/newnhs.htm (accessed on 10 February 2010).
- Department of Health (1996a). *Immunisation against Infectious Disease 1996. The Green Book*. London: Department of Health. Available at: www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4072984.pdf (accessed on 26 January 2010).
- Department of Health (1996b). *The National Health Service: A service with ambitions*. Cm 3245. London: The Stationery Office.
- Department of Health (1995). *A Policy Framework for Commissioning Cancer Services. A report by the Expert Advisory Group on Cancer to the Chief Medical Officers of England and Wales*. London: Department of Health.
- Department of Health (1987). *Promoting Better Health: the Government's programme for improving primary health care*. Cm 249. London: HMSO.
- Department of Health (1980). *Inequalities in Health: Report of a research working group*. London: DHSS.
- Dineen M, Walsh K (1999). 'Incident reporting in the NHS'. *Health Care Risk Report*, vol 5, no. 4, pp 17–22.
- Dixon A (2007). 'Is the British National Health Service equitable?: The evidence of socioeconomic differences in utilization'. *Journal of Health Services Research and Policy*, vol 12, no 2, pp 104–9.
- Dixon A, Khachatryan A, Gilmour S (2010a). 'Does general practice reduce health inequalities? Analysis of quality and outcomes framework data?' In press.
- Dixon A, Peckham S, Khachatryan A, Wallace A, Boyce T (2010b). *Impact of QOF on GP practise, public health outcomes and health inequalities in England. Final report*. SDO Project – 08/1716/207. In press. Available at: www.sdo.nihr.ac.uk/project.php (accessed on 9 March 2010).
- Doran T, Fullwood C, Kontopantelis E, Reeves D (2008). 'Effect of financial incentives on inequalities in the delivery of primary clinical care in England: analysis of clinical activity indicators for the quality and outcomes framework'. *The Lancet*, vol 372(9640), pp 728–36.
- Doran T, Fullwood C, Gravelle H, Reeves D, Kontopantelis E, Hiroeh U, Roland M (2006). 'Pay-for-performance Programs in Family Practices in the United Kingdom'. *New England Journal of Medicine*. 2006, vol 355, no 4, pp 375–84.
- Dyer C (1997). 'Ruling on Interferon Beta will hit all health authorities'. *British Medical Journal*, vol 315, pp 143–8.
- Editorial (1974). 'Towards medical audit'. *British Medical Journal*, vol 1, pp 255–7.
- Elgar FJ, Roberts C, Tudor-Smith C, Moore L. (2005). 'Validity of self-reported height and weight and predictors of bias in adolescents'. *Journal of Adolescent Health*, vol 37, no 5, pp 371–5.

- Evidence Based Medicine Working Group (1992). 'Evidence-based medicine: a new approach to teaching the practice of medicine'. *Journal of the American Medical Association*, vol 268, no 17, pp 2420–5.
- Farrell C, Levenson R, Snape D (1998). *The Patient's Charter: Past and future*. London: The King's Fund.
- The Foresight Programme (2007). *Tackling Obesities – Future Choices*. London: Government Office for Science. Available at: www.foresight.gov.uk/Obesity/17.pdf (accessed on 16 February 2010).
- Freeman P, Robbins A (1994). 'National health care reform minus public health: a formula for failure'. *Journal of Public Health*, vol 15, no 3, pp 261–82.
- Gainsbury S (2009). 'Risks and benefits: changing the nursing skills mix'. *Nursing Times*, vol 105, no 37, pp 8–10.
- Garfield S, Barber N, Walley, Willson A, Eliasson L (2009). 'Quality of medication use in primary care'. *BMC Medicine*, vol 9, p 50.
- Garratt AM, Solheim E, Danielsen K (2008). *National and Cross-national Surveys of Patient Experiences: A structured review*. Oslo: Nasjonalt kunnskapssenter for helsetjenesten. Available at: <http://www.kunnskapssenteret.no/Publikasjoner/2420.cms?threepage=1> (accessed on 23 March 2010).
- General Medical Council (2009). 'GMC calls for a national prescription chart to reduce errors' [online]. Available at: www.gmc-uk.org/news/5156.asp (accessed on 4 March 2010).
- General Medical Council (2006). 'General Medical Council Good Medical Practice' [online]. Available at: www.gmc-uk.org/guidance/good_medical_practice.asp (accessed on 15 March 2010).
- Gershon P (2004). *Releasing Resources to the Front Line: Independent review of public sector efficiency*. London: The Stationery Office. Available at: www.hm-treasury.gov.uk/d/efficiency_review120704.pdf (accessed on 5 March 2010).
- Glover G, Arts G, Babu KS (2006). 'Crisis resolution/home treatment teams and psychiatric admission rates in England'. *British Journal of Psychiatry*, vol 189, pp 441–5.
- Goddard M, Gravelle H, Hole A, Marini G (2009). 'Where did all the GPs go? Increasing supply and geographical equity in England and Scotland'. *Journal of Health Services Research and Policy*, vol 15, no 1, pp 28–35.
- Goddard R, Smith P (1998). *Equity of Access to Health Care*. York: Centre for Health Economics, University of York. Available at: www.york.ac.uk/inst/che/pdf/op32.pdf (accessed on 4 March 2010).
- Goodman P, Agnew M, McCaffrey M, Paul G, Clancy L (2007). 'Effects of the Irish smoke-free laws on respiratory health of bar workers and air quality in Dublin pubs'. *American Journal of Respiratory Critical Care Medicine*, vol 175, pp 840–5.
- Goodrich J, Cornwell J (2008). *Seeing the Person in the Patient: The point of care review paper*. London: The King's Fund. Available at: www.kingsfund.org.uk/research/publications/the_point_of_care.html (accessed on 4 March 2010).
- Gowers SG, Rowlands L (2005). 'Inpatient services'. *Current Opinions in Psychiatry*, vol 18, no 4, pp 445–8.

