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HOW SATISFIED ARE WE WITH THE NHS?

More members of the British public than ever believe that the NHS is doing a good job, according to data analysed here by **John Appleby**. This raises the question of why the government finds it lacking and is pushing for urgent change

Fig 1 | **Satisfaction with the way the NHS is run** (Very + quite satisfied)

Question asked: "All in all, how satisfied or dissatisfied would you say you are with the way in which the National Health Service is run nowadays?"

Source: Appleby and Robinson (2010)

The NHS may be, in the words of former chancellor of the exchequer Nigel Lawson, "the closest thing the English have to a religion" (adding for good measure, "with those who practise in it regarding themselves as a priesthood"[1]). But are we satisfied with it (and the priesthood)?

The longest running survey of public satisfaction with the NHS is the British Social Attitudes (BSA) survey.[2] The first survey was conducted in 1983. With the exception of three years, it has, among a host of questions about the public's attitudes to everything from litter to crime, a continuous run of identical questions about satisfaction with the NHS. The nature of its sampling method makes for valid comparisons between years.

Interpreting responses (and their trends) to questions about satisfaction (with anything, not just the NHS) can be difficult as replies will in part depend on respondents' expectations—some people may be more easily satisfied than others, and expectations for everyone may change over time. Nonetheless, surveys such as the BSA provide a useful indicator of the public's general views about the NHS and its services.

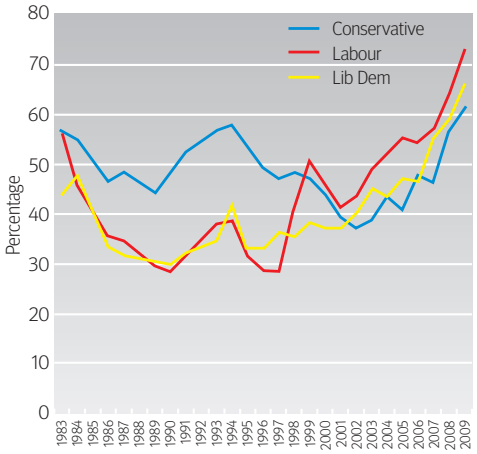
The latest BSA survey reports that 64% of the British public are either very or quite satisfied with the NHS—the highest level of satisfaction since the survey began, and part of a continuous upward trend since 2002 (fig 1).[3]

As for Lawson's "priesthood," satisfaction with general practitioners has now reached 80%—3% short of its highest level in the early 1990s—but for dentists satisfaction fell over the decade to 2009 from 53% to 48% (fig 2). Satisfaction with inpatient services also fell—by one percentage point—over the same period, although it has risen year on year since 2006, after a long decline since 1983. But the public now seems much more satisfied with outpatient and accident and emergency services than in 1999.

Analysis of the BSA question about general satisfaction with the NHS by the political parties that respondents say they identify with (though not necessarily vote for) shows a perhaps expected gap between Conservative and Labour: those identifying with Labour being less satisfied during times of Conservative governments (1983–97) than Conservatives, and vice versa in times of Labour administrations (1997–2009). But it seems that the rising satisfaction with the NHS over the past 10 years or so has also been shared by Conservatives, whose satisfaction is also now the highest since the survey began (fig 3).

Improvements in satisfaction are inversely mirrored by Ipsos-Mori's monthly polling of the

