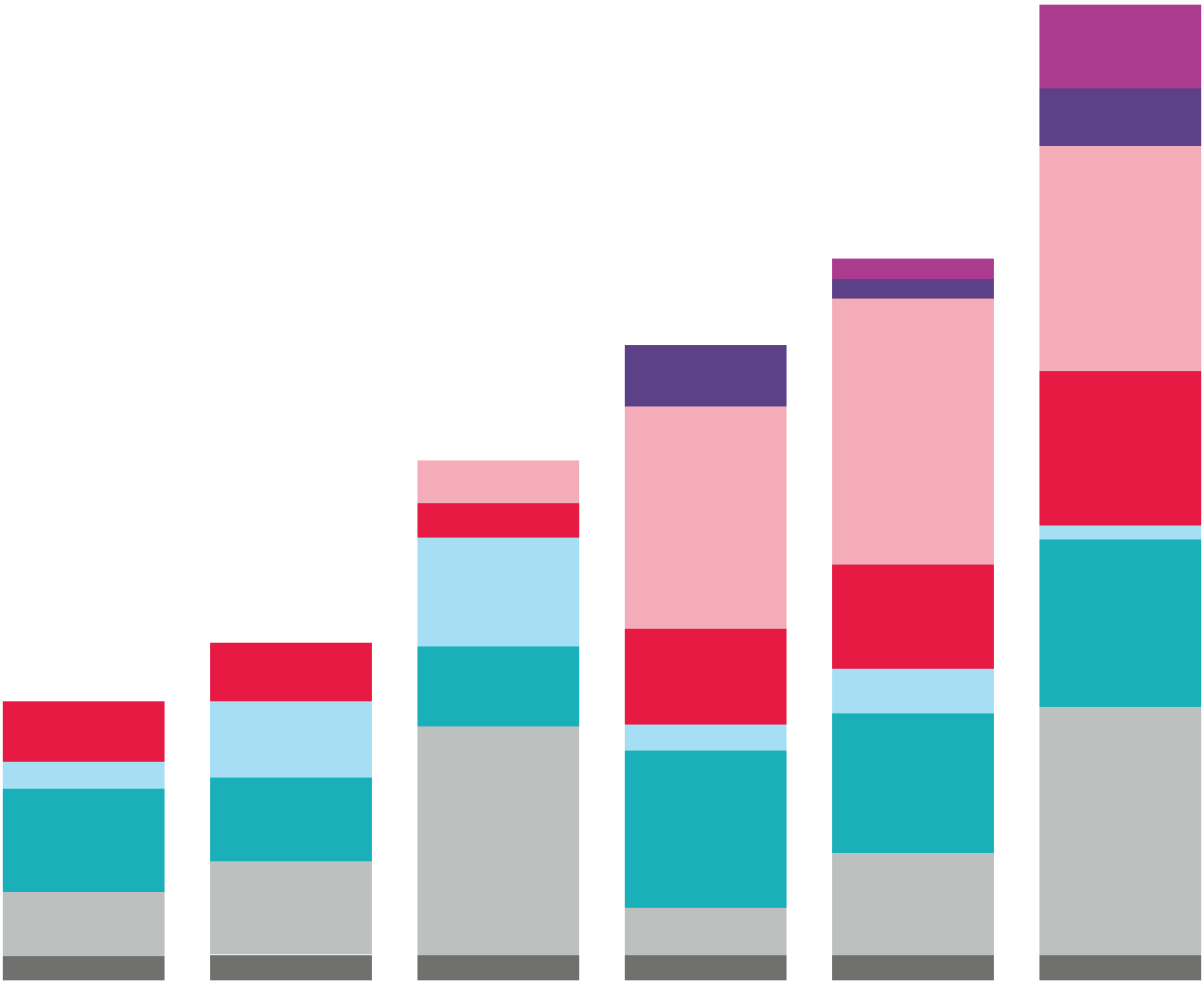
QualityWatch

Is the quality of care in England getting better?

QualityWatch Annual Statement 2013



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About QualityWatch

QualityWatch is a major research programme providing independent scrutiny into how the quality of health and social care is changing over time. Developed in partnership by the Nuffield Trust and the Health Foundation, the programme provides in-depth analysis of key topics and tracks an extensive range of quality indicators. It aims to provide an independent picture of the quality of care, and is designed to help those working in health and social care to identify priority areas for improvement. The programme is primarily focused on the NHS and social care in England, but will draw on evidence from other UK and international health systems.

The QualityWatch website **www.qualitywatch.org.uk** presents key indicators by area of quality and sector of care, together with analysis of the data. This free online resource also provides in-depth analysis of key topics, interactive charts and expert commentary.

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Executive summary

Introduction

The quality of NHS care in England has been scrutinised more in the past year than in any other since 1948. This is because of a number of high-profile failings in care and concern about other potential lapses. Each has been, or is being, subjected to detailed inquiry resulting in several landmark reports, such as Robert Francis QC's inquiry into care failings at Mid Staffordshire NHS Foundation Trust (Francis, 2013); Sir Bruce Keogh's review into the quality of care and treatment provided by 14 hospital trusts in England (Keogh, 2013); Don Berwick's review into patient safety (National Advisory Group on the Safety of Patients in England, 2013); and the Care Quality Commission's (CQC) investigation report into University Hospitals of Morecambe Bay NHS Foundation Trust (CQC, 2012a). However, these reports do not fully answer the question about what is happening overall to the quality of care funded by the NHS and local authorities across England.[*]

There are well documented challenges facing health and social care services, including spending constraints; organisational change resulting from recent reforms to healthcare structures; and growing care needs arising from increasing levels of chronic disease in an ageing population. But there are also opportunities as new treatments emerge and our ability to assess quality increases, in part because of better information technology and greater innovation. Given this, will the quality of care generally improve or worsen? And which aspects will improve or worsen, for which populations, and in which areas of the country?

To try to help answer these questions two independent organisations, the Nuffield Trust and the Health Foundation, have begun a five-year programme of analysis: QualityWatch.

In this programme, an extensive range of indicators will be analysed to assess the quality of health and social care services in England. The indicators will be developed over time so that they provide a more comprehensive assessment of quality. To supplement these indicators, we will also produce a number of in-depth analyses into specific topics in health and social care, using a range of methods.

Every year we will synthesise our research and analysis through an annual statement. This will provide commentary on what we have observed in the landscape of quality in health and social care, and build a picture of the quality of care delivered to patients and service users in England. This report is the first of these annual statements.[†]

The aims of the QualityWatch programme are to:

- provide an authoritative and independent analysis on the quality of health and social care over time, while at the same time augmenting and informing other statutory and non-statutory national initiatives

[*] At the time of writing the CQC were due to publish imminently their State of Care report for 2011/12.
[†] A summary of this annual statement was published on 10 October at: **www.qualitywatch.org.uk/annual-statement**.

- highlight where there are clear and compelling gaps between existing standards of care and what is possible, in order to prompt action to improve quality
- help develop the way quality of care is measured.

The home for all of our analysis is **www.qualitywatch.org.uk**. The website aims to provide useful information on the quality of publicly-funded health and social care services in England.

Our approach

Measuring quality of care services is difficult. Quality of care is complex to define; rigorous and consistent measurement and assessment is therefore challenging; and there are significant limitations to the data available, as adequate indicators do not exist for each domain of quality and each service. For example, there are few indicators of the quality of social care and community services.

Working within these constraints, our approach, which is intended to complement other national initiatives, is based on two elements:

- Developing sets of indicators to measure changes in the quality of care over time. Where possible we will compare areas within England and make comparisons with other countries. We will generally use existing sources of data but may, in the future, commission new ones.
- In-depth analyses on specific topics. We aim to build on the Nuffield Trust's capacity to use complex information and create new approaches and new perspectives on how the quality of NHS and social care is changing. These topics allow us to identify target areas that are potentially important and which would benefit from more detailed quantitative and qualitative analysis.

Developing a range of indicators to assess quality

The indicators are grouped into six domains, drawing on work by Leatherman and Sutherland (2008):

1. **Access:** Care services should be timely and provided within the appropriate setting with access to necessary skills and expertise.
2. **Safety:** Service users should not be harmed by the care they receive or exposed to unnecessary risk.
3. **Effectiveness:** Care services should be based, as far as possible, on relevant rigorous science and research, and/or nationally agreed best practice.
4. **Person-centred care and experience:** Care should be based on partnerships between professionals and service users (and, where appropriate, their families); and be delivered with compassion, empathy and responsiveness to the needs, values and preferences of the individual service user.
5. **Capacity:** Care systems should be sufficiently well resourced and with adequate distribution to enable delivery of appropriate services.

6. **Equity:** Care should be provided on the basis of need, regardless of personal characteristics such as age, gender or ethnicity; and in such a way as to reduce differences in health and wellbeing status and outcomes across sub-groups.

We assess each of these six domains across the following sectors of care: primary and community care, secondary care, mental health, social care, and for populations grouped by geography or by commissioner of publicly-funded care.

We have mainly focused on change in recent years – where possible set within the context of longer-term changes over the past decade. Our intention is to try to place short-term indicator changes within a wider historical context, rather than just report on the latest data. It may be that there is a time lag between current changes in the wider economic climate, or in the provision of care services, and the indicators of quality that we are examining.

We initially identified over 1,500 possible indicators. In discussion with external experts we refined this to approximately 500 indicators, from which nearly 150 were prioritised to form the basis of our first wave of analysis.

Based on the available information, our main findings in each of the six quality domains are:

1. **Access:** In general, waits for elective outpatient and inpatient care, urgent care in accident and emergency (A&E), diagnostic tests, ambulances and cancer treatment remain consistently low overall compared to five and 10 years ago. But the recent increase in the number of people waiting more than four hours for A&E care needs monitoring and there have been some increases in numbers of people with delayed transfers of care (although the absolute numbers are low). A large proportion of people (about a quarter) report they have to wait 'a bit too long' for a GP appointment. About the same number report difficulties with making an appointment with a GP by phone. Many more people would prefer to book their appointment online than do so at the moment.
2. **Safety:** Several indicators relating to safety have improved in the past few years, for example the management of healthcare-acquired infection. Since 2007/08, the number of methicillin-resistant Staphylococcus aureus (MRSA) infections reported to Public Health England has reduced by 79%, from 4,451 to 924 in 2012/13. These numbers are equivalent to 11.9 infections per 100,000 bed days in 2007/08 and 2.7 infections per 100,000 bed days in 2012/13. We have also seen some progress being made in the development of better information sources, which is a critical area. However, as reports from individual organisations have shown, there are also several examples of unacceptably poor care. The Berwick report (National Advisory Group on the Safety of Patients in England, 2013) made clear the scale of the challenge and noted that there are unlikely to be simple, off-the-shelf solutions to deliver harm-free care.
3. **Effectiveness:** A number of indicators show improvement in effectiveness, for example mortality following hip fractures fell by over 22% in the decade up to 2011. However, the indicators available are partial and identify only subsets of patients or treatment types, so it is difficult to make an overall assessment. There is much information from the Quality and Outcomes Framework in primary care, but this is not overly useful in discerning trends in quality.

4. **Person-centred care and experience:** National patient surveys show that patients generally report a positive experience of NHS care. In hospitals, however, a quarter of patients reported that doctors talked in front of them 'as if they weren't there', and one fifth of patients reported that nurses did the same. Although these surveys are good at capturing the 'average' for many patients, they do not help identify instances where serious lapses lead to unacceptable care for a minority.
5. **Capacity:** Care systems should be sufficiently well resourced to deliver an appropriate level of service. Over the past decade the number of NHS staff increased by around 20%. The number of (full-time equivalent) hospital medical staff has shown a large increase (40%) over the past decade. For some staff groups these increases stopped in around 2010, for example the number of (full-time equivalent) nursing staff has dipped slightly over the past two years; however, the number of healthcare assistants has risen significantly since then. Numbers of (full-time equivalent) managerial and other 'infrastructure' staff have also fallen significantly over the past two years as a consequence of cutbacks and NHS reforms. The NHS has also seen a continuing, steady net reduction in the number of acute hospital beds – but this is a long-term trend seen in many Organisation for Economic Co-operation and Development (OECD) member countries.
6. **Equity:** There are well documented trends in inequalities in health and life expectancy, particularly between population groups of different socioeconomic status. There are also differences in how people in different socioeconomic groups use health services. People in more deprived areas, for example, have more hip fractures, higher mortality and higher levels of admission for ambulatory care sensitive conditions (clinical conditions for which an emergency admission could be prevented by good quality primary and preventive care). There is no evidence to suggest that these inequalities have narrowed over the past decade. Although the health status of the population of England as a whole may be improving, the gap between health outcomes for rich and poor seems to be stubbornly persistent.

More generally, we found urgent care to be a significant issue which cuts across the domains of access, effectiveness and capacity, as well as spanning primary and hospital care. A&E services are facing unprecedented demand, which has been associated with the recent increase in the number of patients waiting more than four hours. Rates of emergency admission for conditions that in most cases should not require hospital treatment are rising, especially in older people. Many admissions result in a very short stay in hospital, raising questions as to the quality of out-of-hospital preventive care which led up to the admission and whether alternative forms of care may be more appropriate. This needs to be the focus of much further national and local attention.

In depth analyses on specific topics – 'Focus On' reports

Each year the QualityWatch programme will produce a number of in-depth analyses into specific topics that are critical to the quality of care, using a range of methods. 'Focus On' reports provide snapshots and longitudinal analyses of aspects of quality in a particular area, or areas, of care. These analyses have contributed to our annual

statement, as outlined in this report, but each Focus On report will be published separately on the QualityWatch website at **www.qualitywatch.org.uk/focus-on**.

We have completed analysis of two in-depth Focus On topics so far – both are now available on the QualityWatch website. The first report studies trends in emergency admissions for people with 'ambulatory care sensitive' (ACS) conditions – clinical conditions for which an emergency admission could be prevented by good quality primary and preventive care (Blunt, 2013). We found an overall 26% increase in the (standardised) rate of admissions for these conditions over the past decade, but with differences according to the underlying conditions. Admission rates are higher in the more deprived areas – a pattern that seems to have remained consistent over time. Emergency admissions for ACS conditions represent a measure of the quality of 'out-of-hospital' care and this rise in emergency admissions for ACS conditions needs urgent national and local attention.

The second in-depth analysis is of trends in treatment for people with hip fractures (Smith and others, 2013). There has been a significant improvement in post-operative mortality for people with this condition in the past few years and improvements in terms of the number of people receiving an operation within 24 hours of admission. However, we also observed that the prevalence of hip fracture has remained largely constant – which again suggests the need to improve preventive care.

Recommendations

Improve measurement of quality

Our ability to measure quality of care has improved over the past decade, and the recommendations of the Francis Inquiry into the lapses in quality at Mid Staffordshire NHS Foundation Trust are bringing further changes to the way quality is assessed nationally and locally. Primary responsibility for ensuring good-quality services must continue to rest with individual providers of care, although national regulatory bodies and others can play their part. These providers and regulatory bodies would be helped by further development of reliable and valid indicators (particularly for services where data are currently sparse), which make better use of information from patients and carers, measure reliability of systems and provide better information about potential risks.

We recommend policy-makers prioritise the following areas for further development nationally:

- Improve the scope and robustness of existing data flows, including:
  - clinical markers of quality that extend beyond the basic information in Hospital Episode Statistics towards more detail about the process of care – information on outcomes of care, for example as assessed by patients themselves or through clinical proxies – especially in the area of chronic disease
  - information on care provided in community settings, including the range of social care services
  - a reduction in the time lag in availability of information, particularly at national level
  - greater explicit assurance about the quality of the data.

- Develop measures of quality across care pathways, including:
  - information that spans a patient's journey through care sectors, teams and services through data linkage
  - data to capture the health of people who, for whatever reason, are not accessing care.
- Produce more complete information about patients' experiences of care. In recent years there have been developments in the way that patients' views of services can be captured, such as people contributing their views on web forums. For example, NHS Choices includes free text comments directly from service users. The challenge is whether these can be transformed into a meaningful measure of quality.

Improve urgent care

Clearly there is already policy attention on improving urgent care, and our findings to date emphasise that this needs to continue, in particular to address the quality of out-of-hospital preventive care, including access to GP care.

Monitor numbers of nurses

Our analysis found, as published elsewhere, a slight decline in the number of nursing staff across England since 2010. This needs to be monitored carefully; in particular, variations in nursing numbers by provider should be analysed in association with other quality measures.

Conclusion

This is the first annual statement from the QualityWatch programme. It provides an overview of our initial research into the quality of publicly-funded health and social care services in England. Our analysis reveals three key messages:

- First, over the past decade the overall picture is of improvements in many important aspects of quality of health and social care in England.
- Second, there are some causes for concern: these include the appropriate level of nursing staff and the rising pressure on urgent care, in particular for clinical conditions amenable to treatment in primary care.
- Third, while our ability to measure and assess quality of care is improving, there are still many aspects of care, and care services, for which routinely available information on quality is inadequate or non-existent.

Although our ability to use information on quality has improved, an assessment based purely on existing indicators will be limited. Over time, the QualityWatch programme will continue to develop its approach to assessing quality and, in doing so, make a distinctive addition to existing information.