- Gravelle H, Dusheiko M, Sheaff R, Sargent P, Boaden R, Pickard S, Parker S, Roland M (2007). 'Impact of case management (Evercare) on frail elderly patients: controlled before and after analysis of quantitative outcome data'. *British Medical Journal*, vol 334, pp 31–4.
- Griffiths C, Foster G, Ramsay J, Eldridge S, Taylor S (2007). 'How effective are expert patient (lay led) education programmes for chronic disease?' *British Medical Journal*, vol 334, pp 1254–56.
- Gubb J (2009). 'Have targets done more harm than good in the English NHS? Yes'. *British Medical Journal*, vol 338, pp 442–3. Available at: www.bmj.com/cgi/content/full/338/jan16_2/a3130 (accessed on 10 February 2010).
- Halliday AW, Lees T, Kamugasha D, Grant R, Hoffman A, Rothwell PM, Potter JF, Horrocks M, Naylor R, Rudd AG (2009). 'Waiting times for carotid endarterectomy in UK: observational study'. *British Medical Journal*, vol 338, p b1847.
- Ham C (2010). 'The ten characteristics of the high-performing chronic care system'. *Health Economics, Policy and Law*, vol 5, pp 71–90.
- Hansard (2009a). *Hansard (House of Commons Debates)* (2009–10) 15 July 2009 col 548W. Available at: www.publications.parliament.uk/pa/cm200809/cmhansrd/cm090715/text/90715w0039.htm#09071617002188 (accessed on 10 February 2010).
- Hansard (2009b). *Hansard (House of Commons Debates)* (2009–10) 20 July 2009 col 994W. Available at: www.publications.parliament.uk/pa/cm200809/cmhansrd/cm090720/text/90720w0062.htm#09072167004018 (accessed on 10 February 2010).
- Hansard (2008). *Hansard (House of Commons Debates)* (2008–9) 14 May 2008 col 1646W. Available at: www.publications.parliament.uk/pa/cm200708/cmhansrd/cm080514/text/80514w0016.htm#08051487001276 (accessed on 15 February 2010).
- Hansard (2007a). *Hansard (House of Commons Debates)* (2007–8) 4 July 2007 col 962. Available at: www.publications.parliament.uk/pa/cm200607/cmhansrd/cm070704/debtext/70704-0004.htm#07070441001052 (accessed on 5 March 2010).
- Hansard (2007b). *Hansard (House of Commons Debates)* (2007–8) 18 July 2007 col 466W. Available at: www.publications.parliament.uk/pa/cm200607/cmhansrd/cm070718/text/70718w0027.htm#0707193001081 (accessed on 10 February 2010).
- Harkness E, Bower P, Gask L, Sibbald B (2007). 'Retention and future job intentions of graduate primary care mental health workers: a newly developed role in England'. *Journal of Health Service and Research Policy*, vol 12, pp 18–22.
- Harley M, Mohammed M, Hussain S, Yates J, Almasri A (2005). 'Was Rodney Ledward a Statistical Outlier? Retrospective analysis using routine hospital data to identify gynaecologists' performance'. *British Medical Journal*, vol 330, no 7497, pp 929–32.
- Harnden A, Mayon-White R, Mant D, Kelly D, Pearson G (2009). 'Child deaths: confidential enquiry into the role and quality of UK primary care'. *British Journal of General Practice*, vol 59, pp 819–24.
- Harrison A, Appleby J (2005). *The War on Waiting for Hospital Treatment: What has Labour achieved and what challenges remain?* London: The King's Fund. Available at: www.kingsfund.org.uk/research/publications/the_war_on.html (accessed on 10 February 2010).
- Harrison A (1998). 'The Conservatives and the NHS during the 1990s', in *Health care UK 1997/98: The King's Fund annual review of health care policy*, pp 232–48. London: The King's Fund.

- Harrison A, New B, eds (1997). *Health Care UK 1996/97. The King's Fund annual review of health policy*. London: The King's Fund.
- Haward RA (2006). 'The Calman–Hine report: a personal retrospective on the UK's first comprehensive policy on cancer services'. *Lancet Oncology*, vol 7, issue 4, pp 336–46.
- Hawe E (2009). *OHE Compendium of Health Statistics*. 20th Edition. London: Radcliffe.
- Health and Social Care Act* (2001). c15. Available at: www.opsi.gov.uk/Acts/acts2001/ukpga_20010015_en_1 (accessed on 15 March 2010).
- Health Protection Agency (2009a). *Healthcare-associated Infections in England: 2008–2009 Report*. London: Health Protection Agency.
- Health Protection Agency (2009b). 'Results from the mandatory surveillance of MRSA bacteraemia'. Health Protection Agency website. Available at: www.hpa.org.uk/web/HPAweb&HPAwebStandard/HPAweb_C/1233906819629 (accessed on 25 March 2010).
- Health Service Journal* (2009). 'World class commissioning league table' [online]. *Health Service Journal*, 5 March. Available at: www.hsj.co.uk/Journals/2/Files/2009/5/11/4–2002410.pdf (accessed on 10 February 2010).
- Healthcare Commission (2009a). *Equality in Later Life: A national study of older people's mental health services*. London: Commission for Healthcare Audit and Inspection. Available at: www.cqc.org.uk/_db/_documents/Equality_in_later_life.pdf (accessed on 15 March 2010).
- Healthcare Commission (2009b). *Investigation into Mid Staffordshire NHS Foundation Trust*. London: Commission for Healthcare Audit and Inspection. Available at: www.cqc.org.uk/_db/_documents/Investigation_into_Mid_Staffordshire_NHS_Foundation_Trust.pdf (accessed on 8 March 2010).
- Healthcare Commission (2008). *Towards Better Births: A review of maternity services in England* [online]. Available at: www.cqc.org.uk/_db/_documents/Towards_better_births_200807221338.pdf (accessed on 4 March 2010).
- Healthcare Commission (2007). *Investigation into Outbreaks of Clostridium difficile at Maidstone and Tunbridge Wells NHS Trust*. London: Commission for Healthcare Audit and Inspection. Available at: www.cqc.org.uk/_db/_documents/Maidstone_and_Tunbridge_Wells_investigation_report_Oct_2007.pdf (accessed on 8 March 2010).
- Healthcare Commission and Audit Commission (2008). *Is the Treatment Working?* London: Audit Commission. Available at: www.audit-commission.gov.uk/nationalstudies/health/financialmanagement/pages/isthetreatmentworking.aspx (accessed on 10 February 2010).
- HM Government (2010). *A Smokefree Future. A comprehensive tobacco control strategy for England*. London: The Stationery Office. Available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_111749 (accessed on 2 February 2010).
- HM Government (2009a). *Building Britain's Future*. Cm 7654. London: The Stationery Office. Available at: www.hmg.gov.uk/media/27749/full_document.pdf (accessed on 9 March 2010).
- HM Government (2009b). *PSA Delivery Agreement 25. Reducing the harm caused by alcohol and drugs*. London: The Stationery Office. Available at: www.alcohollearningcentre.org.uk/_library/Resources/ALC/OtherOrganisation/PSA_25.pdf (accessed on 13 November 2009).