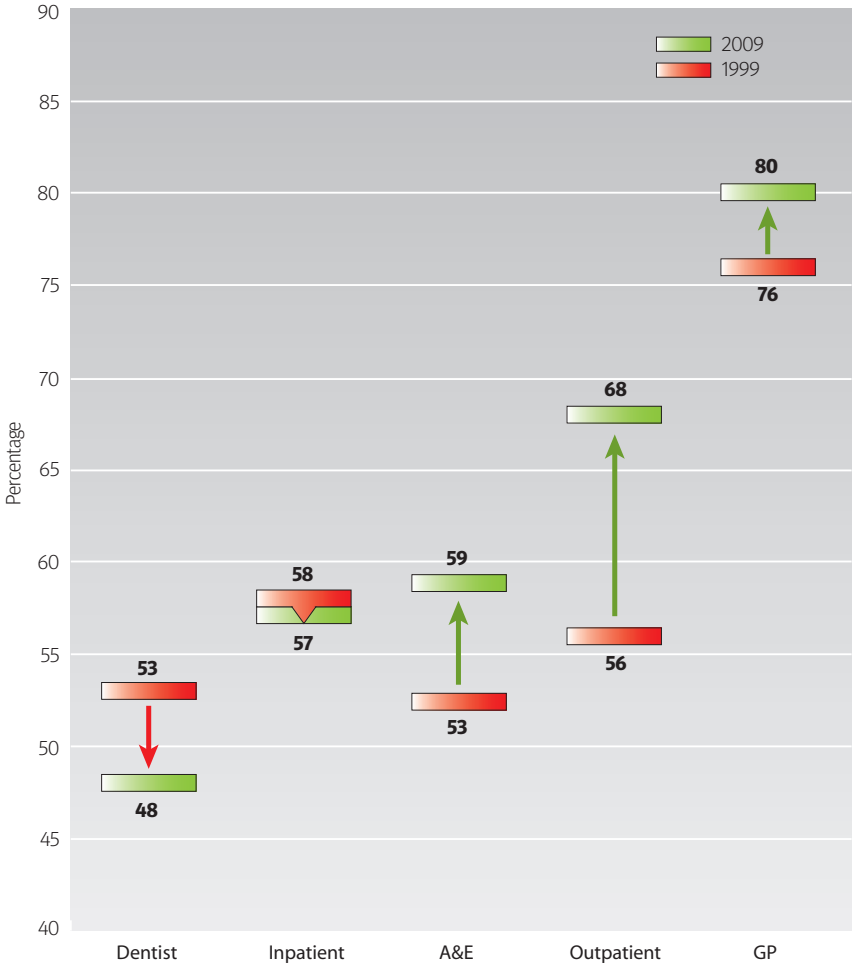
Fig 3 | Satisfaction with how the NHS is run (Very + quite satisfied) by political identification



Question asked: "All in all how satisfied or dissatisfied would you say you are with the way in which the National Health Service is run nowadays?" (Note: no surveys in 1985,1988, and 1992; data for these years based on an average of years either side)

Source: Appleby and Robinson (2010)

Fig 2 | Satisfaction with GPs, dentists, inpatients, outpatients, and accident and emergency services (Very + quite satisfied)



Question asked: "From your own experience, or from what you have heard, please say how satisfied or dissatisfied you are with the way in which each of these parts of the National Health Service runs nowadays: . . . local doctors or GPs? . . . National Health Service dentists? . . . being in hospital as an inpatient? . . . attending hospital as an outpatient? . . . accident and emergency departments?

Source: Appleby and Robinson (2010)

"most important issues facing Britain today."[4] From the turn of the century, when around seven out of 10 people said it was an "issue," the number of people concerned about the NHS fell to a low of just over one in 10 in 2009 and, most recently, one in five this year (fig 4). Worries about the economy, on the other hand, dramatically reflect the global banking crisis and ensuing recession.

Leaving aside the unlikely explanation that expectations have been taking a dive over the past decade, the NHS must have been doing something right to earn this extra satisfaction—something even Conservative supporters have noticed—and something probably not unadjacent to the large rise in funding since 2000. Future BSA surveys will reveal how satisfied the public remains as funding for the NHS is squeezed and the government's proposed reforms take shape on the ground.