Next steps

Over the next five years we will be developing and refining new indicators and quantitative methods of analysis with experts in the field and, where possible, making international comparisons. We will also identify new topics for more detailed analysis.

The NHS and social care system will be subject to continuing financial pressure during an unprecedented period of austerity. Our focus on the overall quality of services during that period will provide an independent reference point, a stimulus for debate about the state of health and social care, and goals for action where there is a clear gap between current performance and what is achievable.

To keep up to date with our latest research and analysis, visit **www.qualitywatch.org.uk**

You can also sign up for email updates at **www.qualitywatch.org.uk/newsletter**

1

Background to the QualityWatch programme

The quality of care funded by the NHS has been scrutinised in the past year, probably more than in any other since 1948. This is because of a number of high-profile failings in care and concern about other potential lapses, for example in Mid Staffordshire NHS Foundation Trust, Winterbourne View and Morecombe Bay. Each has been, or is being, subject to detailed inquiry resulting in several landmark reports (Healthcare Commission, 2009a; Francis, 2013; Keogh, 2013; National Advisory Group on the Safety of Patients in England, 2013; Department of Health, 2013a; Care Quality Commission, 2012a).

The failures of care in these organisations, and in others before them, are clearly very important and there is much to learn from them. Millions of people use care services each year and not enough attention has been paid to the overall quality of care they receive.

Health and care services currently face profound challenges on three fronts: spending constraints; organisational change resulting from recent reforms to healthcare structures; and the growing need for care, in part due to the increasing and ageing population, and an increase in the prevalence of chronic health problems.

Real-terms growth in resources for the NHS to 2015 is likely to be close to zero, compared with an average of 5% per year since 2002 and the long-term average of 3% since the 1970s. Current forecasts for the 10 years after 2015 show that it is unlikely that the NHS will receive, through tax funding, anything like the level of real-terms growth experienced over the last decade. Funding for social care is also constrained in the period to at least 2015, with most local authorities now providing tax-funded social care only to those with needs assessed as critical or substantial. These challenges will test our health and social care services as never before.

The interaction between the quality of care and the resources available to fund it is complex. Dramatic improvement has been seen in some areas following an increase in resources (for example, generous investment during the 2000s undoubtedly led to a reduction in waiting times for hospital treatment). Yet improving other aspects of quality need not necessarily incur additional cost; treating people with dignity, for example, or providing timely and effective ambulatory care. Indeed, these improvements may even be cost saving, and there is some evidence that poor quality care itself can be costly (Øvretveit, 2009). But given constraints in resources for the NHS and social care in the next decade, a key concern must be the extent to which quality of care may change. If providers of care are unduly focused on making financial ends meet, will this come at the expense of quality, as recent cases show?

Reorganisation poses a further threat, as Sir David Nicholson commented in the preface to the 2013 report of the National Quality Board:

> *"We also need to consider the impact of restructuring the management and regulation of the NHS, as the distraction and confusion this creates can pose one of the greatest risks to quality. Careful consideration needs to be given to the consequences for quality if further reorganisation of this kind is to be embarked upon."* (National Quality Board, 2013)

Growth and ageing of the population, alongside rising prevalence of chronic conditions, are creating pressure on care services. While the growing and ageing population is often cited as driving the rise in demand for healthcare, the increase in age- and sex-specific hospital activity for chronic conditions presents an equal or greater pressure (Roberts and others, 2012). Medium-term impacts of the economic climate are building upon the long-term trends of increasing population age and care needs, and may add further pressures. There is a wide and well-established literature looking at the relationship between measures of socioeconomic disadvantage and health status (Marmot, 2010; Barr and others, 2012; Cylus and others, 2012). A variety of mechanisms underlie such relationships, ranging from environmental effects of poor housing, educational attainment and opportunity, as well as the physical and psychological consequences of unemployment, and of inequality itself. Moreover, we might expect these impacts to be especially pronounced for some social care groups and some parts of the country that will be most vulnerable to increases in material disadvantage, with a subsequent further increase in levels of inequality.

Because of these forces, and the seriousness of recent lapses in care, quality of care needs to be monitored more carefully than ever before.

Monitoring quality

Many organisations have a role in monitoring the quality of NHS-funded care. Table 1.1, adapted from a recent report by the National Quality Board (National Quality Board, 2013), provides a summary. This list continues to evolve as organisations respond to the Francis Report and recent reforms, for example the establishment of three Chief Inspector posts within the Care Quality Commission (CQC).

Table 1.1: Responsibilities for monitoring quality

Provider organisations	Continuous monitoring of quality and performance metrics collected as part of the provision of care.
Clinical commissioning groups	Information gathering and reporting as part of contract management and from wider sources; data analysis may be carried out by commissioning support units.
NHS England	National Quality Dashboard and corporate intelligence from local area, regional and national support teams.
CQC	Quality and Risk Profiles; information from people using services; inspection and investigation.

Healthwatch	Healthwatch will be the new consumer champion for both health and social care; existing in two distinct forms – local Healthwatch and Healthwatch England*.
Monitor	Via third party information, e.g. CQC's Quality and Risk Profiles.
Public Health England	Through the work of the Chief Knowledge Officer on the health of the nation and the support to the commissioners of public health services.
Professional regulators	Assessment of individual competence through revalidation/re-registration and investigation of complaints about individuals; quality assurance of education and training.
NHS Trust Development Authority	Continuous monitoring of performance of NHS trusts against agreed plans.
Health Service Ombudsman	Provides information to the CQC, Monitor and the professional regulators to assist them in their regulatory role.
Department of Health	Monitoring of performance of the NHS overall against the indicators in the NHS Outcomes Framework; regular assessment of the performance of arm's length bodies against their objectives.

These organisations and their roles are developing, as is how they assess quality individually and collectively. The essential point to note is that far more effort is now devoted to monitoring quality by the organisations listed above. In addition, the service aims to ensure that the information gathered is more effectively shared across these organisations; that more data are available for public scrutiny; that the public and patients' views of quality are taken into account more; and that accountability for the quality of care is strengthened, particularly relative to accountability for managing finance.

The QualityWatch programme

Each of the organisations listed in Table 1.1 presents a view of quality from a particular perspective in keeping with their responsibilities. The national bodies are also statutory. We consider there is also room for external, independent scrutiny by organisations outside the statutory health and social care system, that can take an overall and comprehensive view and are not bound by specific responsibilities. The Nuffield Trust and the Health Foundation have therefore joined forces to fulfil this role and provide analysis of how the quality of care is changing, which will both augment and inform other statutory national initiatives.

* Healthwatch England published their Annual Report for 2012/13 on 8 October (Healthwatch England, 2013). It is available at: **www.healthwatch.co.uk/news/our-annual-report-201213.**

Our aims are to:

- provide an authoritative and independent analysis on the quality of health and social care over time, while at the same time augmenting and informing other statutory and non-statutory national initiatives
- highlight where there are clear and compelling gaps between existing standards of care and what is possible, in order to prompt action to improve quality
- help develop the way quality of care is measured.

Our programme will:

- link different dimensions of quality across providers and sectors
- explore the potential for services to avoid lapses in quality through comparative analysis across the country
- provide in-depth, flexible analysis of discrete quality issues as they arise.

The two main 'arms' of the QualityWatch programme are:

- **Developing sets of indicators to measure changes in the quality of care**. These will be used to track change over time across areas within England. Where possible we will compare areas within England and make comparisons with other countries. We will generally use existing sources of data but may, in the future, commission new ones.
- **In-depth analyses on specific topics.** We aim to build on the Nuffield Trust's capacity to use complex information to create new approaches and new perspectives on how the quality of NHS and social care is changing. These topics allow us to identify areas that are potentially important and which would benefit from more detailed quantitative and qualitative analysis.

In this annual statement we bring together observations from our early work on QualityWatch. The report is the first in a series of annual statements to be published over the next five years. It provides an overview of activities within the QualityWatch programme in its first year of life. It is not comprehensive but selects elements of the work to outline the way we measure quality and some of the early findings.

The following chapter (Chapter 2) outlines what we mean by quality and analysis of the information available for assessment. Chapter 3 gives an overview of the different domains and the indicators available. Chapter 4 summarises some of the areas we have explored in depth and Chapter 5 provides a short discussion of the findings from our initial assessment.

2

Understanding quality

Dimensions of quality of care

There have been many different ways of defining and categorising elements of quality of care. Donabedian (1985) developed a scheme that categorised elements of care into three groups – structure, process, outcome – which has remained an enduring framework.

Six broader definitions of quality – relevance, accessibility, effectiveness, acceptability, efficiency and equity – were developed by Maxwell (1984), and adapted for use within a health service context. A similar classification was used by Leatherman and colleagues in reports on quality in NHS care (Leatherman and Sutherland, 2008), and has formed the basis for our work in this report. There have been many other approaches. For example: the seven pillars of clinical governance (Department of Health, 1998); the seven domains in the Standards for Better Health (Department of Health, 2004); the six areas within CQC's Essential Standards of Quality and Safety (CQC, 2010); and the six aspects defined by the US Institute of Medicine in *Crossing the Quality Chasm* (Institute of Medicine, 2001).

Most recently, we have seen three simple arms of quality described by Darzi (2008) – effectiveness, patient experience and safety – translated to form the five domains of the NHS Outcomes Framework (Department of Health, 2012b). It is clear that there have been a large number of frameworks describing quality; all similar, all a little different.

We have chosen the framework largely used by Leatherman and Sutherland with six major domains of care, which we consider across different aspects or settings of care provision (primary and community care, secondary acute care, and social care), forming a two dimensional matrix to describe quality (Figure 2.1). We will also analyse quality indicators by particular population groups or cohorts, as the focus for more detailed studies allows us to provide more nuanced information for policy-makers, clinicians and managers.

This framework extends beyond the range of the current NHS Outcomes Framework to include elements on capacity and access. We believe recognition of these domains will allow us to identify changes that may foreshadow future problems in quality and outcomes. Outcomes are important because they capture what is important to patients, the primary recipients of care. Yet health outcomes can sometimes take time to show after a discrete care event, and can be difficult to measure, understand or attribute to any particular factor. Often, good indicators are built on more reliable measures of process, which have known links to eventual outcomes, for example screening for venous thromboembolism (VTE), or where the process itself has some legal or ethical imperative, for example reporting of serious untoward incidents.

Figure 2.1: A framework to structure a range of indicators of quality of care

		Primary and community provision	Secondary tertiary general and acute provision	Secondary tertiary mental health provision	Social care provision	Population/ commissioner level
Range of services available and how quickly a patient can access them	Access					
Indicators of direct patient harm and proxy measures for potential harm	Safety					
Impact of services on improving health at individual and population level	Effectiveness					
Information about patients' experiences and the environment of care	Person-centred care					
Markers of local health infrastructure including capital and staffing	Capacity					
Differences in quality of services associated with social factors	Equity					

Measuring quality

As noted above, measuring the quality of care is complex because quality:

- is multi-dimensional
- can encompass sometimes conflicting perspectives, including those of professionals, care users, and their friends and relatives
- can sometimes only be understood by having very detailed knowledge of what care is provided, e.g. appropriateness of prescribing a particular drug
- is often subjective and can mean different things to different care users
- will vary between areas where services are provided, and vary over time
- may not be immediately visible; the impact of good or bad quality care on the health of an individual may take years to accumulate and be revealed
- can require skilled judgement to assess, for example how to balance the protection of a 'confused' and frail care user, with a respect for a person's basic rights and freedoms.

Despite these challenges, the field of quality measurement has progressed significantly in the past few decades.

Table 2.1 shows the types of information that might be used to assess quality. It is clear that the range of information varies by care sector. In general there is much less routinely-collected and available information on social care and provision of care by non-acute independent providers, compared to NHS organisations. As a consequence, our understanding of quality in these sectors relies heavily on the results of physical inspection of care.

Table 2.1: Examples of different information sources related to quality

Information source	Example indicators
Computerised hospital records	Hospital admissions for effective procedures, e.g. cataracts Hospital specific standardised mortality ratios
Office for National Statistics (ONS) deaths and births	Condition-specific mortality Peri-natal mortality
General practice datasets	Quality and Outcomes Framework indicators Achievement of clinical targets such as HbA1c (blood glucose control)
Aggregate information about general practices	Healthcare-acquired infections, e.g. *Clostridium difficile (C. diff)* surveillance scheme Registries, e.g. National Cancer Registry, National Joint Registry, National Venous Thromboembolism Registry, Renal Registry Radiotherapy datasets Waiting times to see a GP
Specific care registers/databases	Clinical audit datasets, e.g. Myocardial Ischaemia National Audit Project, National Audit of Dementia
Adverse events/ incidents reporting	Serious untoward incidents (SUI), National Reporting and Learning System reports Complaints, e.g. Independent Sector Complaints Adjudication Service Notifications to CQC
Aggregate returns to the Department of Health, CQC or the Health & Social Care Information Centre	Numbers of theatres Delayed transfers of care Staffing levels Estates indicators (estates return information collection) Immunisation coverage statistics, e.g. HPV vaccination uptake Uptake of cancer screening

Information source	Example indicators
Collected only to measure performance (aggregate)	Waiting times, e.g. cancer waiting time data Re-operation after cancellation Local authority indicators on social care provision
Other patient reports	Hospital level monitoring systems, NHS Choices, I want great care Local surveys Healthwatch Patient reported outcome measures (PROMS)
Patient surveys	Inpatient surveys, general practice surveys, social care user surveys, community mental health services survey, cancer patient experience survey
Staff surveys	General Medical Council (GMC) surveys of trainee doctors and trainers Survey of NHS staff – would you recommend the trust as a place to receive treatment?
Other peer reviews/ inspections	CQC Royal colleges/training Cancer peer review Endoscopy peer review Patient Environment Action Team (PEAT)/Patient-Led Assessments of the Care Environment (PLACE)
Accreditation schemes	Imaging services accreditation Physiological diagnostic accreditation A series of accreditations run by the Royal College of Psychiatrists at ward level (other royal colleges may also complete accreditation in their fields too)
Other regulatory findings (using one of the methods above)	Clinical Negligence Scheme for Trusts (CNST) NHS Litigation Authority Ombudsmen reports Auditor statements Health and Safety Executive notifications
Self-assessment	CQC registration data Monitor Quality Governance Framework National Cancer Peer Review (self-assessment component)

Source: Adapted from Nuffield Trust, 2013.

Indicators of quality

The emergence of comparative indicators of quality of care in the NHS began in the 1980s, just as the first micro-computers began to emerge. Especially notable was the work of John Yates and his team in Birmingham (University of Birmingham Health Services Management Centre, 2012) who crafted a completely new way to organise indicators across all NHS bodies, much of which is still in use today.

The breadth of information available has grown over time, as has the sophistication with which data can be manipulated, in particular the exploitation of large person-level datasets such as Hospital Episodes Statistics (HES) or data on quality derived from GP computer systems in the Quality and Outcomes Framework. Attempts to define quality of care have also become more developed, as have the ways by which indicators can be grouped.

There is a large library of existing indicators on which to draw and the past decade has seen new initiatives to structure and develop these (for example, the NHS Outcomes Framework and its derivatives, or Better Value Better Care). Some of the most comprehensive datasets have been developed by regulators, including the Healthcare Commission (Bardsley and others, 2009) and the CQC through the Quality and Risk Profiles (CQC, 2012b).

Despite having access to this deep pool of information, many organisations with national remits find they are constrained in the information they can use to assess quality of care across England and compare between providers. This happens for many understandable reasons, including: the framework within which they regulate/oversee/commission; the need to be consistent between providers; the need to be parsimonious in data collection; the need to establish a wide-range consensus on how indicators are constructed (such as the Summary Hospital-Level Mortality Indicator); and the need to use only the highest quality data for regulatory purposes or performance management.

Our approach

Independent organisations such as the Nuffield Trust and the Health Foundation have the freedom to work beyond some of the constraints on organisations that have a national responsibility. Moreover, we are aware that most sets of indicators give only selected slices of reality (Pencheon, 2008). Indicators thus exist to prompt useful questions, and often are inadequate to provide definitive answers.

Our approach maps a range of existing indicators to a broad framework (see Figure 2.1), as the first step in a process of sifting and concentrating on those that might add most value. In terms of quantitative analyses, the information may be structured in different ways, but will always be examined in one of the following categories:

- change over time at national level
- change at national level with respect to other benchmarks (for example other countries)
- change over time at provider/area level within England
- change in mean across areas/providers

- change in achievement of threshold, for example fewer extremes
- change in relationship to other variables, for example vs deprivation, unemployment or other social factors.

Of the large number of existing indicators relating to quality, we sought to identify a subset that would form a good platform for ongoing monitoring. As a first step, we looked at indicators already used or proposed by a number of organisations (see Table 2.2). Indicators from these sources were identified and mapped to our outline framework identifying the domains of quality and sectors of care (see Figure 2.1).