- HM Government (2009c). *The Local Authority Social Services and National Health Complaints (England) Regulations 2009*. Statutory Instrument 2009, no. 309. Available at: www.opsi.gov.uk/si/si2009/ukSI_20090309_en_1 (accessed on 30 March 2010).
- HM Government (2008). *Healthy Weight, Healthy Lives: A cross-government strategy for England*. London: The Stationery Office. Available at: www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_084024.pdf (accessed on 13 November 2009).
- HM Government (2007a). *Putting People First. A shared vision and commitment to the transformation of Adult Social Care*. London: The Stationery Office. Available at: www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_081119.pdf (accessed on 23 December 2009).
- HM Government (2007b). *Safe. Sensible. Social. The next steps in the National Alcohol Strategy*. London: The Stationery Office. Available at: www.alcohollearningcentre.org.uk/library/Resources/ALC/OtherOrganisation/Safe_Sensible_Social_Full_doc.pdf (accessed on 13 November 2009).
- HM Government (1999). *Saving Lives: Our healthier nation*. Cm 4386. London: The Stationery Office. Available at: www.archive.official-documents.co.uk/document/cm43/4386/4386-01.htm (accessed on 18 November 2009).
- HM Government (1992). *The Health of the Nation*. London: The Stationery Office.
- HM Government (1991). *The Patient's Charter*. London: The Stationery Office.
- HM Treasury (2009). *2009 Value for Money Agreement*. London: HM Treasury.
- HM Treasury (2007). *Meeting the Aspirations of the British People: 2007 Pre-Budget Report and Comprehensive Spending Review*. Cm 7227. London: The Stationery Office.
- HM Treasury (2004). *2004 Spending Review. Stability, Security and Opportunity for All: Investing for Britain's long-term future*. Cm 6237. London: HMSO. Available at: www.hm-treasury.gov.uk/spend_sr04_repindex.htm (accessed on 15 March 2010).
- Hood S, Birnie D, Swan L, Hillis WS (1998). 'Questionnaire Survey of Thrombolytic Treatment in Accident and Emergency Departments in the United Kingdom'. *British Medical Journal*, vol 316, no 7127, p 274.
- House of Commons Health Committee (2010). *Public Expenditure on Health and Personal Social Services 2009*. HC 269-I (2009–10). London: The Stationery Office. Available at: <http://www.publications.parliament.uk/pa/cm200910/cmselect/cmhealth/269/269i.pdf> (accessed on 23 March 2010).
- House of Commons Health Committee (2009a). *Health Inequalities*. HC 286-I (2008–09). London: The Stationery Office. Available at: www.publications.parliament.uk/pa/cm200809/cmselect/cmhealth/286/286.pdf (accessed on 23 March 2010).
- House of Commons Health Committee (2009b). *Patient Safety*. London: The Stationery Office.
- House of Commons Health Committee (2008). *Foundation Trusts and Monitor*. HC 833-I (2007–08). London: The Stationery Office. Available at: www.publications.parliament.uk/pa/cm200708/cmselect/cmhealth/833/833.pdf (accessed on 10 February 2010).
- House of Commons Health Committee (2007). *Patient and Public Involvement in the NHS*. HC 278-I (2006–07). London: The Stationery Office. Available at: www.publications.parliament.uk/pa/cm200607/cmselect/cmhealth/278/278i.pdf (accessed on 10 February 2010).

House of Commons Health Committee (2006a). 'Letter from Rosie Winterton MP, Minister of State, Department of Health, to Dr Richard Taylor MP: Annex A. *Health Select Committee Minutes of Evidence*, 26 January [online]. Available at: www.publications.parliament.uk/pa/cm200506/cmselect/cmhealth/866/6012601.htm (accessed on 10 February 2010).

House of Commons Health Committee (2006b). *NHS Charges*. HC-815 I (2005–06). London: The Stationery Office. Available at: www.publications.parliament.uk/pa/cm200506/cmselect/cmhealth/815/815-i.pdf (accessed on 23 March 2010).

House of Commons Public Accounts Committee (2010). *Young People's Sexual Health: The National Chlamydia Screening Programme*. HC-283 (2009–10). London: The Stationery Office. Available at: www.publications.parliament.uk/pa/cm200910/cmselect/cmpubacc/283/283.pdf (accessed on 28 January 2010).

House of Commons Public Accounts Committee (2009). *Reducing Healthcare Associated Infection in Hospitals in England*. HC-812 (2008–2009). London: The Stationery Office. Available at: www.publications.parliament.uk/pa/cm200809/cmselect/cmpubacc/812/812.pdf (accessed on 23 March 2010).

House of Commons Public Accounts Committee (2006). *A Safer Place for Patients*. HC-831 (2005–06). London: The Stationery Office. Available at: www.publications.parliament.uk/pa/cm200506/cmselect/cmpubacc/831/831.pdf (accessed on 23 March 2010).

House of Commons Public Administration Select Committee (2003). *On Target? Government by measurement*. HC 62–1 (2002–03). London: The Stationery Office. Available at: www.publications.parliament.uk/pa/cm200203/cmselect/cmpubadm/62/62.pdf (accessed on 10 February 2010).

Hutchinson A, Young TA, Cooper KL, McIntosh A, Karnon JD, Scobie S, Thomson RG (2009). 'Trends in healthcare incident reporting and relationship to safety and quality data in acute hospitals: results from the National Reporting and Learning System'. *Quality and Safety in Health Care*, vol 18, pp 5–10.

Institute for Healthcare Improvement (2008). 'Achieving the Vision of Excellence in Quality: Recommendations for the English NHS System of Quality Improvement. Submitted to the Department of Health by the Institute for Healthcare Improvement, January 31, 2008.' Available at: www.policyexchange.org.uk/assets/IHI_report.pdf (accessed on 22 March 2010).

Institute of Medicine (2000). *To Err is Human: Building a safer health system*. Washington DC: Institute of Medicine.

Johnson A (2008). 'Speech by the Rt Hon Alan Johnson MP, Secretary of State for Health, 27 November 2008 at the New Savoy Partnership Annual Conference: Psychological therapies in the NHS: science, practice and policy' [online]. Available at: www.dh.gov.uk/en/News/Speeches/DH_091251 (accessed on 4 March 2010).

Johnson S, Nolan F, Hoult J, White IR, Bebbington P, Sandor A, McKenzie N, Patel S, Pilling S (2005a). 'Outcomes of crises before and after introduction of a crisis resolution team'. *British Journal of Psychiatry*, vol 187, pp 68–75.

Johnson S, Nolan F, Pilling S, Sandor A, Hoult J, McKenzie N, White IR, Thompson M, Bebbington P (2005b). 'Randomised controlled trial of acute mental health care by a crisis resolution team: the north Islington crisis study'. *British Medical Journal*, vol 331, pp 599–604.