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2 National Centre for Social research (NatCen). The British Social Attitudes Survey. 2011. www.natcen.ac.uk/series/british-social-attitudes.
3 Appleby J, Robertson R. A healthy improvement? Satisfaction with the NHS under Labour. In: Park A, Phillips M, Clery E, Curtice J, eds. *British Social Attitudes Survey 2010-2011: Exploring Labour's legacy—the 27th report*. Sage, 2010.
4 Ipsos-Mori. Issues index: trends since 1997. The most important issues facing Britain today. 2011. www.ipsos-mori.com/researchpublications/researcharchive/poll.aspx?oItemID=56&view=wide.

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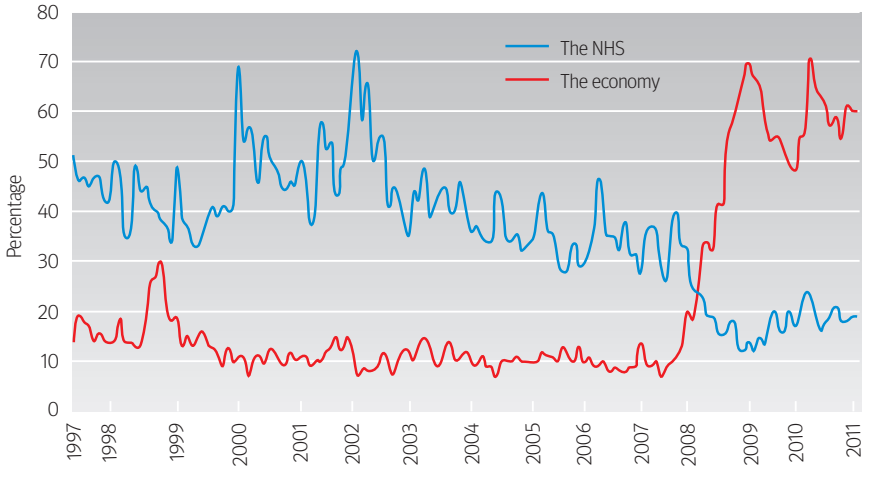
Fig 4 | The most important issues facing Britain today



Question asked: "What would you say is the most important issue facing Britain today?" + "What do you see as other important issues facing Britain today?" (Unprompted—combined answers)

Source: Ipsos-Mori (2011)

A glimpse of the future of healthcare

Combining health and social care at a seaside authority on the south coast of England has proved so successful it's prompted the NHS chief executive to anoint it as "the future." **Peter Davies** investigates

Compound interests: (above) Mandy Seymour, Torbay care trust's chief operating officer; (picture on right) general practitioner Sam Barrell

An 85 year old woman living alone in Torbay has transformed health and social care there. Mrs Smith helped the NHS and the local authority break down barriers that elsewhere have dogged attempts to integrate services. So successful has she been that NHS chief executive, David Nicholson, declared: "I've seen the future. It's Torbay."

Mrs Smith is known to all local general practitioners, health and social care staff, patients, and carers, who immediately recognised her experiences of the frustrations, delays, and duplicated effort inherent in navigating a fragmented system. For several years no discussion about health or social care in Torbay has taken place without her.

In reality Mrs Smith is a fictitious character invented by the then chief executive of the newly formed Torbay care trust, which combined health and adult social care in 2005. By contrasting her story with a vision of how integrated services could operate under the care trust, she became a powerful symbol of the new organisation.

"When we started, no presentation in this organisation would happen without talking about Mrs Smith, and we still do it now," says Mandy Seymour, the care trust's chief operating officer. "We were trying to get everyone to understand what we wanted to achieve: being focused on the needs of the patient. It's very simple. Everything we do is around delivering benefits to Mrs Smith."

Those benefits have been remarkable. Torbay has the lowest rate of emergency admissions in south west England: even after a harsh winter they were 3% below contracted levels for this year. By developing intermediate care services, acute beds have been reduced from 750 in 1999 to 490. The average age of a Torbay citizen admitted to a residential nursing home has now reached 86 (the national average is 85 according to consultants Laing and Buisson), and the care trust supports 144 fewer people in such homes than in 2007 even though numbers of elderly people locally have remained constant. Combining the primary care trust with the social services department has cut management costs by £250 000 (€290 000; $400 000).