Table 2.2: Sources of initial indicators

CQC	Quality and Risk Profiles
Monitor	Compliance Framework 2012/13
Monitor	Quality Governance Framework
NHS Choices	Indicators
Department of Health	Outcomes Framework 2012/13
Department of Health	Quality and Outcomes Framework 2012/13
NHS England	Commissioning Outcomes Framework
Department of Health	Public Health Outcomes Framework 2013–2016
Department of Health	Adult Social Care Outcomes Framework 2011/12
Organisation for Economic Co-operation and Development (OECD)	Health at a Glance Indicators
Health & Social Care Information Centre	Indicators for Quality Improvement
Right Care	NHS Atlas of Variation in Healthcare Series
Nuffield Trust	Quest for Quality

Our initial processing identified 1,503 indicators which were unevenly distributed across the matrix. The raw numbers of indicators in each category can be misleading since some indicators are more valuable in understanding quality than others. Nevertheless, the process did highlight gaps, for example a relatively low number of indicators in the areas of equity of access to care and social care (Table 2.3).

Table 2.3: Distribution of 1,503 existing or proposed indicators within the quality matrix

Domain	Social care provision	Primary/ community provision	Ambulance, A&E and secondary/ tertiary acute care	Mental health provision	Population/ commissioning	Total
Access	13	46	75	41	9	**184**
Safety	11	66	160	82	7	**326**
Effectiveness	13	147	274	26	82	**542**
Person-centred care	18	27	159	77	5	**286**
Capacity	30	35	47	24	1	**137**
Equity	0	7	10	10	1	**28**
Total	**85**	**328**	**725**	**260**	**105**	**1,503**

Note: These are based on early analysis of existing indicator lists described in Table 2.2.

As can be seen, a very large number of indicators were identified. We used the following criteria to identify a smaller set, which was more manageable for analysis:

- Does the indicator describe the quality of care?
- Is it able to distinguish good from bad?
- Is it capable of showing change over time?
- Does it cover enough people/services/organisations to have sufficient impact?
- Is it reliably measured?
- Is it important in national policy terms?
- The avoidance of duplication of indicators which measure the same underlying aspect of quality.

In doing this, we used internal discussions between analysts within the team, and advice from a number of external experts who were presented with a long list of indicators and asked to comment on ones that had little or no value, and identify important indicators that were missing. Comments from these experts were collated and used to refine the indicator lists. We found:

- both consensus and some disparate opinions on which indicators were most important
- different views as to the underlying aspect of quality the indicators were measuring
- that some indicators thought to be suitable did not currently have historical data and therefore were not suitable for a time series analysis
- that there were a lot of indicators for some aspects of quality and thus debate on whether composite indicators should be created

- some areas were mainly covered by the same data source, introducing a data source bias to the measurement of the quality dimension
- that there was a tendency to relax thresholds for inclusion in areas where there were few indicators available.

Applying these criteria, we eventually identified a list of approximately 500 indicators, from which around 100 were prioritised to form the basis for our first wave of analysis. Our choice of these final 100 was pragmatic and preferred indictors where data were currently available and able to show some form of trend over time. We also sought indicators from across our framework, covering all domains of quality and sectors of care.

This initial set of indicators is on our website at **www.qualitywatch.org.uk/indicators**.

Refinement and adaptation

We intend to add to and refine the indicator set as the QualityWatch programme develops. Further refinement will include: seeking feedback on our choices and analyses from a wider group of people such as users of the website; and testing whether formal consensus development methods (such as Delphi or nominal group technique) can be used to select the most valuable indicators based on the views of professional groups or representatives of the general public. We will explore these options in the coming year.

3

Overview of indicators

Chapter 2 outlined the process we used in selecting an initial set of indicators. In this chapter, summary observations are drawn from our analysis of some of these indicators. These are examples of the stories that these indicators tell, rather than a systematic summary of all of them.

The review is not comprehensive given the large number of indicators we have examined (for more information, see **www.qualitywatch.org.uk/indicators**). However, the intention is to highlight some emerging issues, including some of the successes, as well as the challenges. It should be noted that we have used the data as we found them, subject to the tests for inclusion set out in Chapter 2. This means we are working in a situation where the domains and sectors have uneven coverage in data. It also means accepting that the data are sufficiently reliable for the purpose in which we have used them. Very few datasets we examined are externally audited, although many more are derived directly from IT systems used to deliver care, so should form a reasonable representation of the care given. The NHS is also well served by large national patient surveys compared with other health systems.

The following sections are organised into six domains of care as noted in Chapter 1:

- access
- safety
- effectiveness
- person-centred care and experience
- capacity
- equity.

Access

Care services should be timely and provided within the appropriate setting with access to necessary skills, expertise and technology.

Waiting times for care

Waiting times for acute care are a commonly used yardstick of how well the NHS is performing. Long waits are undesirable for patients who may be in unnecessary pain or discomfort while waiting for treatment, suffer the anxiety and uncertainty of waiting for a diagnosis, or whose condition may deteriorate.

With regard to the quality of care, the number of people on 'the waiting list' is less important than how long people actually wait for care. There are a number of ways of measuring this (see for example Table 3.1), but currently the most common

measurement is against a threshold that marks an unacceptable standard, for example the number or proportion of people waiting over 18 weeks for the start of their consultant-led treatment from referral for non-urgent conditions. There is a range of thresholds for waits for other forms of care such as A&E treatment, specific diagnostic tests, GP appointments, social care assessments, ambulances (in terms of response times), or transfer of care across providers.

The many different indicators that can be used to assess waiting times are summarised in Table 3.1.

Table 3.1: Example indicators relating to waiting times

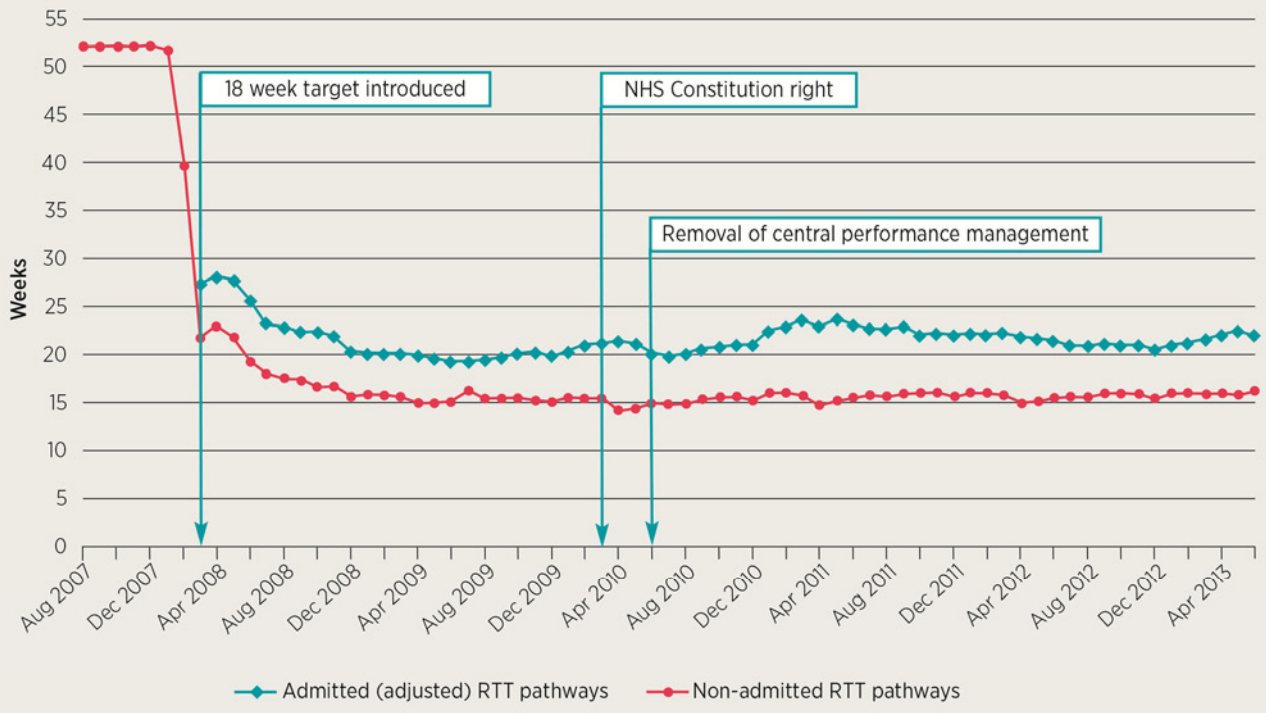
Ambulance category A calls – Response within eight minutes
Ambulance category A calls – Response within 19 minutes
Measures of the longest waiting times to consultant-led treatment from referral for non-urgent (elective) conditions (weeks)
Diagnostic waits – Percentage of patients waiting over six weeks
Comparison of the median time spent in A&E to the national median for admitted patients
Comparison of the median time spent in A&E to the national median for non-admitted patients
The proportion of patients first seen by a specialist within two weeks when urgently referred by their GP or dentist with suspected cancer
The proportion of respondents to the outpatient survey who said that from the time they were told they needed an appointment, to the time they went to the outpatients department, was more than five months
Proportion of patients not placed in a bed on a ward within four hours of a decision to admit
Proportion of patients who were admitted to a stroke unit within four hours
Ratio of Improving Access to Psychological Therapies (IAPT) programme active referrals who have waited more than 28 days from referral to first treatment/first therapeutic session
Proportion of patients waiting more than three weeks for a first intervention for substance misuse

Waiting for elective treatment

Figure 3.1 shows the changes in waiting times from referral to the start of consultant-led treatment for non-urgent (elective) conditions (in terms of the 95th percentile waiting time of the group of patients waiting). The blue line shows waiting times for pathways where the patient was admitted for treatment. Only patients who completed their pathways/started treatment are included; patients still on the waiting list are excluded ('adjusted' in the chart). The red line shows waiting times where the patient

has been treated but wasn't admitted to hospital, for example treatment in an outpatient setting.

Figure 3.1: 95th percentile waiting times from referral to elective treatment (August 2007 to June 2013)

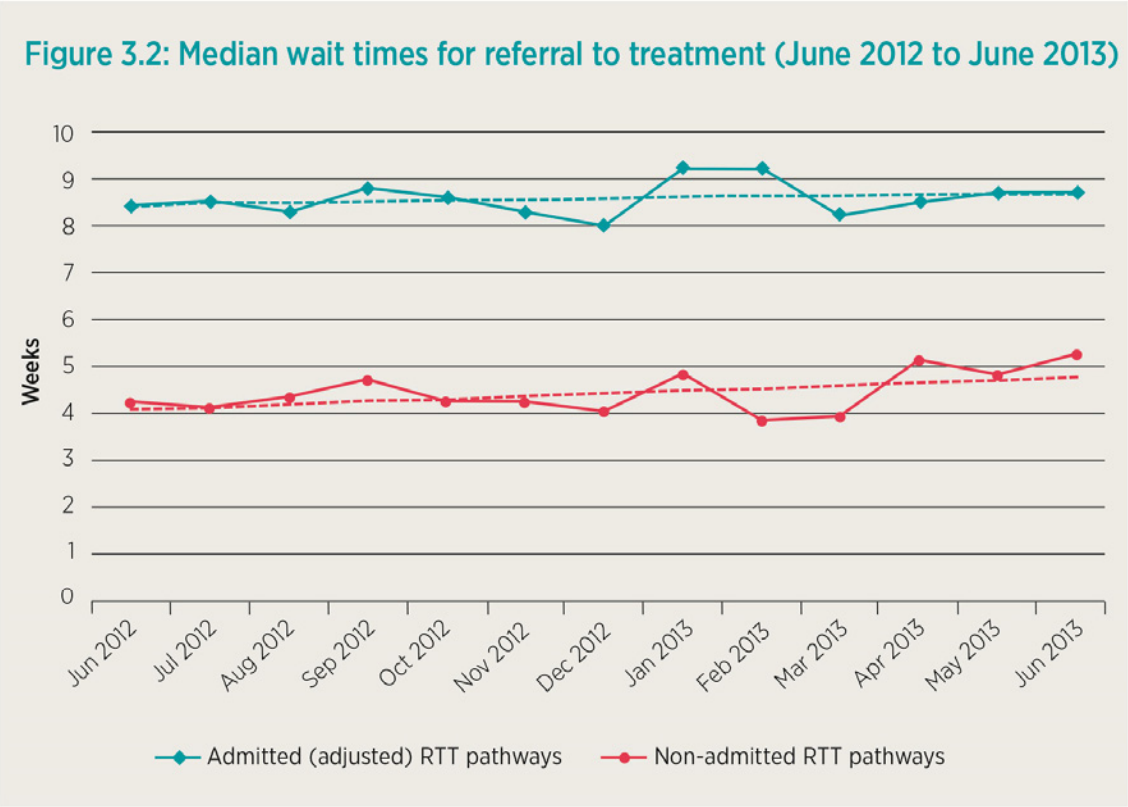


Source: NHS England, Referral to Treatment waiting times statistics; RTT: Referral to Treatment.

Figure 3.1 shows that there was a steep decline in waiting times from January 2008 to March 2008. This relates to the introduction of the government's target of a maximum of 18 weeks from referral to treatment for waiting times, and its inclusion as part of the Healthcare Commission's Annual Health Check under the national priorities for acute trusts (Healthcare Commission, 2008).

The '18 week target' introduced in 2008 was replaced by the patient right in the NHS Constitution in March 2010 (Department of Health, 2013b) to '*start consultant-led non-emergency treatment within a maximum of 18 weeks of a GP referral and for the NHS to take all reasonable steps to offer a range of alternatives if this is not possible'.*

Figure 3.2 gives more detail on the last 12 months, showing the median wait time for referral to elective admitted and non-admitted treatment over this period (the median is perhaps a more intuitive measure of waiting). Although the waiting times were shorter than in earlier years, over the past 12 months there has been a slight increase, especially for patients that are not admitted.

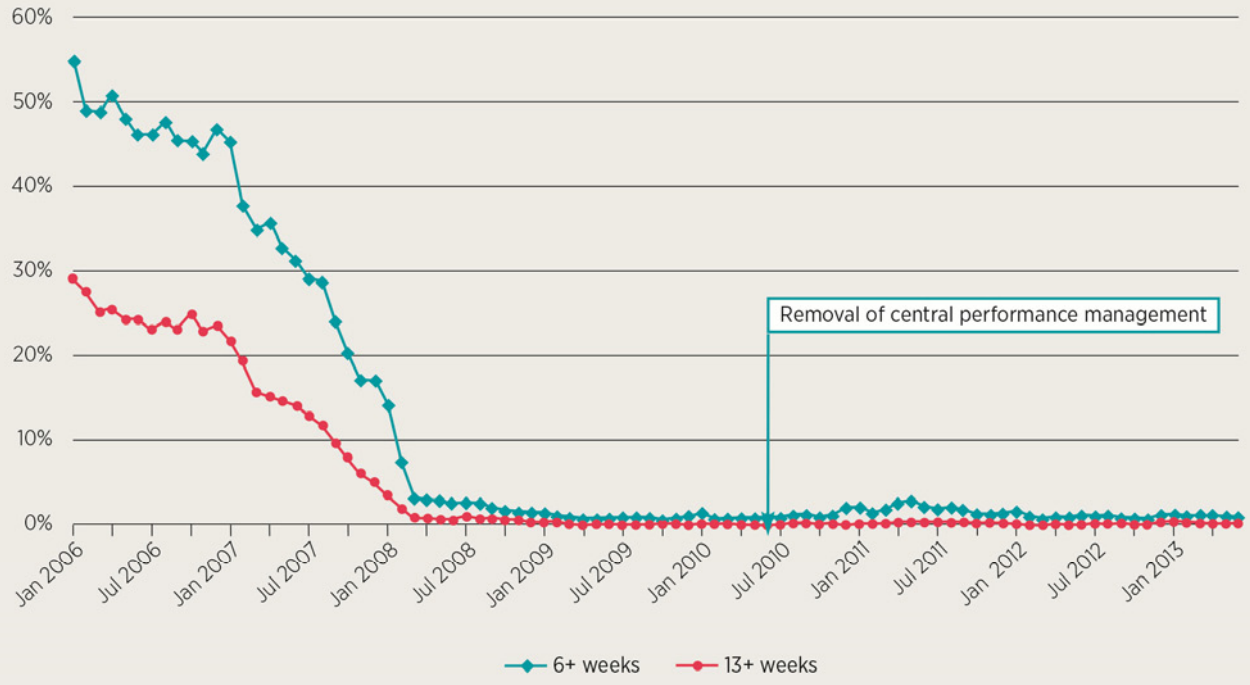


Source: NHS England, Referral to Treatment waiting times statistics; RTT: Referral to Treatment.

Waiting for diagnostic tests

Figure 3.3 shows the proportion of diagnostic tests that were still on the waiting list after six weeks and after 13 weeks. The figure shows that the number of patients waiting more than 13 weeks fell dramatically in the period before March 2008, and has remained consistently low after that point. Central performance management of this target was stopped in summer 2010. The figure shows the subsequent increase in patients waiting more than six weeks for tests from May 2011, despite the six week standard being continued as a pledge within the NHS Constitution (Department of Health, 2013b).

Figure 3.3: Proportion of people waiting more than six weeks for a diagnostic test (January 2006 to June 2013)



Source: NHS England, Diagnostic Waiting Times and Activity.