- Joint Committee International (2008). *Quality Oversight in England: Findings, observations and recommendations for a new model. Submitted to Department of Health United Kingdom (England) 30 January 2008*. [online] Available at: www.policyexchange.org.uk/assets/JCI_report.pdf (accessed on 22 March 2010).
- Kennedy A, Reeves D, Bower P, Lee V, Middleton E, Richardson G (2007). 'The effectiveness and cost effectiveness of a national lay-led self care support programme for patients with long-term conditions: a pragmatic randomised controlled trial'. *Journal of Epidemiology and Community Health*, 2007, vol 61, no 254–61.
- Killaspy H, Bebbington P, Blizard R, Johnson S, Nolan F, Pilling S, King M (2006). 'The REACT study: randomised evaluation of assertive community treatment in north London'. *British Medical Journal*, vol 332, pp 815–20.
- Klein R (2006). *The New Politics of the NHS*. Oxford: Radcliffe Press.
- Klein R, Day P, Redmayne S (1995). 'Rationing in the NHS: The dance of the seven veils-in reverse'. *British Medical Bulletin*, vol 51, no 4, pp 769–80.
- Kostopoulou O, Delaney BC, Munro CW (2008). 'Diagnostic difficulty and error in primary care – a systematic review', *Family Practice*, vol 25, no 6, pp 400–13.
- Labour Party (2005). *Britain Forward not Back. The Labour Party manifesto 2005*. London: The Labour Party.
- Laurance J (1999). 'Changes in care may end "postcode lottery"'. *Independent*, 1 April.
- Leatherman S, Sutherland K (2008). *The Quest for Quality: Refining the NHS Reforms. A policy analysis and chartbook*. London: The Nuffield Trust.
- Leatherman S, Sutherland K (2007). *Patient and Public Experience in the NHS: A quality chartbook*. London: The Health Foundation. Available at: www.health.org.uk/publications/research_reports/patient_and_public.html (accessed on 23 March 2010).
- Lloyd-Evans B, Slade M, Jagielska D, Johnson S (2009). 'Residential alternatives to acute psychiatric hospital admission: systematic review'. *British Journal of Psychiatry*, vol 195, no 2, pp 109–17.
- London Health Observatory (2009). 'Health Inequalities Intervention Tools'. London Health Observatory website. Available at: www.lho.org.uk/LHO_Topics/Analytic_Tools/HealthInequalitiesInterventionToolkit.aspx (accessed on 15 March 2010).
- McAllister-Williams RH, Foran K, Forrest S, Forrest S, Ingram G, McMahon L, Taylor M, Rajwal M, Cornwall L (2006). 'NICE guidelines on antidepressants'. *British Journal of General Practice*, vol 56(531), p 798.
- McCrone P, Dhanasiri S, Patel A, Knapp M, Lawton-Smith S (2008). *Paying the Price. The cost of mental health care in England to 2026*. London: The King's Fund.
- McMahon L, Foran KM, Forrest SD, Taylor ML, Ingram G, Rajwal M, Cornwall PL, McAllister-Williams RH (2007). 'Graduate mental health worker case management of depression in UK primary care: a pilot study'. *British Journal of General Practice*, vol 57, pp 880–5.
- McManus S, Meltzer H, Brugha T, Bebbington P, Jenkins R (2009). *Adult Psychiatric Morbidity in England, 2007. Results of a household survey*. Leeds: NHS Information Centre.
- McPherson K, Brown M, Marsh T, Byatt T (2009). 'Obesity: recent trends in children aged 2–11y and 12–19y. Analysis from the Health Survey for England 1993 – 2007' [online]. National Heart Forum. Available at: www.heartforum.org.uk/downloads/Child_Obesity_short_Oct_09.pdf (accessed on 17 February 2010).

Maheswaran R, Pearson T, Munro J, Jiwa M, Campbell MJ, Nicholl J (2007). 'Impact of NHS walk-in centres on primary care access times: ecological study'. *British Medical Journal*, vol 334, p 838.

The Marmot Review (2010). *Fair Society, Healthy Lives. Strategic Review of Health Inequalities in England post-2010*. London: The Marmot Review. Available at: www.ucl.ac.uk/ghcg/marmotreview (accessed on 15 February 2010).

Maxwell RJ (1984). 'Quality Assessment in Health'. *British Medical Journal*, vol 288, pp 1470–2. Available at: www.bmj.com/cgi/reprint/288/6428/1470?maxtoshow=&hits=10&RESULTFORMAT=&fulltext=%22quality+assessment+in+health%22&searchid=1&FIRSTINDEX=0&sortspec=date&resourcetype=HWCIT (accessed on 15 March 2010).

Medicines and Healthcare products Regulatory Agency (2009). 'Yellow card' [online]. Available at: <http://yellowcard.mhra.gov.uk> (accessed 15 January 2010).

Medicines and Healthcare products Regulatory Agency (2007). *Anti-Counterfeiting Strategy 2007–2010*. London: MHRA.

Meltzer H, Gatward R, Corbin R, Ford T (2003). *Persistence, Onset, Risk Factors and Outcomes of Childhood Mental Health Disorders*. London: The Stationery Office.

Mental Health Foundation (2008). *While We Are Waiting* [online]. Available at: www.mentalhealth.org.uk/publications/?EntryId5=62499 (accessed on 4 March 2010).

Millett C, Gray J, Saxena S, Netuveli G, Khunti K, Majeed A (2007). 'Ethnic Disparities in Diabetes Management and Pay-for-performance in the UK: the Wandsworth Prospective Diabetes Study'. *PLoS Medicine*, vol 4, no 6, e191. Available at: www.ncbi.nlm.nih.gov/pmc/articles/PMC1891316/ (accessed on 15 March 2010).

Ministry of Health (1948). *The New National Health Service Central Office of Information*. London: HMSO.

Monitor (2010). 'NHS foundation trust directory' [online]. Available at: www.monitor-nhsft.gov.uk/home/about-nhs-foundation-trusts/nhs-foundation-trust-directory (accessed on 18 February 2010).

Monitor (2009). *Annual Report and Accounts 2008–09*. HC 621. London: The Stationery Office. Available at: www.monitor-nhsft.gov.uk/home/our-publications/browse-category/about-monitor/annual-reports-and-accounts/monitors-annual-repo-4 (accessed on 19 March 2010).

Muscular Dystrophy Campaign (2009). *Equipment Shortfall: how disabled children are being failed* [online]. Available at: www.muscular-dystrophy.org/assets/0000/6665/Equipment_shortfall_-_How_Disabled_Children_Are_Being_Failed.pdf (accessed on 4 March 2010).