ROUGH GUIDE TO TORBAY

Population: 140 000

Proportion aged over 65: 23% (national average 16%)

Main towns: Torquay, Paignton, Brixham

Industry: tourism and fishing—both in decline

The care trust

Staff: 1300

Community hospitals: 2

Kaiser NHS beacon site

Integrated care pilot site

Partner organisations include: South Devon Healthcare Foundation Trust, Devon Partnership NHS Trust (mental health), Torbay council

How it works

On the front line, the care trust has divided its catchment area into five zones, each covered by an integrated health and social care team whose work is aligned with the general practices in its zone. Teams are large, numbering about 100 staff, all of whom get to know their local population and the vulnerable people in it. Each team has a single general manager overseeing community nurses, physiotherapists, occupational therapists, and social workers, all located together. They use the same assessment process and deal with every type of case.

"Nurses probably say they do some work that in another organisation would be deemed social care," says Ms Seymour. All nurses are trained in social care assessment. "If they see someone who's self neglecting or has other problems, because we want to reduce the need for another referral when they get back to the office, there's a requirement that they do something more holistically. To start with they weren't happy about that."

But as the over-riding principle has been "doing what's right for Mrs Smith," objections have proved hard to sustain. Compensation comes in the form of enhanced job satisfaction from knowing that care that would once have taken 10 days to organise will now reach the patient in two hours.

Perhaps most importantly, each team has a single point of contact for all referrals. Torbay invented the post of health and social care coordinator for this purpose, and now employs about 25. They take referrals from general practitioners, other health and social care professionals, carers, and from Mrs Smith herself.

"Now even on a Friday night at 5.45 pm I can sort out my frail elderly person who has a urine infection, who doesn't really need to go to hospital but is too vulnerable to be left on their own at home," says Sam Barrell, a Brixham general practitioner and the care trust's director of transition and commissioning. "I can ring the health and social care coordinator, who'll say: 'Thanks very much. I'll sort it out for you.'"

Coordinators and team members are available from 8 am to 6 pm during the week, plus one works with the out of hours team until 11 pm and another with the intermediate care team over the weekend. They are trained to national vocational qualification (NVQ) level 4 in health and social care and have another 18 months' internal training. They do not have a professional background but need effective interpersonal skills and problem solving ability. "They network, and they know all the various services, care equipment, and tests that might need to be used," says Ms Seymour.

Breaking down barriers

"They're very competent and you trust them," says Dr Barrell. "In some services, if you try to get help for a patient you get barrier after barrier. The coordinators don't put barriers up. They're

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also there for patients and relatives, who form a relationship with their coordinator. As GPs we traditionally used to get a load of calls that we don't get now."

She adds: "When I sat beside one to see what they do, it's interesting how many calls they take from people having a panic about a relative's health. Because the relative now knows something will be done in a specific time frame, that prevents them from thinking, 'Oh I'll just run my mum into the hospital.'"

Each team holds a meeting with the general practices in its zone every one or two months. "When I was a zone manager I met regularly with GPs and reported to them what was happening, and they influenced what I did and how I did it," says Ms Seymour. The team's four professional leads usually attend, and perhaps a community matron responsible for supporting people with complex needs, as well as a hospital manager. Teams appreciate that busy GPs "just want the system to work for them" and meetings must be productive, says Ms Seymour.

Integration is now being extended to secondary care. Coordinators have been installed on eight wards at Torbay Hospital for the past six months, where they can use the community information technology system to access Mrs Smith's history when she is admitted. Their role revolves around supporting patients' families and carers to enable prompt discharge. Length of stay has been cut, bed utilisation improved, and nursing time freed for additional care. Feedback from consultants and nurses has been "very positive," reports Ms Seymour, and patient experience is better too.