Waiting for ambulances to respond

The main indicator now used in relation to ambulance waiting times is the proportion of cases receiving an ambulance vehicle capable of transporting the patient within 19 minutes of the request for transport being made. Overall, the proportion of category A calls (immediately life-threatening) resulting in an ambulance arriving at the scene within 19 minutes has been steadily falling since April 2011. Most ambulance trusts in England have always achieved the standard of 95% of category A calls receiving an ambulance within 19 minutes (the exception was during one month and was linked specifically with one trust).

Waiting for cancer treatment

Improvements that were made in waiting times for cancer treatment over the past five years have been sustained. The proportion of people receiving their first treatment within 31 days is consistently high, at over 98%, and the percentage of urgent referrals receiving an outpatient appointment within two weeks is stable at 95-96%.

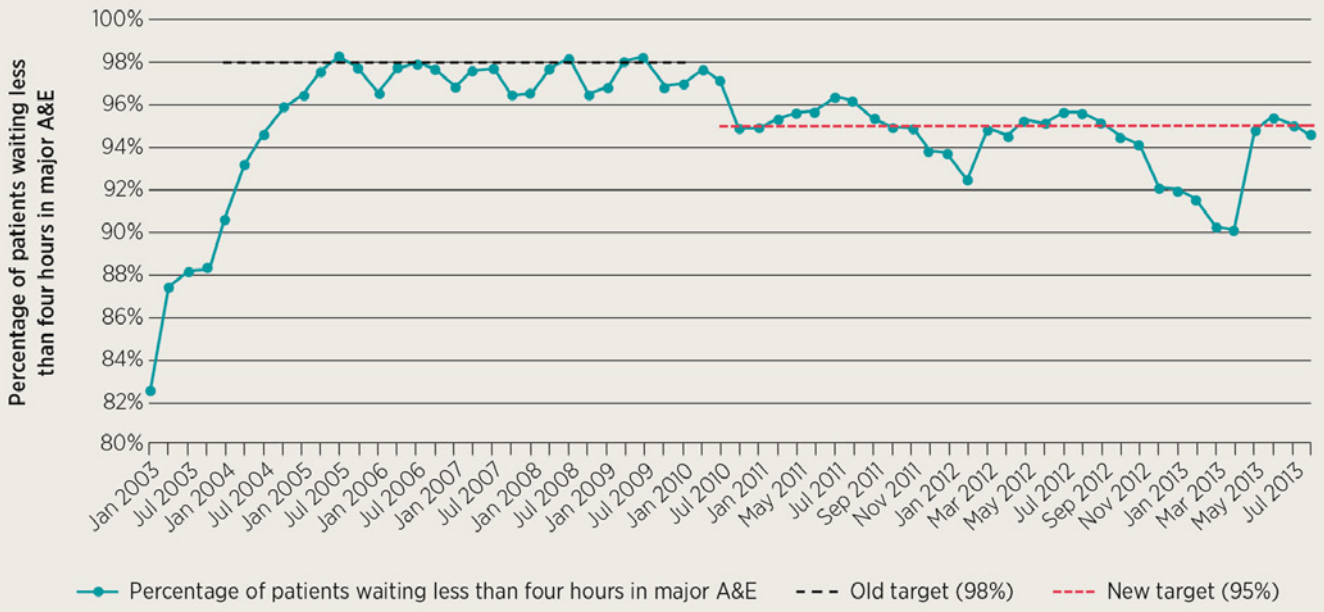
Waiting in accident and emergency departments

The target that 98% of patients arriving at A&E will be seen and either discharged or admitted to an inpatient bed within four hours has been controversial. But there can be little doubt that it changed the way A&E departments operate. In 2003, before the

introduction of the target, 87% of attendees at a major A&E department completed their journey through A&E in less than four hours. In 2005 this proportion was 97% (Department of Health, 2011).

It is a mark of the target's success, and its resonance with the public, that it was one of the few targets that was performance managed nationally after the change of government in 2010. However, the incoming coalition government did relax the target to 95% of attendees being seen within four hours. This relaxation was associated with an almost immediate fall in the proportion of people seen inside four hours to an average of 95% in 2011 (NHS England, 2013a).

Figure 3.4: Percentage of patients waiting less than four hours in major A&E (January 2003 to August 2013)



Source: Department of Health (2011) Quarterly Monitoring of A&E, NHS England (2013) A&E Waiting Times and Activity.

Performance was maintained at the 95% level until September 2012, when it began to drop. By April 2013, achievement of the target had fallen to just 90% – the lowest level since the introduction of the four hour target in January 2004. While the time from arrival to departure is the highest profile performance indicator, it is not the only way of gauging the performance of an A&E department. 'Trolley waits' – that is, the time between the A&E doctor making the decision to admit and the patient arriving in an inpatient bed – also increased over the same period (NHS England, 2013a), adding to overcrowding in A&E departments.

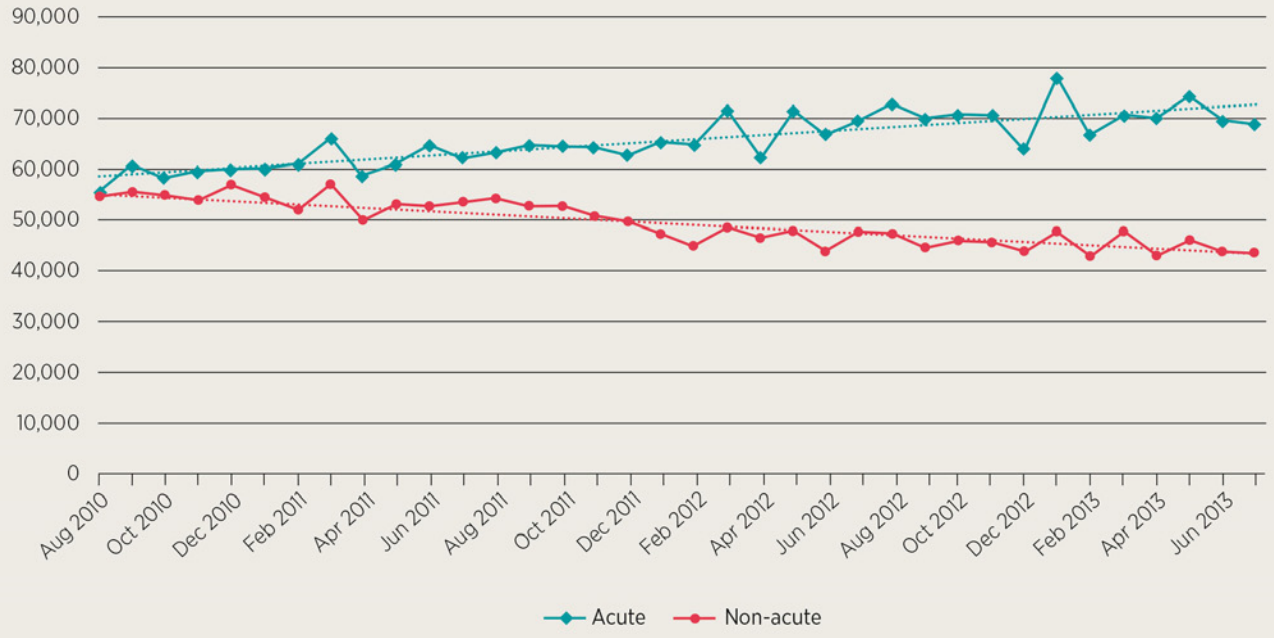
This issue has prompted a huge amount of attention and debate, and it is notable that since May 2013 the proportion of people waiting in A&E for four hours or less has returned to around the 95% level. The Department of Health has also made £500m available to ease winter pressures on A&E over the next two years. It remains to be seen if these improvements in performance (and increase in funding) are sustained in the long term.

Delayed transfer of care

Routine data collected monthly by providers in their 'Situation Reports' show the number of people who have 'delayed transfer of care': where a patient is deemed medically fit to be transferred/discharged from their current care, but is not due to 'non-clinical' reasons. This information is collected across providers of NHS-funded care for both non-acute services (such as providers of community and mental healthcare) as well as acute services. Which organisation is responsible for the delay, what type of care the patient received and the reason for the delay is also collected. This is in part because the *Community Care (Delayed Discharges etc.) Act 2003* (Her Majesty's Stationery Office, 2003) introduced a requirement on local authorities to reimburse NHS trusts for each day a patient's discharge from the trust is delayed where the sole reason for that delay is the responsibility of social services, either in making an assessment for community care services or in providing those services. The total number of people delayed fell during August 2010 to July 2013, although the number of bed days increased for some providers – suggesting that fewer people are actually waiting longer.

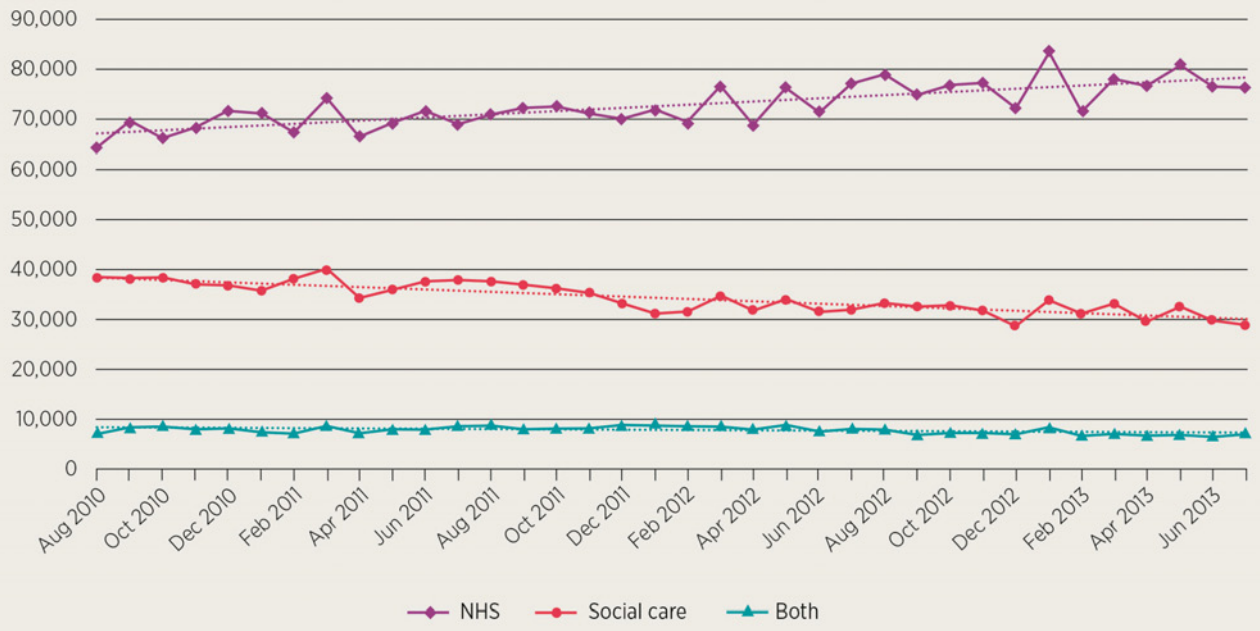
Figure 3.5a plots the total numbers of delayed bed days for acute and non-acute trusts from August 2010. The number of bed days is rising in acute trusts but falling in non-acute trusts. The reasons for the increasing delays are linked with the NHS rather than social care (Figure 3.5b).

Figure 3.5a: Number of days delayed based on care received by the patients (August 2011 to July 2013)



Source: NHS England, Delayed Transfers of Care: monthly situation reports.

Figure 3.5b: Number of days delayed by organisation responsible for the delay (August 2011 to July 2013)



Source: NHS England, Delayed Transfers of Care: monthly situation reports.

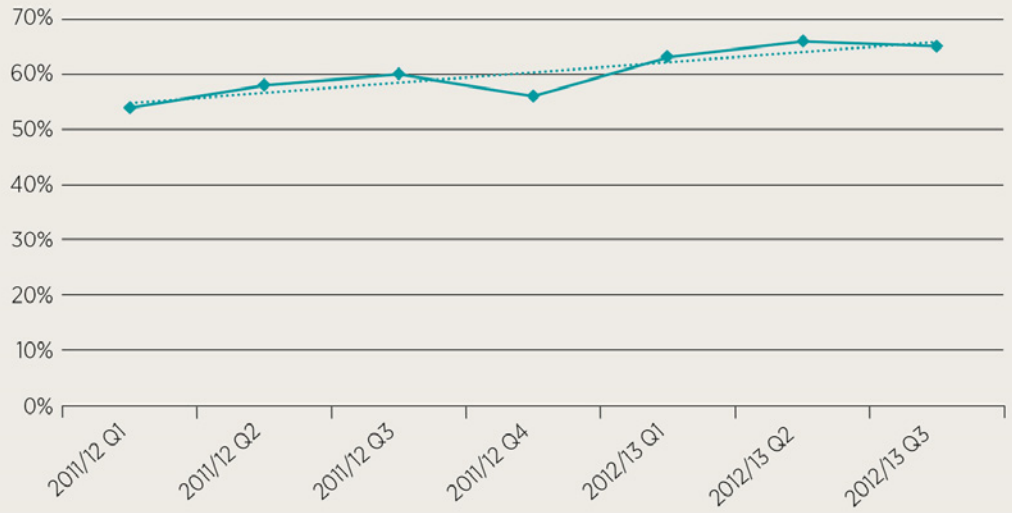
Although most aspects of waiting times have held steady, some are increasing. These may be indicative of growing strains in the healthcare system, in particular in A&E attendances and in some transfers of care. The scale of the increases, however, is still far below the level of waiting times endured five years ago.

Access to selected services

A sign of a good-quality health service is that patients are able to access the service most appropriate to their particular need, or to new forms of care or treatment. In times of financial constraint there is the danger that access to new or specialised care may suffer when the priority is to maintain the more general services for a wider population.

There are a number of indicators that look at access to specialised services. For example, Figure 3.6 is taken from the Royal College of Physicians (RCP) stroke audit and shows the proportion of people who are admitted to a specialised stroke unit within four hours – a standard drawn from the National Institute for Health and Care Excellence (NICE) stroke guidelines launched in 2008 (NICE, 2008).

Figure 3.6: Proportion of those with stroke who received specialised care within four hours (quarter 1 2011/12 to quarter 3 2012/13)



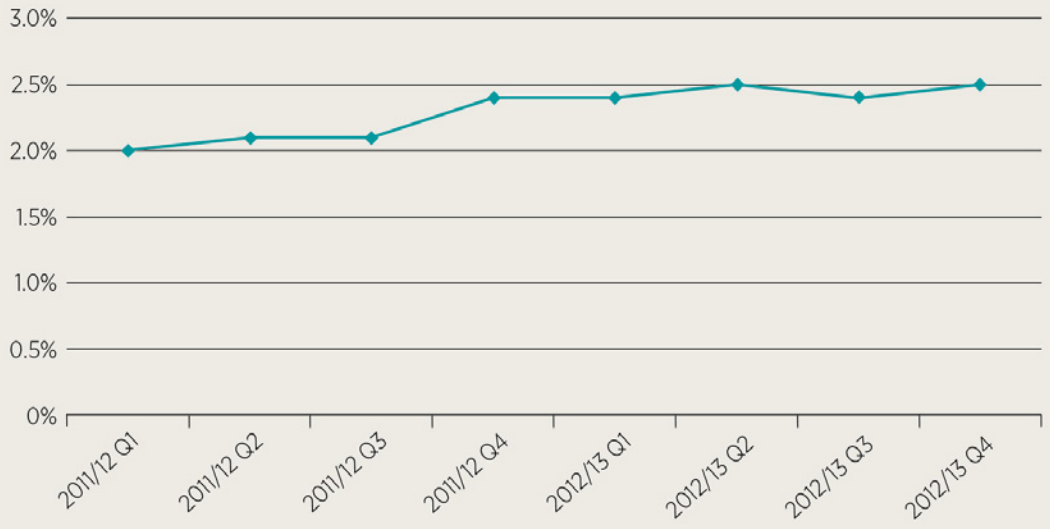
Source: The Royal College of Physicians, National Stroke Audit.

One area that has come to national attention is the Improving Access to Psychological Therapies Programme (IAPT), which is designed to support the NHS in delivering evidence-based therapies for patients with depression or anxiety. Once again, this programme is linked to NICE guidelines.

Access to this service is measured using an indicator measuring the proportion of people with anxiety and/or depression who have received IAPT services. This proportion was 2.5% in the final quarter of 2012/13, which is a slight increase from 2% in the first quarter of 2011/12, when this measure was first used. The extra 0.5% equates to nearly 31,000 extra individuals per quarter with anxiety and/or depression receiving IAPT services in just over a year. Yet currently only a tiny minority of those suffering from anxiety and/or depression have access to these services.

These types of specialised services can be vulnerable when financial cuts are needed. However, assessing change can be difficult with routine indicators. First, information about basic service provision is not always kept consistently, centrally or collected on a national basis. It generally falls to specialist interest groups to monitor these areas. Second, these services tend not to be standard across the country. National agencies also tend to have fewer expectations as to the specialised services that should be in place locally.