Mutuo and University of Birmingham (2008). *Membership Governance in NHS Foundation Trusts: A review for the Department of Health* [online]. Available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_086374 (accessed on 10 February 2010).

Myocardial Ischaemia National Audit Project (MINAP) (2009). *How the NHS Manages Heart Attacks*. Eighth Public Report [online]. London: National Institute for Clinical Outcomes Research. Available at: www.rcplondon.ac.uk/media/Documents/press-release-documents/public_report_2009.pdf (accessed on 15 March 2010).

National Audit Office (2010). *Improving Dementia Services in England – an Interim Report*. London: The Stationery Office.

- National Audit Office (2009a). *NHS Pay Modernisation in England: Agenda for Change*. HC 125. London: The Stationery Office. Available at: www.nao.org.uk/publications/0809/nhs_pay_modernisation.aspx (accessed on 30 March 2010).
- National Audit Office (2009b). *Young People's Sexual Health: The National Chlamydia Screening Programme*. London: The Stationery Office. Available at: www.nao.org.uk/publications/0809/young_peoples_sexual_health.aspx (accessed on 13 November 2009).
- National Audit Office (2008a). *End of Life Care*. HC 1043, 2007–2008. London: The Stationery Office. Available at: www.nao.org.uk/publications/0708/end_of_life_care.aspx (accessed on 22 February 2010).
- National Audit Office (2008b). *Feeding Back? Learning from complaints handling in health and social care*. London: The Stationery Office.
- National Audit Office (2008c). *Pay Modernisation: New contracts for general practice services in England*. London: The Stationery Office. Available at: www.nao.org.uk/publications/0708/new_contracts_for_general_prac.aspx (accessed on 6 August 2009).
- National Audit Office (2007a). *Pay Modernisation: A new contract for NHS consultants in England*. London: The Stationery Office.
- National Audit Office (2007b). *Prescribing Costs in Primary Care*. London: The Stationery Office.
- National Audit Office (2006). *The Provision of Out of Hours Care in England*. London: The Stationery Office.
- National Audit Office (2005). *A Safer Place for Patients: Learning to improve patient safety*. HC 456 (2005–2006). London: The Stationery Office.
- National Audit Office (2001). *Inappropriate Adjustments to NHS Waiting Lists*. HC 452 (2001–02). London: The Stationery Office. Available at: www.nao.org.uk/publications/0102/inappropriate_adjustments_nhs.aspx?alreadysearchfor=yes (accessed on 10 February 2010).
- National Cancer Action Team (2008). *National Cancer Peer Review Programme 2004–2007. National Report*. London: National Cancer Action Team.
- National Centre for Involvement (2008). *The Current State of Patient and Public Involvement in NHS Trusts across England: Findings of the national survey 2008* [online]. Available at: www.nhscentreforinvolvement.nhs.uk/index.cfm?Content=222 (accessed on 10 February 2010).
- National Confidential Enquiry into Perioperative Deaths (1997). *Who Operates When?* London: NCEPOD.
- National Institute for Health and Clinical Excellence (2010). *Evaluation and Review of NICE Implementation Evidence* [online]. At: www.nice.org.uk/usingguidance/evaluationandreviewofniceimplementationevidenceernie/evaluation_and_review_of_nice_implementation_evidence_ernie.jsp (accessed 12 February 2010).
- National Institute for Health and Clinical Excellence (2009). *Cost Saving Guidance* [online]. Available at: www.nice.org.uk/usingguidance/benefitsofimplementation/costsavingguidance.jsp (accessed on 4 March 2010).
- National Mental Health Development Unit (2009). *National Suicide Prevention Strategy for England. Annual report on progress 2008* [online]. Available at: www.nmhdu.org.uk/silo/files/national-suicide-prevention-strategy-for-england--annual-report-on-progress-2008.pdf (accessed on 4 March 2010).

National Patient Safety Agency (2009a). *Never Events Framework 2009–10*. London: NPSA.

National Patient Safety Agency (2009b). *NRLS Quarterly Data Summary 14*, November. London: NPSA.

National Patient Safety Agency (2005). *Being Open: Communicating patient safety incidents with patients and their carers*. London: NPSA.

National Radiotherapy Advisory Group (2007). *Radiotherapy: Delivering a world class service for England*. Report to Ministers [online]. Available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_074575 (accessed on 9 March 2010).

NHS Choices (2010). 'Authorities and Trusts'. NHS Choices website. Available at: www.nhs.uk/ServiceDirectories/Pages/AcuteTrustListing.aspx (accessed on 18 February 2010).

NHS Choices (2009). *Annual Report 2009* [online]. Available at: www.nhs.uk/aboutNHSChoices/Documents/2009/AnnualReportNHSChoices09.pdf (accessed on 4 March 2010).

NHS Confederation and Independent Healthcare Advisory Services (2009). *What's it all for? Removing unnecessary bureaucracy in regulation*. London: NHS Confederation. Available at: www.nhsconfed.org/Publications/Documents/Whats_it_all_for.pdf (accessed on 10 February 2010).

NHS Executive (1999a). *Controls Assurance Standards for Medicines Management*. London: The Stationery Office.

NHS Executive (1999b). *Review of NHS Procurement HSC1999/143: implementing the recommendations* [online]. Available at: www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Healthservicecirculars/DH_4004246 (accessed on 4 March 2010).

NHS Executive (1996). *Promoting Clinical Effectiveness: A framework for action in and through the NHS*. London: NHS Executive.

NHS Information Centre (2010a). *Breast Screening Programme, England 2008–09* [online]. Available at: www.ic.nhs.uk/webfiles/publications/breast_screening/Breast_Screening_Programme_Report_2008_09.pdf (accessed on 22 January 2010).

NHS Information Centre (2010b). 'GP Earnings and Expenses Reports' 2004–2008 [online]. Available at: www.ic.nhs.uk/statistics-and-data-collections/primary-care/general-practice (accessed on 8 March 2010).

NHS Information Centre (2010c). 'HES Online' [online]. NHS Information Centre website. Available at: www.hesonline.nhs.uk/Ease/servlet/ContentServer?siteID=1937&categoryID=193 (accessed on 8 March 2010).

NHS Information Centre (2010d). 'Hospital Estates and Facilities Statistics' 1999–2009 [online]. NHS Information Centre website. Available at: www.hefs.ic.nhs.uk/ReportFilterTop.asp (accessed on 24 March 2010).

