»Summary

A high-performing NHS?

A review of progress 1997–2010

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 chronic illness; clinically effective and 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

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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.

Health promotion and managing chronic illness

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 has 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.