Figure 3.7: Estimated proportion of people with anxiety/depression who have received treatment from IAPT services (2011/12 to 2012/13)



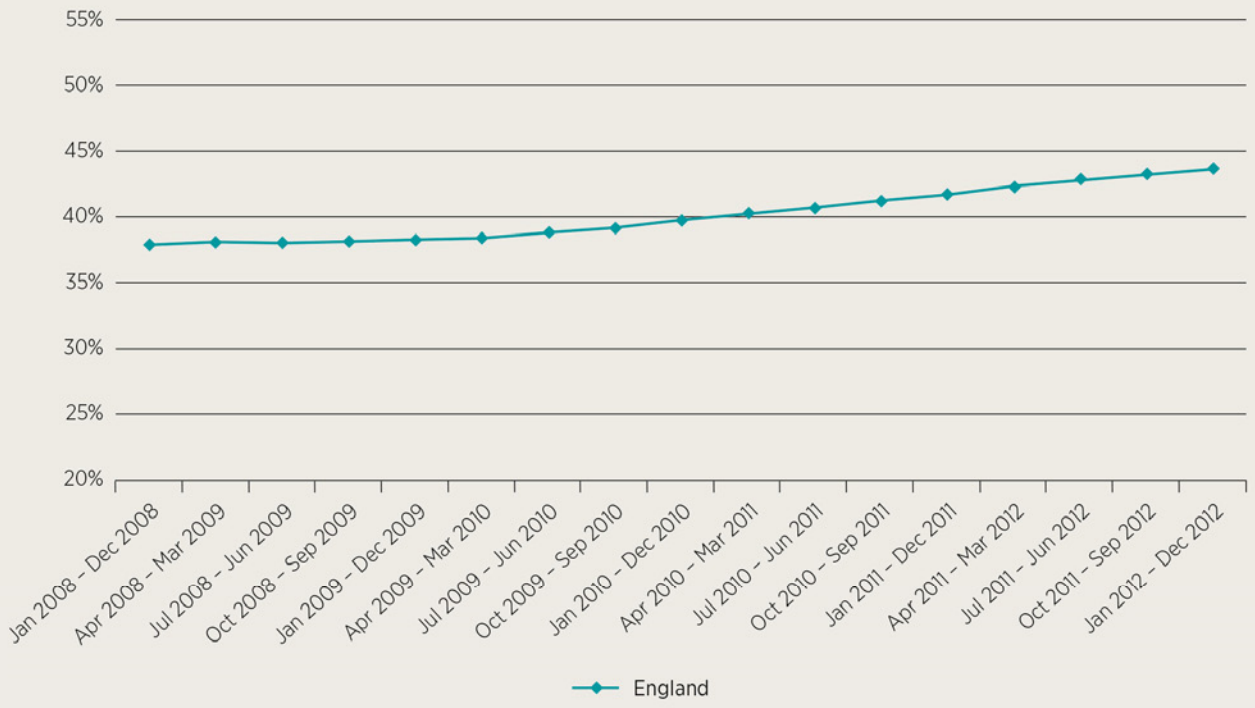
Source: Health & Social Care Information Centre, Improving Access to Psychological Services.

Access to home-based services for terminally ill people

It is clear from a number of surveys that terminally ill people would prefer to die at home rather than in hospital (Department of Health, 2012c).

Figure 3.8 shows that there has been a gradual increase in the proportion of people who are dying in their usual place of residence (mainly home or care homes). Not shown is the corresponding reduction in the numbers dying in hospital. While there was a degree of variation between regions of the country, an increasing proportion of people appear to be dying at home in all areas.

Figure 3.8: Twelve month rolling average proportion of deaths in usual place of residence (January 2008 to December 2012)



Source: National end of life care intelligence network, End of life care profiles.

Access to general practices

One of the more commonly used datasets on access to GP services is derived from the GP patient survey (Ipsos MORI, 2013). The 2012/13 survey reported on over one million responses. Table 3.2 summarises some of the findings. The majority of people report being satisfied with the access they have to GP care. Yet in the responses to the question *'How do you feel about how long you normally have to wait to be seen?'*, 24% of people reported having to wait 'a bit too long' and a further 8% 'far too long'. Although overall 76.3% of respondents rated their experience of making an appointment as good, this has fallen from 79.2% in 2011/12; a statistically significant drop of 2.8 percentage points.

Table 3.2: Headline results from recent surveys of general practice

For most patients (75%), it is easy to get through to someone at their GP surgery on the phone; down from 77% of patients who said this previously. Around one in five (22%) patients feel the opposite, saying it is not easy. Few patients (just 3%) have not tried to get through to their GP surgery on the phone.
Almost nine out of 10 patients (88%) find the receptionists at their GP surgery helpful. Few patients (just 10%) do not find receptionists at their GP surgery helpful.

Over four in five patients (83%) say that other patients can overhear what they say to the surgery's receptionist. However, three in five (57%) do not mind this. A quarter of patients (25%) say that they can be overheard and are not happy about it. Around one in 12 patients (8%) report that they cannot be overheard.
The majority of patients (90%) usually book their appointments by phone, while three in 10 (30%) book their appointments in person (patients were allowed to select multiple methods). Few patients (3% or less) book their appointments online, despite three in 10 (31%) stating a preference for booking their appointments online. Apart from this, preferred methods of booking appointments generally reflect those currently used by patients.
Over half of patients (56%) have a preferred GP and, of those, two-fifths (40%) 'always or almost always' get to see them. Around a quarter of patients (23%) see their preferred GP 'a lot of the time', with a slightly greater proportion (30%) saying 'some of the time'. Few patients (7%) 'never or almost never' get to see their preferred GP.

Source: Ipsos MORI, 2013

Safety

Service users should not be harmed by the care they receive or be exposed to unnecessary risk.

The safety of care, more than any other dimension of quality, demonstrates the imbalance between our desire for measures that allow us to assess safety and our inability to provide them. Whether a service is 'safe' is a question that is almost unanswerable without a long list of caveats and cautions.

The difficulty with assessing safety is that:

- Unsafe practice is not always apparent and may not lead to immediate harm. It may only be relatively rare that a patient suffers the detectable consequences of poor practice.
- The consequences of unsafe practices in patients' terms are difficult to distinguish from other elements of suboptimal treatment, and it can be hard to assess whether treatments are successful.
- Safety is about doing things right; lots of different processes of care and in an organisation that promotes a culture of safety. As such, safe care permeates all aspects of care and the breadth of activities covered makes measurement very difficult.
- Measuring when things go wrong as a consequence of reports from patients or staff is complicated by the problem that a high level of reported incidence may be an indication of good safety practice (that is an open and straightforward reporting/complaints process) rather than the failure of care.
- The recording of certain health problems, which have a high probability of being related to lapses in safety, can be inconsistent.

Put together this means answering the question 'Is a hospital safe?' is not easy. The complexities described above apply equally to non-acute healthcare and social care, but in the latter case, the amount of information we have is often extremely small. As a recent inquiry into patient safety advised: *"Use quantitative targets with caution. Such goals do have an important role en route to progress, but should never displace the primary goal of better care"* (National Advisory Group on the Safety of Patients in England, 2013).

Indicators of safety can reflect a number of dimensions, such as measures of harm (both psychological and physical that arise from unsafe care), as well as measures of the process and environment of care that may be linked to safety. A recent review of safety gives an in-depth analysis of the dimensions of safety and how it may best be assessed (Vincent and others, 2013).

Safe environments and processes to ensure safe care

Indicators that look to monitor safe processes of care are fairly limited in the spread of information they use. Almost all focus on the acute care sector, with very little on primary and social care.

Cleanliness

There has been significant work in the past few years to improve the cleanliness of hospitals. The impact of this is its contribution to the reduction in the prevalence of healthcare-acquired infections, a trend which appears to be sustained. In 2011, the majority of patients surveyed reported that in their opinion the outpatient department was either very or fairly clean (98%). The percentage reporting that it was very clean was 65%, which is greater than in any of the previous three surveys.

Organisational standards for risk management

The Clinical Negligence Scheme for Trusts (CNST; run by the NHS Litigation Authority (NHS LA)), handles all clinical negligence claims against member NHS bodies. The costs of the scheme are met by membership contributions and these contributions are reduced where an organisation meets higher levels of risk management. The level of risk management is initially determined by the trust, but this self-assessment is reviewed by the NHS LA and is either accepted or reduced depending on their findings. It can be used as an indicator of the extent to which organisations manage potential risks of clinical negligence. Table 3.3 summarises the position in 2011/12, showing that only a minority of trusts were achieving the highest level (level 3), and there were no community or ambulance trusts achieving the highest level. Two trusts were at the lowest CNST level. The information produced from the scheme is a broad indicator of the safety of the clinical environment in which care is given, but is difficult to interpret at a more detailed level.

Table 3.3: Risk management standard assessment – overall levels achieved by NHS trusts (at year end 2011/12)

	Trust type/risk management assessment				
Current level*	Acute	Ambulance	Community	Maternity	Mental health and learning disabilities
0	1	0	0	1	0
1	77	10	13	68	41
2	56	1	0	60	13
3	30	0	0	13	1

**The levels go from bad (level 0) to good (level 3)*

Source: NHS LA Risk Management Standards Assessments, factsheet 4

Incident reporting

Reporting serious or untoward incidents* is often considered a fundamental step in improving safety and it is now national practice to learn and improve care in light of these reports. However, the reporting of such incidents may not be a reliable marker of safety because of variability in the propensity to report incidents (in part because of fear that this might result in possible sanctions) and inconsistency in reporting. It is important that incident reporting is encouraged as part of good safety management, and isn't seen as a potential criticism of the service. The frequency of incident reports therefore has to be treated with caution.

Levels of avoidable harm

As we noted earlier, progress in developing reliable and trusted metrics to give information on harm has been slow. As a recent review, *The Measurement and Monitoring of Safety*, noted:

> *"A very large number of quality outcomes have been specified but the approach to safety has been much narrower, leaving many areas of safety unexplored. The measurement of harm, so important in the evolution of patient safety, has been almost completely neglected."* (Vincent and others, 2013, p.12)

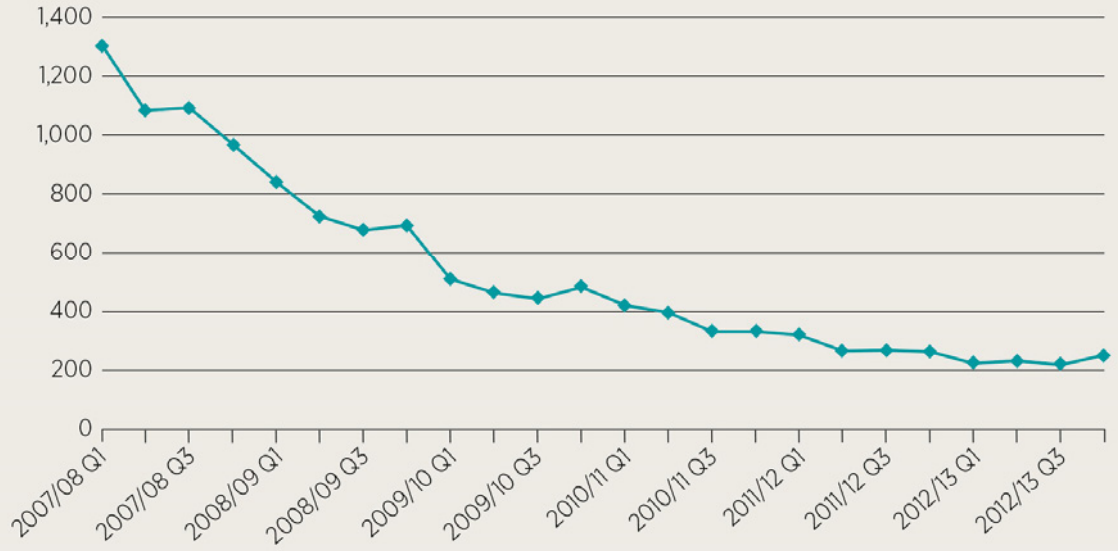
There is a lot of activity to measure the extent of avoidable infection in care settings. For example, there are mandatory and voluntary reporting schemes (to Public Health England) on infections in the healthcare setting which have significant antimicrobial resistance (Health Protection Agency, 2013).

From 2007, the level of healthcare-acquired infections, initially for MRSA followed by *C. diff,* became a major national concern, in particular following the Healthcare Commission's investigation into Maidstone and Tunbridge Wells NHS Trust (Healthcare Commission, 2007). Action to address these problems was far-reaching and included

* A patient safety incident is any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care.

new legislation, as well as focused investment, regulation and performance monitoring against targets. As a result, the reported incidence of MRSA and *C. diff* infections fell and have continued to fall or at least stabilise (see Figure 3.9). For these indicators, and other markers of healthcare-acquired infection, there is now the challenge to understand how low these incident rates can go.

Figure 3.9: Total quarterly meticillin-resistant Staphylococcus aureus (MRSA) counts (quarter 1 2007/08 to quarter 4 2012/13)

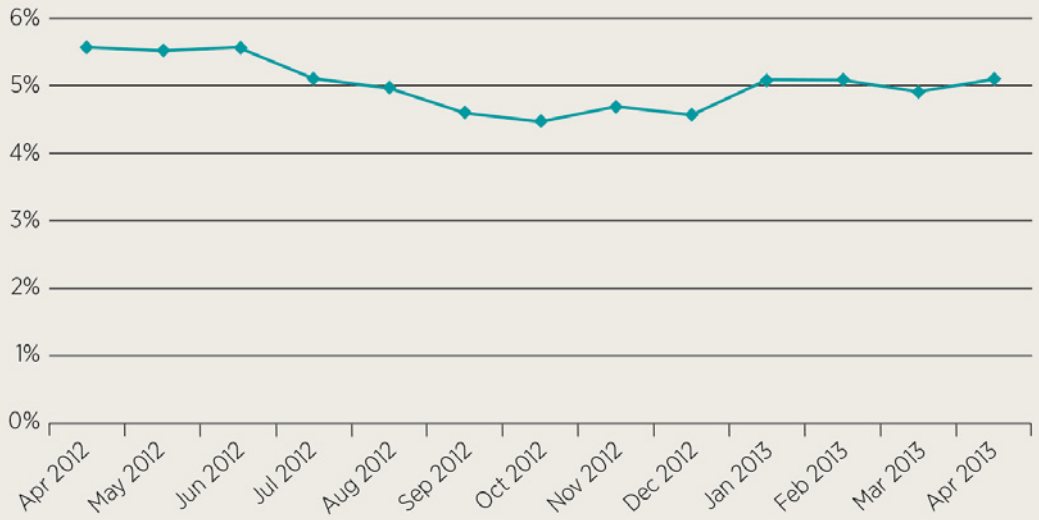


Source: Public Health England, Mandatory Surveillance of Staphylococcus aureus bacteraemia.

The NHS Safety Thermometer (Health & Social Care Information Centre, 2013a; Department of Health, 2012d) is a tool for measuring, monitoring and analysing the extent of 'harm-free' care locally, and has been introduced in the past year. The thermometer focuses on harms selected because they are common, and clinical consensus exists that they are largely preventable through appropriate patient care. The reporting on this tool is fairly new and, as with many other metrics, may not be reliable for comparative analyses for reasons outlined above. The harms covered include pressure ulcers, harm from a fall, urinary infection (in patients with a catheter) and new VTE.

The prevention of pressure ulcers has been the focus for a number of studies over the years. Initial results from the thermometer suggest that the overall incidence is declining, but not in acute hospitals (see Figure 3.10). However, the NHS Safety Thermometer is still under development and some aspects of the data used appear unstable at present (and labelled 'experimental' by the Health & Social Care Information Centre). As an example, the number of patients included by care setting more than doubled between the start and end of 2012/13.

Figure 3.10: Reported incidence of pressure ulcers in acute hospitals (April 2012 to April 2013)



Source: Department of Health, NHS Safety Thermometer.

Hospital specific mortality

In recent years there has been a lot of attention focused on looking at deaths in hospital as markers of safety through metrics such as the hospital specific mortality ratios. These are measured either in the form of the Hospital Standardised Mortality Ratio (HSMR) or the Standardised Hospital Mortality Index (SHMI; Jarman and others, 2004; Aylin and others, 2009; Black, 2010; Lilford and Pronovost, 2010; Health & Social Care Information Centre, 2013b).

Interpreting these measures can be difficult – a recent study reviewed case notes and found that there were significant problems in using standardised mortality ratios as comparative measures of performance (Hogan and others, 2012).

However, there may be a strong argument for using mortality ratios as triggers for further investigation: the original Mid Staffordshire NHS Foundation Trust investigation arose from analysis of trends in case specific mortality rates, rather than a hospital-wide aggregate (Healthcare Commission, 2009b; Keogh, 2013). Despite all this activity, there have been few studies examining the effectiveness of mortality ratios *per se* as diagnostic tools; a current study to compare HSMRs/SHMIs to findings of avoidable deaths from case note reviews should help in this area.

Effectiveness

Care services should be based, as far as possible, on relevant rigorous science and research, and/or nationally agreed best practice.