NHS Information Centre (2009a). *Cervical Screening Programme England 2008–09* [online]. Available at: www.ic.nhs.uk/webfiles/publications/cervscreen0809/Cervical_Screening_Programme_2008_09_Report.pdf (accessed on 20 November 2009).

NHS Information Centre (2009b). *Data on Written Complaints in the NHS 2008–2009* [online]. Available at: www.ic.nhs.uk/webfiles/publications/complaints/Data_on_written_complaints_in_the_NHS_2008_09_Report.pdf (accessed on 7 January 2009).

- NHS Information Centre (2009c). *National Lung Cancer Audit* [online]. Available at: www.ic.nhs.uk/canceraudits/lung (accessed on 4 March 2010).
- NHS Information Centre (2009d). *NHS GP Patient Survey 2007/8* [online]. Available at: www.ic.nhs.uk/pubs/gpps08 (accessed on 4 March 2010).
- NHS Information Centre (2009e). *NHS Immunisation Statistics* [online]. Available at: www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/immunisation/nhs-immunisation-statistics-england-2008-09 (accessed on 23 March 2010).
- NHS Information Centre (2009f). *NHS Staff 1998–2008 (Non-Medical)* [online]. Available at: www.ic.nhs.uk/statistics-and-data-collections/workforce/nhs-staff-numbers/nhs-staff-1998--2008-non-medical (accessed on 4 March 2010).
- NHS Information Centre (2009g). *Smoking, Drinking and Drug Use Among Young People in England in 2008* [online]. Available at: www.ic.nhs.uk/webfiles/publications/sdd08fullreport/SDD_England_2008_full_report.pdf (accessed on 12 November 2009).
- NHS Information Centre (2009h). *Statistics on Alcohol: England, 2009*. Available at: www.ic.nhs.uk/webfiles/publications/alcoholeng2009/Final%20Format%20draft%202009%20v7.pdf (accessed on 29 October 2009).
- NHS Information Centre (2009i). *Statistics on NHS Stop Smoking Services: England, April 2008 to March 2009* [online]. Available at: www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/nhs-stop-smoking-services/statistics-on-nhs-stop-smoking-services-england-april-2008-to-march-2009 (accessed on 12 November 2009).
- NHS Information Centre (2009j). *Statistics on Obesity, Physical Activity and Diet: England, February 2009* [online]. Available at: www.ic.nhs.uk/webfiles/publications/opan09/OPAD%20Feb%202009%20final.pdf (accessed on 29 October 2009).
- NHS Information Centre (2009k). *Statistics on Smoking: England, 2009* [online]. Available at: www.ic.nhs.uk/webfiles/publications/smoking09/Statistics_on_smoking_England_2009.pdf (accessed on 29 October 2009).
- NHS Information Centre (2008). 'National Diabetes Audit. Executive Summary. Key findings about the quality of care for people with diabetes in England and Wales. Report for the audit period 2007–2008' [online]. Available at: www.ic.nhs.uk/webfiles/Services/NCASP/audits%20and%20reports/7121_National%20Diabetes%20Audit_final.pdf (accessed on 10 August 2009).
- NHS Institute for Innovation and Improvement (2009). *High Impact Actions for Nursing and Midwifery* [online]. Available at: www.institute.nhs.uk/building_capability/general/aims (accessed on 4 March 2010).
- NHS Management Executive (1993). *EL(93)115: Improving clinical effectiveness*. Leeds: Department of Health.
- Nolte E, Wait S, McKee M (2006). *Investing in Health: Benchmarking health systems*. London: Nuffield Trust.
- O'Cathain A, Coster J, Salisbury C, Pearson T, Maheswaran R, Nicholl J (2009). 'Do walk-in centres for commuters work? A mixed methods evaluation'. *British Journal of General Practice*, vol 59, pp 934–9.
- Office for National Statistics (2010). 'Suicide rates in England and Wales 1991–2008' [online]. Office for National Statistics website. Available at: www.statistics.gov.uk/StatBase/Product.asp?vlnk=13618&Pos=&ColRank=1&Rank=224 (accessed on 15 March 2010).

- Office for National Statistics (2009a). 'Correction notice. Total public service output and productivity' [online]. Office for National Statistics Website. Available at: www.statistics.gov.uk/articles/nojournal/TotalPublicServiceFinalv5.pdf (accessed on 8 March 2010).
- Office for National Statistics (2009b). *United Kingdom Health Statistics No. 3, 2009* online update. Available at: www.statistics.gov.uk/statbase/Prep/6637.asp (accessed on 26 November 2009).
- Office for National Statistics (2007). *General Household Survey, Smoking and Drinking among Adults, 2007*. Newport: Office for National Statistics. Available at: www.statistics.gov.uk/ghs/ (accessed on 15 March 2010).
- Office of Fair Trading (2007). *The Pharmaceutical Price Regulation Scheme: An OFT market study*. London: Office of Fair Trading. Available at: www.offt.gov.uk/shared_offt/reports/comp_policy/oft885.pdf (accessed on 23 March 2010).
- Office of Government Commerce (2008). *Procurement Capability Review Programme*. London: Department of Health. Available at: www.ogc.gov.uk/documents/PCR_Tranche3report.pdf (accessed on 4 March 2010).
- Office of Public Sector Reform (2003). *Inspecting for Improvement: Developing a customer focused approach*. London: Cabinet Office. Available at: <http://archive.cabinetoffice.gov.uk/opsr/documents/pdf/inspecting.pdf> (accessed on 10 February 2010).
- Opinion Leader Research (2006). *Your Health, Your Care, Your Say: Research report*. London: Opinion Leader Research.
- Organisation for Economic Co-operation and Development (2010). 'OECD Health Care Quality Indicators Project' [online]. Available at: www.oecd.org/document/48/0,3343,en_2649_33929_37090416_1_1_1_37407,00.html (accessed on 15 March 2010).
- Organisation for Economic Co-operation and Development (2009a). 'Health Care Quality Indicators'. OECD website. Available at: www.oecd.org/health/hcqi (accessed on 25 March 2010).
- Organisation for Economic Co-operation and Development (2009b). 'OECD Health Data 2009: Statistics and Indicators for 30 Countries'. Available at: www.oecd.org/document/30/0,3343,en_2649_34631_12968734_1_1_1_1,00.html (accessed on 25 March 2010).
- Oxford Healthcare Associates (2009). *Access to Cardiac Care in the UK: A report on invasive procedures in cardiac conditions. Recent trends, variations in access and future need*. Oxford: Oxford Healthcare Associates. Available at: www.bcs.com/documents/Access_to_Cardiac_Care_in_the_UK_-_Full_Version_FINAL_1_07_09.pdf (accessed on 4 March 2010).
- Oxera (2001). *Fundamental Review of the Generic Drugs Industry*. Oxford: Oxera. Available from: www.oxera.com/main.aspx?id=351 (requires log-in) (accessed on 23 March 2010).
- Palser TR, Cromwell DA, Hardwick RH, Riley SA, Greenaway K, Allum W, van der Meulen JHP (2009). 'Reorganisation of oesophago-gastric cancer care in England'. *BMC Health Services Research*, vol 9, p 204.
- Panesar SS, Cleary K, Sheikh A, Donaldson L (2009). 'The WHO Checklist: a global tool to prevent errors in surgery'. *Patient Safety in Surgery*, vol 3, p 9.
- Pears R (2009). 'What is the future for Spearhead PCTs?' *British Journal of Healthcare Management*, vol 15, no 1, pp 28–32.