"Winter has been really well managed by members of the team across the whole system working together," she says. "You haven't heard those stories of people being in accident and emergency for a long time and on trolleys. We've learnt so much this year."

The care trust is also exploring opportunities for an elderly care consultant from the acute trust to support primary care, a legacy from its participation in the Department of Health's two year integrated care pilot programme.

"A culture is developing of everyone working together much more, of listening to secondary care and vice versa," says Dr Barrell. "Most GPs locally believe in integrated clinical partnerships, stopping the organisational boundary between primary and secondary care getting in the way."

Clinical commissioning groups with equal numbers of primary and secondary care doctors have been set up and work to "dashboards" containing information on referrals, length of stay, finance, and quality. "There are good relationships at the managerial and clinical levels all the way through the system. In the past, the managers were all talking but the clinicians weren't so involved."

Future directions

Dr Barrell chairs the 21 practice GP consortium that will take over responsibility for commissioning Torbay's healthcare and has high hopes for a newly formed "clinical cabinet" comprising GP and consultant leaders that will decide priorities. "Even though the consultants are part of the provision of services, we wanted to make sure any decisions about commissioning priorities were collectively agreed across the system rather than the GPs saying, 'We're doing this now' and the consultants having to follow. We knew that wouldn't work."

"Torbay has the lowest rate of emergency admissions in south west England: even after a harsh winter these were 3% below contracted levels"

How easy would it be for Torbay's integrated care model to be replicated elsewhere? The care trust was undoubtedly blessed with certain advantages from the start. Local NHS organisations and the council had a longstanding commitment to joint working, and their leaders collaborated well. Torbay primary care trust's chief executive was familiar with the Kaiser Permanente model of integrated care in California, while the primary care trust enjoyed sound finances and was perceived as successful. By contrast, adult social services were poor, and a desire to rescue them before they failed provided the impetus to weld health and social care together. "It was a moment in our history when the opportunity was grasped and taken forward," says Ms Seymour.

The union was tried first in Brixham, which had a community hospital, a local authority residential home, and a distinct community identity. "The GP leadership there was very positive and forward thinking," says Ms Seymour. "We started with simple objectives. We asked the people of Brixham what they wanted, and asked GPs and staff what caused them daily frustration. It was very much bottom-up and evolutionary. If it worked, we did a bit more of it. If it didn't, we didn't do it anymore. We'd evaluate all the time and modify until we felt we'd got it right. We'd share lots of good practice. It wasn't a quick fix. After about two years we knew what we wanted."

Only then was the care trust formally set up. Over two years £2m was invested in intermediate care plus more on employing the coordinators, training, and information technology.

But it has not been all plain sailing on the English Riviera. "One person's integration is another's fragmentation," says Ms Seymour. "To integrate something you might have to take it away from somewhere else." GPs in Torquay south zone were reluctant to surrender their community nurses but were eventually persuaded to do so on a trial basis. "I feel some would still like their nurses back, but most would think they've lost their nurses and gained a multidisciplinary team. You have to work hard to develop those relationships and keep them up by continuing to go into practices."

What of the future? From April Torbay care trust will be a provider-only organisation and must decide whether to become a social enterprise or a community foundation trust. It will extend its reach into south Devon, taking over nine community hospitals while doubling its staff and population. Ms Seymour says: "They haven't had any investment yet in community services. It's a very bed based health system."

Expect Mrs Smith to appear there soon.

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See ANALYSIS, p 740

HEALTH COMMUNICATOR OF THE YEAR

Health communicators have the extra factor

Trevor Jackson introduces the shortlist

What makes a successful health communicator in the digital age? Where once a poster or a pamphlet would have sufficed, today's would be health communicators need an X factor Simon Cowell would be proud of. It is not enough to want to change the way people think about important issues; you also have to be able to use imaginative and effective methods of communication to do so. That means standing out from the crowd and being noticed, in addition to demonstrating balance, accuracy, and an evidence base.