Whilst we take for granted the desire to ensure health and care services are effective, this can be a difficult concept to measure in practice. Effectiveness includes delivering timely treatment to the right patients, and ultimately producing improved health benefits for patients. But the ultimate benefits, such as improved wellbeing, are often hard to measure on a routine basis, in part because of the time it takes to see the patient benefits. In England, we have begun using patient reported measures of outcome for a very few elective conditions (see, for example, NHS Choices, 2013) – the challenges will be about using these techniques for chronic disease and looking at changes in health status over a long time span.

For this reason, the assessment of effectiveness often relies on various forms of proxy measurement, such as avoiding a hospital readmission, or being able to live well at home; or clinical measures such as glycaemic control in people with diabetes. In this section we have chosen therefore to group our observations under five headings.

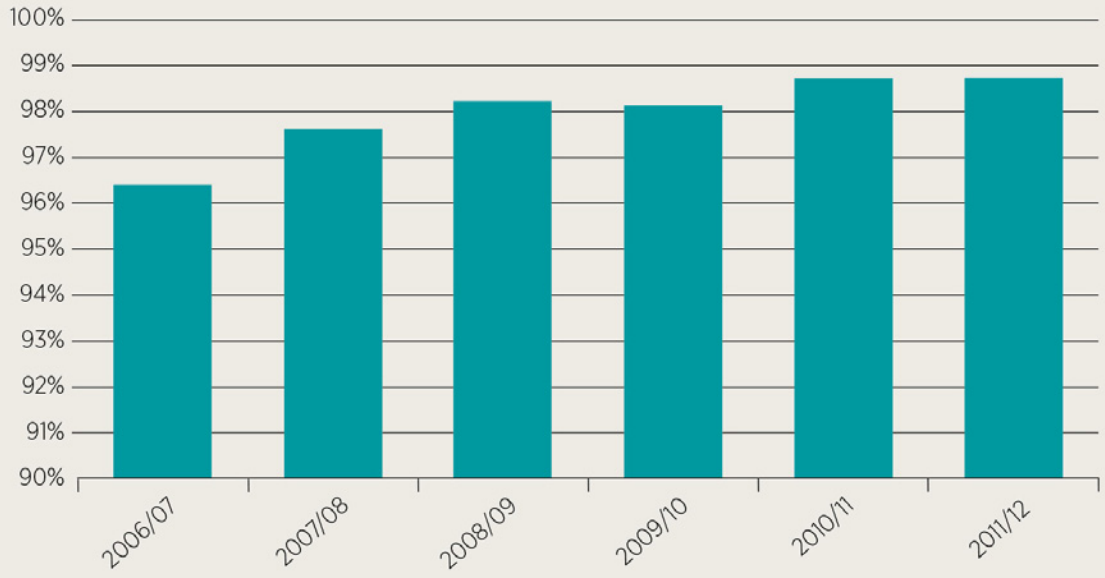
Adhering to clinical good practice

To assess whether good practice is being adhered to, there are two main sources of information available nationally: the Quality and Outcomes Framework (QOF) metrics available for primary care; and the use of clinical audits.

The QOF has incentivised the collection of better information in primary care and established a set of specific clinical targets for the treatment of people with specific conditions. Comparisons of trends over time are difficult as the QOF targets are recalibrated at various points. However, it is clear that over the past few years:

- The vast majority of England's 8,000 (approximately) general practices are achieving their QOF targets for the disease management of all conditions specified. In most of the established indicators for long-term conditions, most practices achieve between 95 and 100% of the specified activities for care (although QOF rules allow certain patients to be excluded from these measures). This level of performance has been fairly static over the past five years, with no signs of a fall. Figure 3.11 gives the example of the points gained by practices for management of individuals with asthma.
- There are two clinical conditions for which performance against the QOF metrics is lower. These are achievement on the more recent targets for depression (which averages only 80%) and palliative care (about 90%).

Figure 3.11: Typical example of consistent achievement on QOF points achieved – in this case the proportion of asthma indicator points attained nationally (2006/07 to 2011/12)



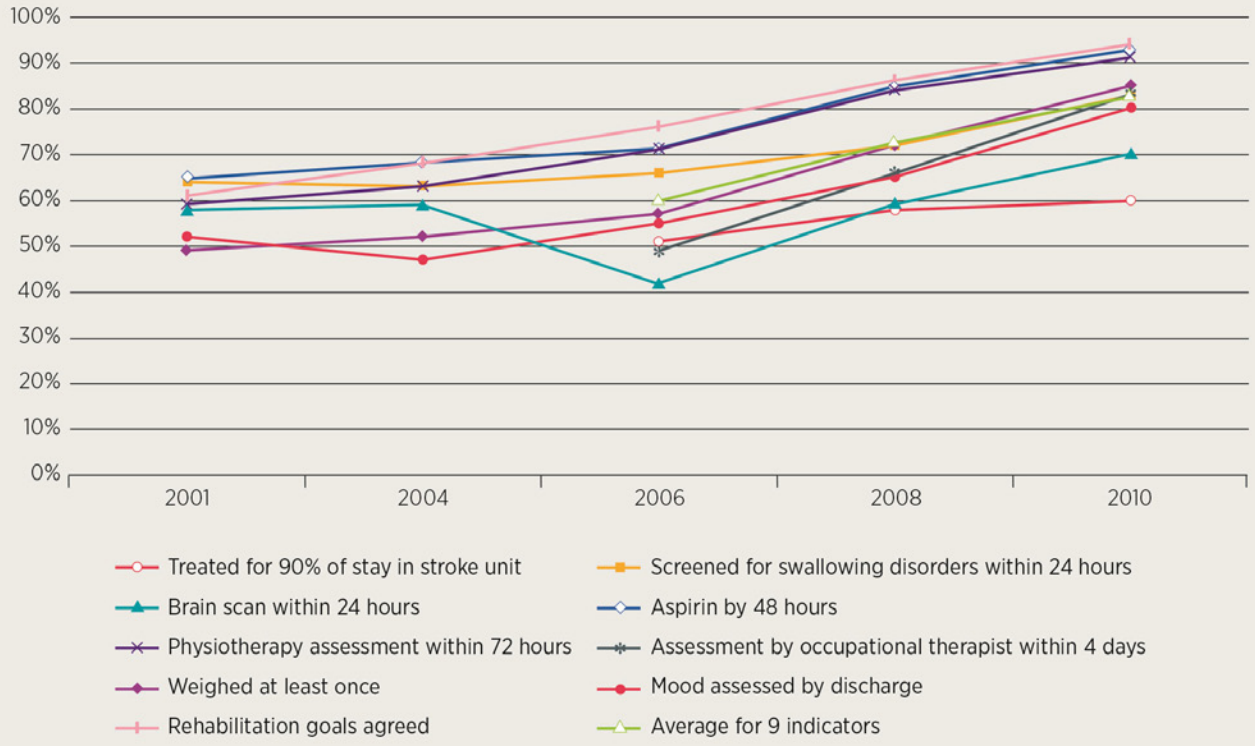
Source: Health & Social Care Information Centre, Quality and Outcomes Framework.

For acute care, the routinely collected data allow limited understanding of the adherence to good practice treatment; they mainly focusing on time to treatment (for example, time from admission to operation for hip fracture). National clinical audits provide information on the number of patients that receive specific processes of care. Information derived from clinical audit data is a potentially valuable probe into individual clinical areas (see for example **www.hqip.org.uk/**), although most audits do not allow analysis over long timescales. There are some important exceptions and a number of routine reporting systems have emerged in areas of care such as for cardiovascular disease (National Institute for Cardiovascular Outcomes Research, 2013), stroke (RCP, 2013), renal disease (Renal Association 2012), orthopaedics (National Joint Registry, 2013) and intensive care (Intensive Care National Audit and Research Centre, 2013) or trauma (Trauma Audit and Research Network, 2013).

Through audit of treatments for renal disease, the Renal Association reported improved survival rates in 2012 (Renal Association, 2012). In patients aged over 65, one year survival increased from 63.9% in 1997 to 77.0% in the 2010 cohort. An increase in survival was also observed between the 2009 cohort and 2010 cohort.

The National Stroke Audit (which applies across England, Scotland and Wales) has been running for a number of years and, as the most recent report notes, there has been considerable progress in stroke care during that time. Figure 3.12 shows the rise in compliance with the nine key indicators of good care for people with stroke. The latest report indicates that priority for care is now in the delivery of care in the community after discharge from hospital (RCP, 2013).

Figure 3.12: Percentage of compliance for the nine key indicators of good care for people with stroke (2001 to 2010)



Source: The Royal College of Physicians, National Stroke Audit.

Reducing premature mortality

The most obvious way to measure the effectiveness of care is survival after treatment. The measure used is often premature mortality; typically deaths under age 65, or infant mortality (first year of life). The use of the first measure does not mean that deaths over 65 do not matter, rather that it is considered a good metric to identify differences between areas. But, as noted above, the relationship between health services and mortality rates is not simple because:

- There are many other factors affecting the health of an individual or population than the quality of healthcare provided.
- Where the quality of health services does influence mortality rates, the largest effects are population based, which may take a long time to emerge. For example, a campaign to reduce smoking may take 20 years to show public health benefit.
- Some cases of premature deaths result from errors in the healthcare systems, yet the volume of these at a population level is very low.

Mortality rates are usually considered in three ways:

- Population level mortality rates. Rates can be presented in different formats as either life expectancy, directly standardised rates per 10,000 population, or expressed relative to a national average in a Standardised Mortality Ratio. The NHS

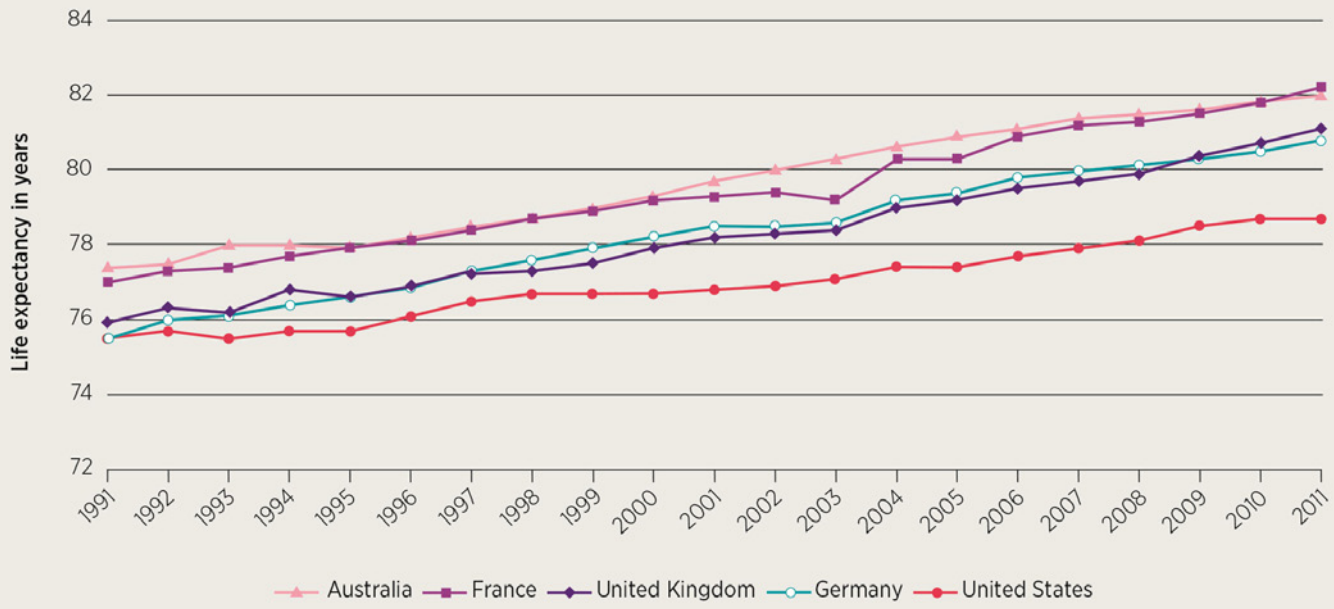
Outcomes Framework uses another metric: potential years of life lost (Department of Health, 2012b).

- Condition- or event-specific mortality, including peri-natal mortality or deaths following events such as routine elective surgery.
- Aggregated measures of deaths in hospitals compared to some case mix adjusted expected value, as discussed earlier.

Population mortality rates have been falling consistently over time and so life expectancy is rising. From 1999 to 2009, male life expectancy at birth increased by over three years for men (75.3 to 78.2 years) and around 2.5 years for women (80.0 to 82.5 years). Much of this increase is linked to improved life expectancy in those aged over 65. These changes are a product of many complex factors related to genetic inheritance, the environment and health behaviours.

Figure 3.13 shows the trend in overall life expectancy for different countries (taken from OECD figures). Between 1991 and 2011, life expectancy in the UK rose by about five years, which is similar to other countries. However, our absolute life expectancy is similar to Germany, lower than France and Australia, but higher than the USA.

Figure 3.13: Life expectancy in years by country (1991 to 2011)



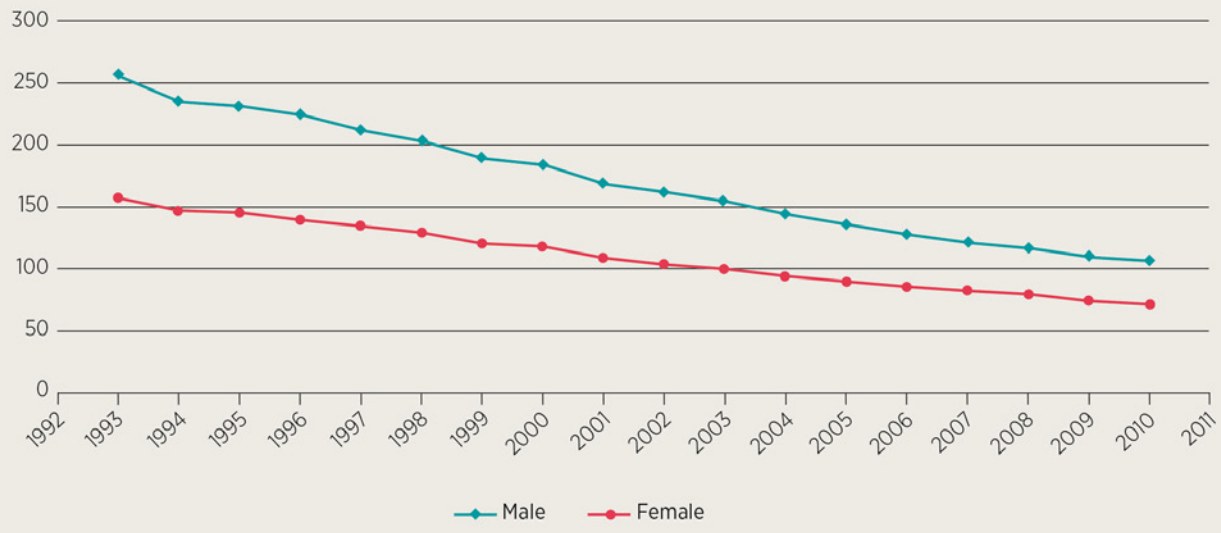
Source: Organisation for Economic Co-operation and Development (OECD), Health data 2013.

The contribution that better health services have made to the mortality rates across a population is difficult to assess. One commonly used approach is to look at the causes of death that are more amenable to healthcare, that is, causes where there is evidence that healthcare interventions that are timely, appropriate and of high quality can reduce age-specific mortality. These include interventions that prevent disease onset as well as treatment of existing disease. So, for example, the Office for National Statistics reported that, in 2011, deaths from potentially avoidable causes accounted

for approximately 24% of all deaths registered in England and Wales, and that avoidable mortality rates fell by 28% from 243.2 to 175.8 per 100,000 population between 2001 and 2011. The leading cause of avoidable deaths was ischaemic heart disease in males and lung cancer in females.

Figure 3.14 shows overall trends in avoidable deaths between 1993 and 2010. It shows that avoidable death is higher in males than in females, but the decline over time is fastest for males.

Figure 3.14: Trends in avoidable mortality, directly age-standardised rates (DSR) in England (1993 to 2011)



Source: Health & Social Care Information Centre, Mortality from causes considered amenable to health care.

One indicator in the NHS Outcomes Framework focuses on the avoidable mortality rate for people with mental health problems, which is over three times as high as the rest of the population. Success in improving care is based on an indicator calculated from the difference in age standardised mortality rates for people with known mental health problems, compared with the general population. Table 3.4 shows some headline results for three time periods. It shows much higher mortality in people with mental health problems and little progress to reduce the gap over this time period.