- Pearson A, Saini P, Da Cruz D, Miles C, While D, Swinson N, Williams A, Shaw J, Appleby L, Kapur N (2009). 'Primary care contact prior to suicide in individuals with mental illness'. *British Journal of General Practice*, vol 59, pp 825–32.
- Pell JP, Haw S, Cobbe S, Newby DE, Pell AC, Fischbacher C, McConnachie A, Pringle S, Murdoch D, Dunn F, Oldroyd K, Macintyre P, O'Rourke B, Borland W (2008). 'Smoke-free legislation and hospitalizations for acute coronary syndrome'. *New England Journal of Medicine*, vol 359, pp 482–91.
- Pell J, Pell A, Norie J, Ford I, Cobbe SM (2000). 'Effect of socioeconomic deprivation on waiting time for cardiac surgery: retrospective cohort study'. *British Medical Journal*, vol 320, pp 15–19.
- Picker Institute Europe (2009a). 'The Key Findings Report for the 2008 Inpatient Survey' [online]. NHS Surveys website. Available at: www.nhssurveys.org/Filestore/documents/Key_Findings_report_for_the_2008__Inpatient_Survey.pdf (accessed on 23 March 2010).
- Picker Institute Europe (2009b). *The Key Findings Report: Emergency Department survey results 2008*. Oxford: Picker Institute Europe. Available at: www.nhssurveys.org/survey/704 (accessed on 15 March 2010).
- Picker Institute Europe (2009c). *Patient and Public Engagement – the early impact of World Class Commissioning: A survey of PCTs*. Oxford: Picker Institute Europe. Available at: www.pickereurope.org/Filestore/PIE_reports/project_reports/PCT_Commissioning_Survey_2009_FINAL_TO_LYNX_with_cover.pdf (accessed on 10 February 2010).
- Picker Institute Europe (2008). *The Key Findings Report: PCT survey results 2008*. Oxford: Picker Institute Europe. Available at: www.nhssurveys.org/survey/697 (accessed 8 March 2010).
- Price D (1996). 'Lessons for health care rationing from the case of child B'. *British Medical Journal*, vol 312, pp 167–9.
- Prime Minister's Strategy Unit (2004). *Alcohol Harm Reduction Strategy for England* [online]. Available at: www.cabinetoffice.gov.uk/media/cabinetoffice/strategy/assets/caboffice%20alcoholhar.pdf (accessed on 13 November 2009).
- Pronovost P, Sexton B (2005). 'Assessing safety culture: guidelines and recommendations'. *Quality and Safety in Health Care*, vol 14, pp 231–3.
- Purchasing and Supply Agency (2009). *Annual Report and Accounts 2008/9*. HC 683. London: The Stationery Office. Available at: www.pasa.nhs.uk/Corporaterpt/2008_9/index.htm (accessed on 8 March 2010).
- QResearch and the NHS Information Centre (2009). 'Trends in Consultation Rates in General Practice'. Available at: www.ic.nhs.uk/statistics-and-data-collections/primary-care/general-practice/trends-in-consultation-rates-in-general-practice--1995--2009 (accessed on 25 March 2010).
- Raine R, Wong W (2010). 'Social variations in access to hospital care for patients with colorectal, breast, and lung cancer between 1999 and 2006 : retrospective analysis of hospital episode statistics'. *British Medical Journal*, vol 340, no 7741, p 302.
- Raleigh V, Cooper J, Bremner SA, Scobie S (2008). 'Patient safety indicators for England from hospital administrative data: case-control analysis and comparison with US data'. *British Medical Journal*, vol 337, pp 1219–22.
- Rankin J (2005). *Mental Health in the Mainstream*. London: Institute for Public Policy Research.

- Reeves R, Seccombe I (2008). 'Do patient surveys work? The influence of a national survey programme on local quality-improvement initiatives'. *Quality and Safety in Health Care*, vol 17, no 6, pp 437–41.
- Richards M (2009). 'The size of the prize for earlier diagnosis of cancer in England'. *British Journal of Cancer*, vol 101, pp S125–9.
- Richards M (2008). 'Improving access to medicines for NHS patients: a report for the Secretary of State for Health by Professor Mike Richards' [online]. Department of Health website. Available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_089927 (accessed on 5 March 2010).
- Richards M, Hiom S, eds (2009). 'Diagnosing cancer earlier: evidence for a national awareness and early diagnosis initiative'. *British Journal of Cancer*, vol 101, issue S2, pp S1–129.
- Richards N, Coulter A (2007). *Is the NHS Becoming More Patient Centred? Trends from the national surveys of patients in England 2002–2007*. Oxford: Picker Institute. Available at: www.pickereurope.org/Filestore/PIE_reports/project_reports/Trends_2007_final.pdf (accessed on 4 March 2010).
- Robertson R, Dixon A (2009). *Choice at the Point of Referral: Early results of a patients' survey*. London: The King's Fund. Available at: www.kingsfund.org.uk/research/publications/choice_at_the_point.html (accessed on 4 March 2010).
- Robinson P (2010). 'Are emergency admissions out of control?' [online]. Available at: [www.chks.co.uk/assets/files/Published%20articles/Are_hospital_admissions_out_of_control_final_report\(1\).pdf](http://www.chks.co.uk/assets/files/Published%20articles/Are_hospital_admissions_out_of_control_final_report(1).pdf) (accessed on 17 February 2010).
- Rogers A, Pilgrim D (2001). *Mental Health Policy in Britain*. New York: Palgrave Macmillan.
- Roland M, Dusheiko M, Gravelle H, Parker S (2005). 'Follow up of people aged 65 and over with a history of emergency admissions: analysis of routine admission data'. *British Medical Journal*, vol 330, pp 289–92.
- Rosen R, Smith A, Harrison A (2006). *Future Trends and Challenges for Cancer Services in England*. London: The King's Fund.
- Royal College of Physicians (RCP) Clinical Effectiveness and Evaluation Unit (2009). *National Sentinel Stroke Audit Phase II (clinical audit) 2008* [online]. Available at: www.rcplondon.ac.uk/clinical-standards/ceeu/Current-work/stroke/Documents/stroke-audit-report-2008.pdf (accessed on 30 March 2010).
- Royal National Institute for the Deaf (2007). 'Hearing aid waits top two and a half years'. Press release, 31 December.
- Sanders J, Esmail A (2001). 'Threats to patient safety in primary care. A review of the research into the frequency and nature of error in primary care. A report for the Department of Health'. Manchester: University of Manchester.
- Santry C (2009). 'Voters halve as foundation trust governors win elections uncontested'. *Health Service Journal* [online]. Available at: www.hsj.co.uk/news/policy/voters-halve-as-foundation-trust-governors-win-elections-uncontested/5008058.article (subscribers only) (accessed on 10 February 2010).
- Sari AB-A, Sheldon TA, Cracknell A, Turnbull A (2007). 'Sensitivity of routine systems for reporting patient safety incidents in an NHS hospital: retrospective patient case note review'. *British Medical Journal*, vol 334, pp 79–82.