All three of the shortlisted entries for this year's BMJ Group health communicator of the year award have that something extra. Selected from a total of 15 strong entries, the shortlist includes one doctor, one broadcaster, and one film maker.



Communicators: (from left) Ann McPherson, Fergus Walsh, and Tom Gibb

Ann McPherson

Ann McPherson is a general practitioner who in 2001 cofounded DIPEx (database of individual patient experiences), a web based resource in which patients describe their experiences of health and illness. Ten years on, and renamed HealthTalkOnline, the site has sections on 60 illnesses or health related issues. Each month it receives two million hits and attracts 80 000 unique users.

Ann was inspired to set up the site after having breast cancer diagnosed. It aims to enable patients, families, and healthcare professionals to benefit from the experiences of others. Eager for the website to be authoritative and reliable, Ann was careful to ensure that the DIPEx project used systematic qualitative research to gather the experiences of patients from different backgrounds. She says that the site is "intended to overcome the inadequacies of other resources for health information on the internet by using the same degree of rigour in the collection and analysis of the narrative interviews as is expected of evidence based medicine."

Over the past year Ann has appeared in the media arguing in favour of the principle of assisted dying. She is also the author or coauthor of 30 health related books, one of which, *The Diary of a Teenage Health Freak* (see *BMJ* 2009;339:b3355), has sold a million copies, been translated into 27 languages, and been made into a six part television series.

Fergus Walsh

As the BBC's medical correspondent, Fergus Walsh covers a huge range of stories on television, radio, and online. In June 2010 he became the first person to have all his genes sequenced by the NHS, and his subsequent report showed his skill in making complex science accessible to a lay audience. Fergus used this report as an opportunity to relaunch his blog from the previous year, "Fergus on Flu," renaming it "Fergus's Medical Files," and giving it a wider remit. In the new blog Fergus has analysed some *Lancet* research on attention-deficit/hyperactivity disorder, talked about the risks and benefits of low dose daily aspirin, and reported on the re-emergence of A/H1N1 flu.

When before Christmas 2010 the National Blood Service put out an appeal for O negative donors to give blood (which received almost no coverage elsewhere in the media), Fergus did not simply cover the story, he gave blood on camera (he is O negative). In early January he received an email from the deputy director of blood donation to say: "In the days after your broadcast we had record numbers of O negative donors turning up at our sessions across the country. Despite the worst that the British weather could throw at us . . . we have managed to sustain supplies safely to patients across all of the hospitals that we serve."

Tom Gibb

Tom Gibb is a journalist and film maker whose documentary *A Trial For Life* tells the story of the Developing Antiretroviral Therapy in Africa (DART) trial, the largest and longest running trial of treatment for HIV/AIDS conducted in Africa. Tom's film, which is aimed at an African audience and has been widely distributed in Africa, shows why it has been so difficult to get medicines to all who need them in Africa and why DART is so relevant. It also explains how a clinical trial works and what it is like to take part in one—which is why it is narrated by one of the trial participants.

DART followed 3300 participants in Uganda and Zimbabwe and found that many of the expensive routine laboratory blood tests done to monitor antiretroviral therapy in wealthy countries have little or no benefit for patients.

Tom made different versions of the film, including one before the end of the trial that was broadcast on Uganda's main television channels, helping to fulfil an obligation for researchers to inform the communities involved. Another version acted as a tool for briefing policy makers and activists on the trial outcome.

The film relied on close consultation with the scientists and doctors in London, Uganda, and Zimbabwe. The script was widely circulated to make sure that health messages were accurate, which allowed direct input by doctors, scientists, and trial participants, something that is not possible in most documentaries. It was thus able to break down barriers that sometimes prevent good reporting of medical research.

The judges for this award are Vikki Entwistle, professor of values in healthcare at the University of Dundee; *Guardian* columnist Polly Toynbee; *BMJ* columnist Nigel Hawkes; and last year's winner, Sarah Boseley, health editor of the *Guardian*.

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