Table 3.4: Summary score on indicators of excess mortality rate for people under 75 with serious mental health problems. Directly standardised mortality rates (DSR) per 100,000 population, 99% Confidence Intervals (CI) (2009 to 2011)

	3 years ending	General population DSR	Mental health DSR	Indicator value (excess mortality in mental health)*
Female	2011	321.1	1,050.6	729.5
	2010	321.0	1,015.7	694.7
	2009	335.7	1,091.7	756.0
Male	2011	483.3	1,598.0	1,114.7
	2010	487.8	1,577.9	1,090.1
	2009	503.7	1,643.3	1,139.7

Source: Health & Social Care Information Centre, NHS Outcomes Framework; Indicator 1.5

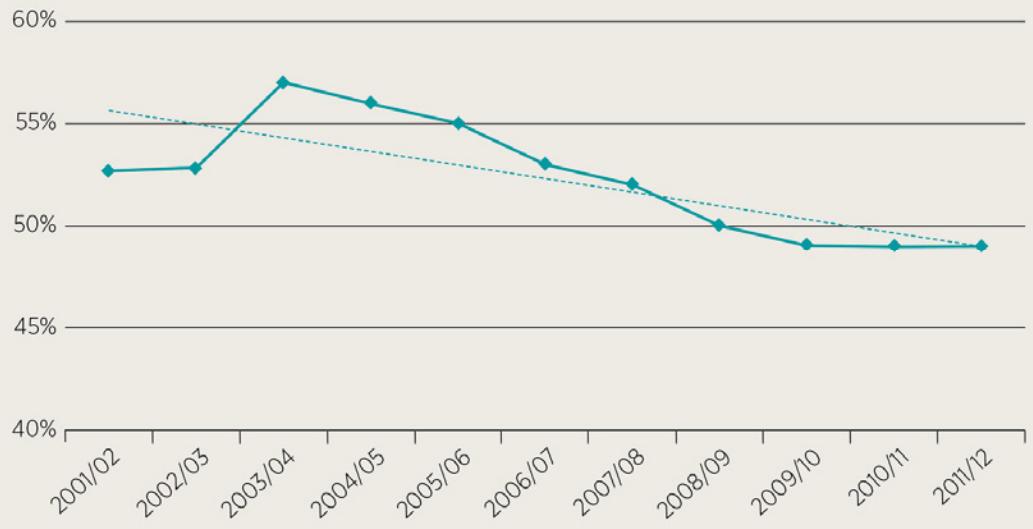
Reducing avoidable risk factors of morbidity

Smoking is the main risk factor for early death and ill health in England. Reducing the number of people who smoke is therefore a key priority in improving the health of the population. One available indicator measures the proportion of adults (over 16s) who quit smoking within four weeks of an initial appointment through the NHS Stop Smoking service. 'Quitters' are those who have not smoked at all in the two weeks leading up to a four-week follow-up appointment (self-reported). A 10-year evaluation of the NHS Stop Smoking service noted that the service had reached many individuals, but even by 2010/11 it reached just 8% of all smokers in England (West and others, 2013).

As Figure 3.15 shows, the highest proportion of quitters was seen in 2003/04, when 57% of people who set a quit date quit smoking within four weeks. Since then the proportion of quitters has steadily declined to a low of 49% in 2009/10, where it has remained. In 2003/04, the Department of Health's first integrated smoking campaign was launched, which may have been responsible for the high quitting rates seen that year (NHS Smokefree Resource Centre, 2013).

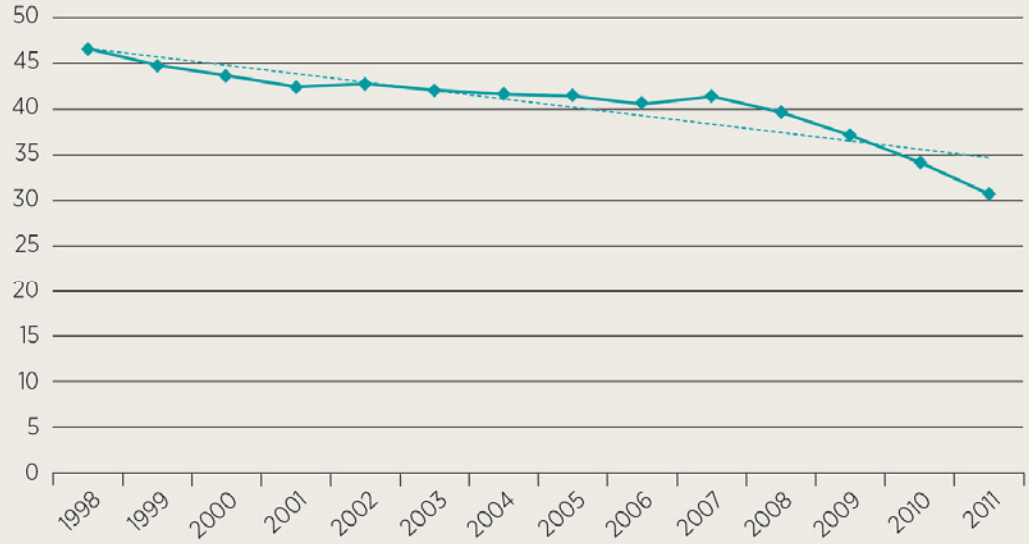
Another area of health-related behaviour where there appears to have been sustainable progress is in the reduction in teenage conceptions, which has been a policy target for many years. As Figure 3.16 shows, rates have fallen significantly over the past decade, with an accelerated rate of decline since 2007.

Figure 3.15: Proportion of adults who quit smoking after four weeks (2001/02 to 2011/12)



Source: Health & Social Care Information Centre, NHS Stop Smoking Services.

Figure 3.16: Conception rate per 1, 000 women under 18 (1998 to 2011)



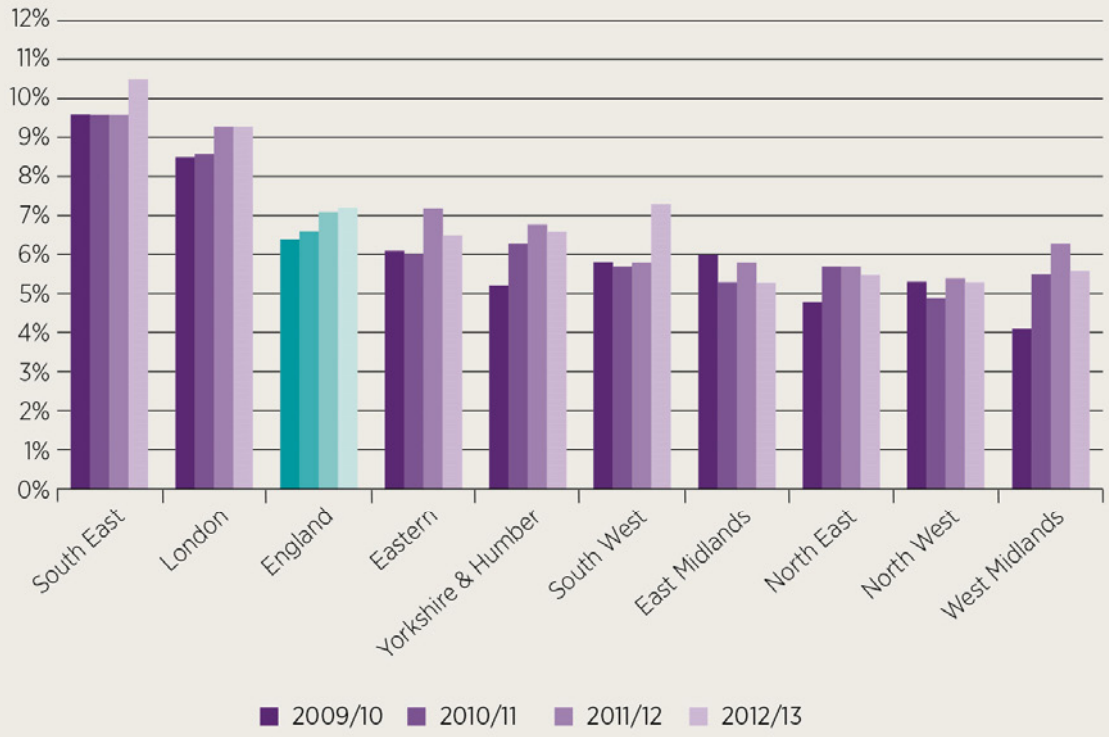
Source: Office for National Statistics, Conception Statistics.

Ability to live independently

For many aspects of care, the most desirable outcomes are not about curing diseases or improving health states, but simply about helping people to live their lives as closely as possible to the way they want. A common marker is whether people are able to live independently, in their own homes and, where appropriate, have employment.

So, for example, the adult social care survey includes a number of measures related to independent living for care users. Figure 3.17 gives one example showing the level of employment and the large regional differences for people with learning difficulties in paid employment. The South East and London have the highest proportions of adults with learning disabilities in employment, and both have been increasing in the past two years. However, in many other regions, the 2012/13 figures show a slight decline.

Figure 3.17: Proportion of adults with learning difficulties in paid employment by region (2009/10 to 2012/13)



Source: Health & Social Care Information Centre, Adult Social Care – Combined Activity Return.

For older people admitted to hospital, one of the key markers of good quality care is the proportion of people able to return and stay at home. Figure 3.18 shows that in general between 80 and 85% of over-65s are still at home 91 days after discharge from hospital care; a proportion that has been broadly stable over time.

Figure 3.18: Proportion of older people (over 65) who are still at home 91 days after discharge from hospital into reablement/rehabilitation services by region (2009/10 to 2012/13)

Source: Health & Social Care Information Centre, Adult Social Care – Combined Activity Return.

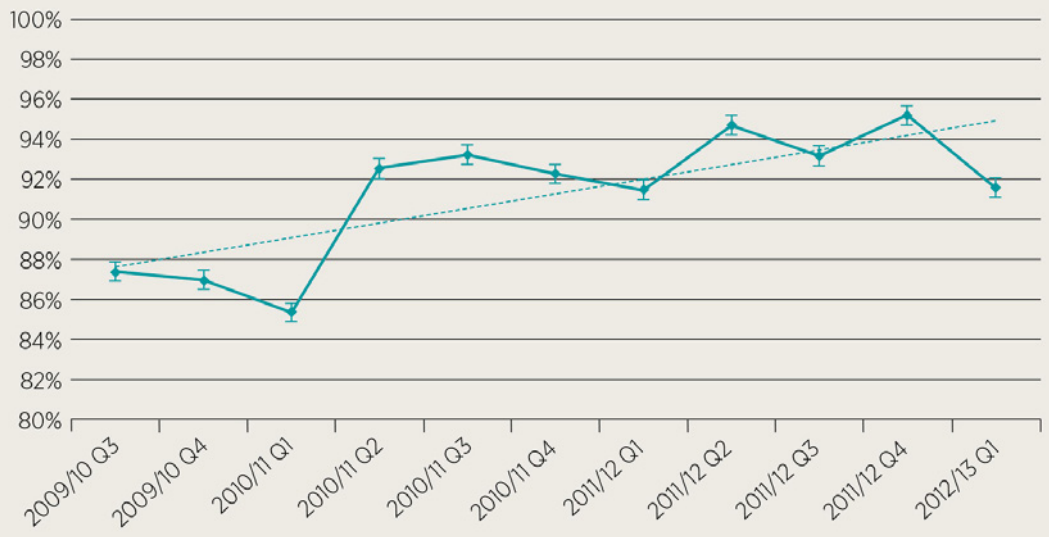
There are regional differences in absolute levels and in trends, as also shown in Figure 3.18. The proportion of older people who are still at home 91 days after discharge from hospital into reablement/rehabilitation services varied by 8.0% in 2012/13; the highest was 85.9% in London and the lowest was 77.9% in the East Midlands.

Providing the right level of preventive care

The prevention of ill health is a central priority for health services and there are a range of preventive services such as prenatal care, immunisations and screening. In some cases the effectiveness of these programmes is the subject of some debate (Marmot and others, 2013); in other areas they are generally accepted.

One example of preventive care is prenatal services, such as receiving a first antenatal assessment under 13 weeks. The ratio of maternity cases in which this was achieved has been increasing and is high at over 91.0%. There are annual fluctuations in coverage rate, but this is due to the annual fluctuation in the number of maternity cases (although it could be argued that the service should be responsive to uneven demand).

Figure 3.19: The ratio of maternity cases which had the first antenatal appointment before 12 weeks 6 days (quarter 3 2009/10 to quarter 1 2012/13)



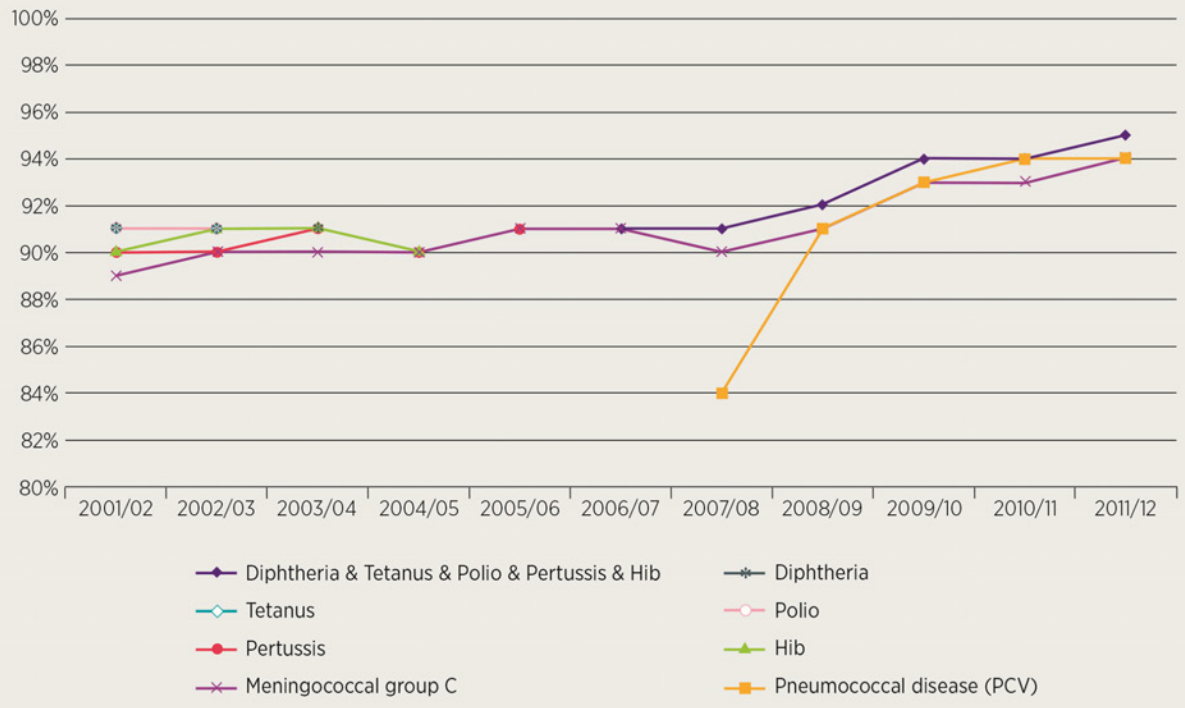
Source: Health & Social Care Information Centre, Vital Signs and NHS Maternity statistics.

One of the most effective elements of NHS care has been the public health role in combatting infectious diseases through immunisation and vaccination programmes. These programmes operate not just on the immunised person but also at a community level (herd protection) to reduce the chances of disease transmission. Success is therefore measured in terms of population coverage of vaccination.

In England, the percentage of children who have completed a primary course of an immunisation for diphtheria, tetanus, polio, pertussis and *Haemophilus influenzae* type b (Hib) has increased over the past 10 years from a baseline of around 90-91% (depending on the vaccination), to approximately 94% for all in 2011/12 (Figure 3.20). The pattern of MMR (measles, mumps and rubella) vaccination over the past decade is unusual, having been strongly influenced by external events. In England between 1991/92 to 1996/97, there was a relatively steady rate of MMR vaccinations in children by their second birthday, and the proportion vaccinated was consistently over 90% (Figure 3.21). However, this decreased between 1997/98 and 2003/04. This decrease was linked to a now discredited article that appeared in *The Lancet* in 1998 purporting to show a link between the combined MMR vaccination and autism. *The Lancet* partially retracted the paper in 2004 and fully retracted it in 2010. However, at the lowest coverage (2003/04), only 80% of children were vaccinated (which is below the levels required for herd immunity) and subsequently there have been outbreaks of these diseases in England in recent years. Vaccination rates have now increased to their former levels of over 90%.

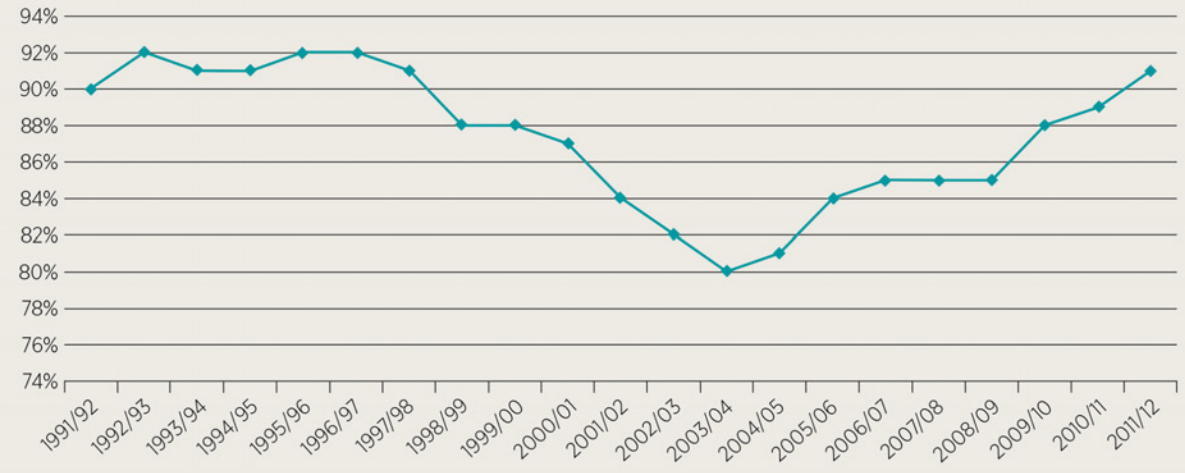
In contrast, the overall trend for the coverage of individuals over 65 receiving the influenza vaccination remains fairly static at between 70 and 75% over the time period recorded (Figure 3.22).