- Sheridan A, White JL, Barlow T, Soldan K (2010). 'Annual HPV vaccine uptake in England: 2008/09' [online]. Available at: www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_111676.pdf (accessed on 18 February 2010).
- Singh D (2005). *Which Staff Improve Care for People with Long-term Conditions? A rapid review of the literature* [online]. Available at: www.hsmc.bham.ac.uk/publications/pdfs/Workforce_Implications_Review.pdf (accessed on 9 December 2009).
- Smith L, Foxcroft D (2009). *Drinking in the UK: An exploration of trends* [online]. Available at: www.jrf.org.uk/publications/drinking-in-the-uk (accessed on 3 December 2009).
- Snow T (2007). 'Survey reveals shortfall in community matrons'. *Nursing Standard*, vol 21, no 29, p 11.
- Soljak M, Majeed A, Eliahoo J, Dornhorst A (2007). 'Ethnic Inequalities in the Treatment and Outcome of Diabetes in three English Primary Care Trusts'. *International Journal for Equity in Health*, vol 6, no 8, pp 6–8. Available at: www.ncbi.nlm.nih.gov/pmc/articles/PMC1995195/ (accessed on 15 March 2010).
- State of Readiness Group (2009). *The NHS Constitution State of Readiness Group: Final report* [online]. Available at: www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/@sta/@perf/documents/digitalasset/dh_109416.pdf (accessed on 10 February 2010).
- Stevens S (2004). 'Reform strategies for the English NHS'. *Health Affairs*, vol 23, no 3, pp 37–44.
- Taylor SJC, Candy B, Bryar RM, Ramsay J, Vrijhoef HJM, Esmond G, Wedzicha JA, Griffiths CJ (2005). 'Effectiveness of innovations in nurse led chronic disease management for patients with chronic obstructive pulmonary disease: systematic review of evidence'. *British Medical Journal*, vol 331, p 485. Available at: www.bmj.com/cgi/content/abstract/331/7515/485 (accessed on 11 December 2009).
- Verdecchia A, Francisci S, Brenner H, Gatta G, Micheli A, Mangone L, Kunkler I, EURO CARE-4 Working Group (2007). 'Recent cancer survival in Europe: a period analysis 2000–02 of the EURO CARE-4 data'. *Lancet Oncology*, vol 8, pp 784–96.
- Vincent C, Aylin P, Franklin BD, Holmes A, Iskander S, Jacklin A, Moorthy K (2008). 'Is health care getting safer?' *British Medical Journal*, vol 337, pp 1205–7.
- Walshe K (2002). 'The rise of regulation in the NHS'. *British Medical Journal*, vol 324, pp 967–70.
- Wanless D (2004). *Securing Good Health for the Whole Population. Final Report*. London: Department of Health. Available at: www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4076134.pdf (accessed on 15 December 2009).
- Wanless D (2002). *Securing our Future Health: Taking a long term view*. London: HM Treasury.
- Wanless D, Appleby J, Harrison A, Patel D (2007). *Our Future Health Secured? A review of NHS funding and performance*. London: The King's Fund.
- Warden J (1994). 'Focus: Westminster: Sir Duncan Nichol breaks new ground'. *British Medical Journal*, vol 309, p 832.

- Welsh Assembly (2007). 'Free Prescriptions: a Welsh solution to Welsh Health Problems'. Welsh Assembly Government News Release, 30 March. Available at: www.wales.nhs.uk/newsitem.cfm?contentid=6493 (accessed 22 January 2010).
- Which? (2006). 'Which Way? Negotiating the out of hours maze'. Which? London: Consumers' Association. Available at: www.which.co.uk/documents/pdf/which-way-negotiating-the-out-of-hours-maze---which---report-176747.pdf (accessed on 15 March 2010).
- Wilkinson E (2009). 'Questions remain over validity of EURO CARE data'. *Lancet*, vol 374, pp 964–5.
- Williams MV, Drinkwater K (2009). 'Geographical variation in radiotherapy services across the UK in 2007 and the effect of deprivation'. *Clinical Oncology*, vol 21, issue 6, pp 431–40.
- Williams S, Buchan J (2006). *Assessing the new NHS Consultant Contract: A something for something deal?* London: The King's Fund. Available at: www.kingsfund.org.uk/document.rm?id=6365 (accessed on 22 March 2010).
- Wise J (2009). 'Personal health budgets are to be piloted in England this summer' [online]. *British Medical Journal*, vol 338, p b210. Available at: www.bmj.com/cgi/content/extract/338/jan20_1/b210 (accessed on 9 December 2009).
- World Health Organization (2008a). *Policies and Practices for Mental Health in Europe – meeting the challenges*. Geneva: WHO. Available at: www.euro.who.int/Document/e91732.pdf (accessed on 4 March 2010).
- World Health Organization (2008b). *The Tallinn Charter: Health systems for health and wealth*. Copenhagen: WHO. Available at: www.euro.who.int/document/E91438.pdf (accessed 5 March 2010).
- World Health Organization (2000). *The World Health Report 2000. Health Systems: improving performance*. Geneva: WHO. Available at: www.who.int/whr/2000/en (accessed on 15 March 2010).
- World Health Organization (1998). *Health Promotion Glossary*. Geneva: WHO. Available at: www.who.int/hpr/NPH/docs/hp_glossary_en.pdf (accessed on 2 December 2009).