Figure 3.20: Coverage of childhood vaccination by 1st birthday (2001/02 to 2011/12)



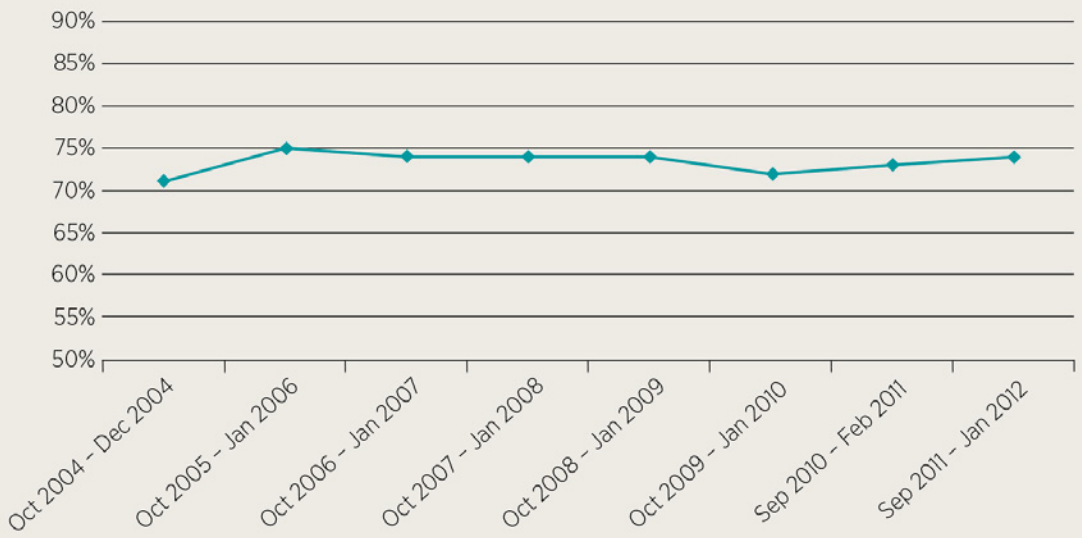
Source: Health & Social Care Information Centre, Screening and Immunisation Statistics.

Figure 3.21: Percentage of children who had their first dose of measles, mumps and rubella (MMR) by their second birthday (1991/92 to 2011/12)



Source: Health & Social Care Information Centre, Screening and Immunisation Statistics.

Figure 3.22: Percentage of people over 65 who have been immunised against influenza (2004 to 2012)



Source: Health & Social Care Information Centre, Screening and Immunisation Statistics.

Cancer screening coverage

Breast cancer screening supports the early detection of breast cancer. In 2013, Professor Marmot published an independent review on the benefits and harms of breast cancer screening and concluded that:

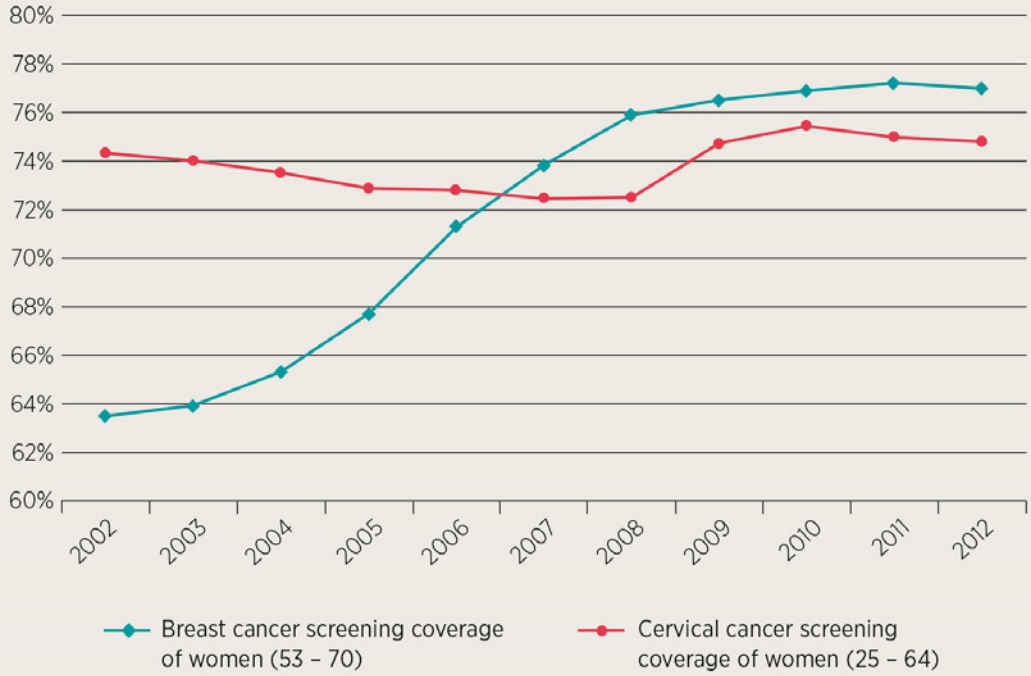
> *"The best estimate is that the breast screening programmes in the UK, inviting women aged 50-70 every three years, prevent about 1,300 breast cancer deaths a year, equivalent to about 22,000 years of life being saved; a most welcome benefit to women and to the public health."* (Marmot and others, 2013)

The panel noted the potential harms of over diagnosis and estimated that 'for each breast cancer death prevented, about three over-diagnosed cases will be identified and treated'. However, the panel emphasised that figures on over diagnosis are the 'best estimates from a paucity of reliable data' (Marmot and others, 2013).

Cervical screening supports the detection of abnormalities of the cervix that if left undetected and untreated may become cancer. Cervical screening is estimated to save 4,500 lives in England each year (Peto and others, 2004).

Here we examine the coverage of these two schemes. For breast cancer, we look at the proportion of women between 53 and 70 who have had a screening result within three years. For cervical screening, we look at the proportion of women between 25 and 49 who have had a screening result within 3.5 years, and women between 50 and 64 who have had a result within five years.

Figure 3.23: Coverage of breast cancer screening and cervical cancer screening (2002 to 2012)

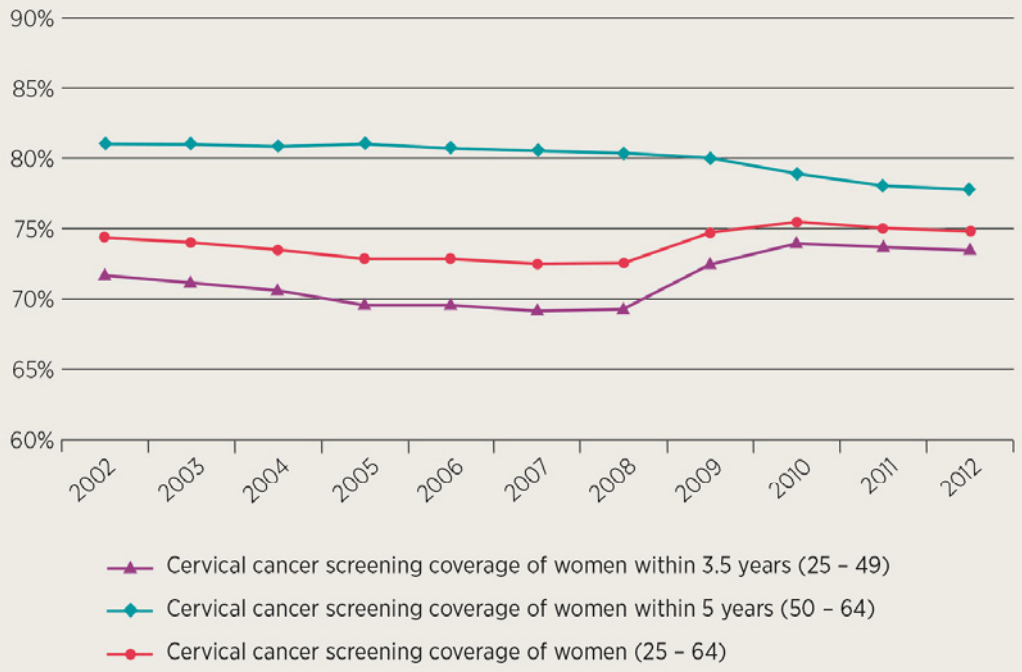


Source: Health & Social Care Information Centre, breast screening programme and cervical screening programme.

Figure 3.23 shows that the rates of breast cancer screening have increased steadily over time. Cervical cancer screening rates, however, have been more variable. They were steadily declining until 2008, when rates rose from 72.5% to a high of 75.5% in 2010. In 2008/09, Jade Goody, a TV celebrity, died an early death of cervical cancer which led to an increase in awareness of cervical cancer screening, which may be responsible for the increase seen at that time.

To look at this in more detail, Figure 3.24 shows the cervical cancer screening coverage in different age groups which should be screened within different time periods. When we separate these groups, the increase in trend is only seen in women aged 25 to 49, who should be screened every 3.5 years. For women aged 50 to 64, who should be screened every five years, coverage has actually decreased over time, with a noticeable decrease from 2009 onwards.

Figure 3.24: Coverage of cervical cancer screening comparison of different age groups (2002 to 2012)



Source: Health & Social Care Information Centre, cervical screening programme.

Person-centred care and experience

Care should be based on partnerships between professionals and service users (and, where appropriate, their families); and be delivered with compassion, empathy and responsiveness to the needs, values and preferences of the individual service user.

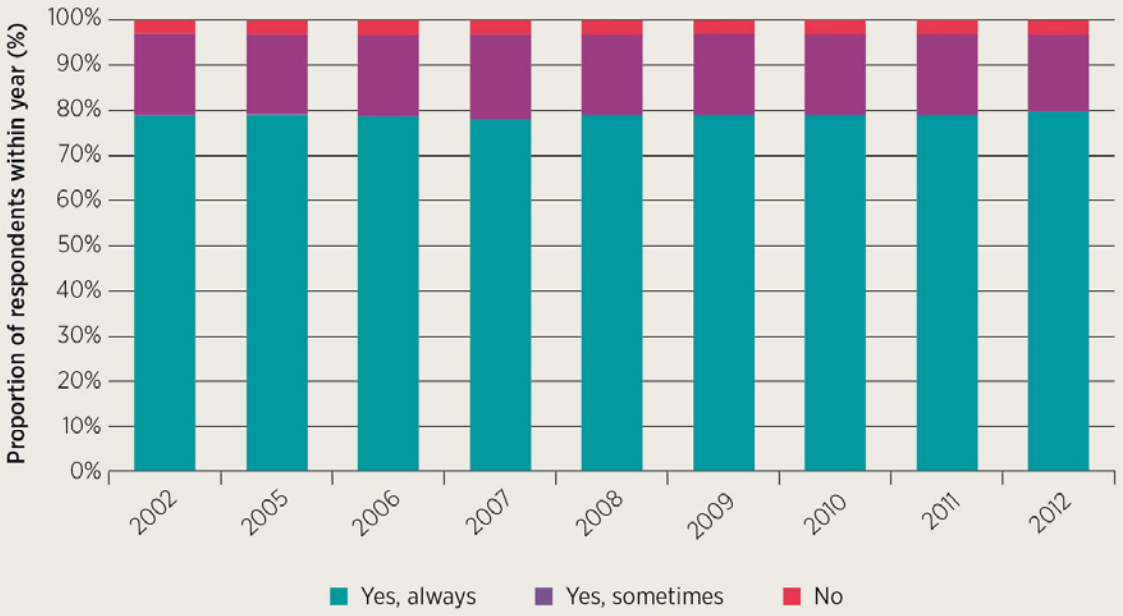
Treating people with dignity and respect

One of the most distressing elements of the inquiry into Mid Staffordshire NHS Foundation Trust was the report of abuse of patients on certain wards; behaviour observed in other organisations and care settings (Parliamentary and Health Service Ombudsmen, 2011). This has been a major concern in the media and there has been much debate about how to address it, for example through developing measures of professional standards and organisational culture.

A key data source on this subject is the national inpatient survey, which has been undertaken on an annual basis since 2002. It is one of the largest patient surveys in the world and is commissioned by the CQC. For example, one of the questions asks: 'Overall, did you feel you were treated with respect and dignity while you were in the hospital?'. Figure 3.25 shows the results of this question since 2002. Responses to this question have been remarkably consistent since 2002. Overall, in 2012, four out of every five patients surveyed felt they were treated with respect and dignity during

their stay in hospital; a statistically significant increase from 79% in the 2011 survey. The proportion of patients who felt they were not treated with dignity and respect during their hospital stay has remained constant, at 3%, since 2002.

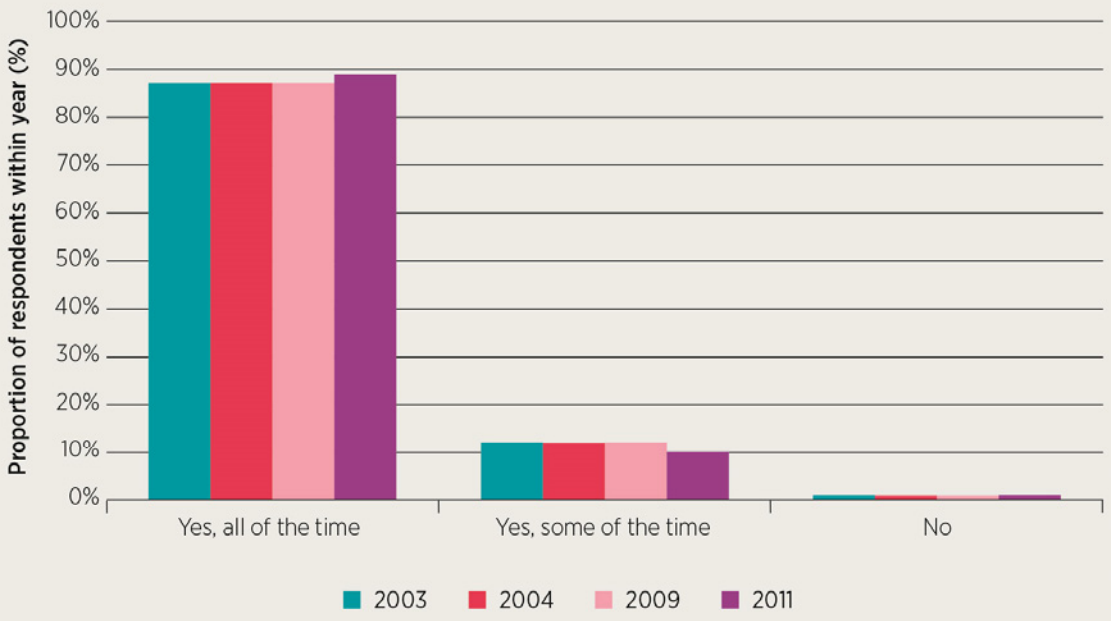
Figure 3.25: Patients' responses to the question "Overall, did you feel you were treated with respect and dignity while you were in the hospital?" (2002 to 2012)



Source: Care Quality Commission, Survey of Adult Inpatients.

Figure 3.26 shows a similar pattern from the outpatient survey. Nationally, the majority (89%) of patients surveyed in 2011 report that they were treated with dignity and respect all of the time at the outpatients department. This was a small increase on the 2009 result (87%), which has not changed since the first time the survey took place in 2003.

Figure 3.26: Outpatients' views on whether they were treated with respect and dignity (2003 to 2011)



Source: Care Quality Commission, Survey of Outpatients.

In July 2013, we saw the first results of the 'Friends and Family Test', which asks patients whether they would recommend A&E and inpatient wards to their friends and family based on their own experiences there. This is a different approach to standard survey methods, and there has been some debate about the consistency of the way scores are derived in different sites. We will be interested to see how this new approach evolves as we understand more about the reliability of the scores and the ways they are used in practice.

These national surveys base results on reported experiences of a sample of patients which, though large in total (and by international standards), represent only around 500 to 1,000 responses per hospital for inpatients at one point in time*. Such surveys are good for looking at broad brush changes. There are millions of transactions between patients and staff providing hospital services, clearly some of which are poor quality, and it is these events we see highlighted in the individual case reports so prevalent in the media in the last year. To assess these types of lapses we need different reporting mechanisms that aim to capture the frequency of unacceptably poor care. This is not simple and in practice we need to rely on a combination of measures drawn from inspection processes and complaints.

The inspection process delivered by the CQC examines dignity and respect in a different way by assessing adherence of providers to basic care standards through

* There is much debate about the value of surveys, their different approaches and their discriminatory ability, which is not discussed here.

direct inspections of care facilities. The CQC's annual report 2011/12 reported the typical picture of generally high levels of compliance (CQC, 2012b).

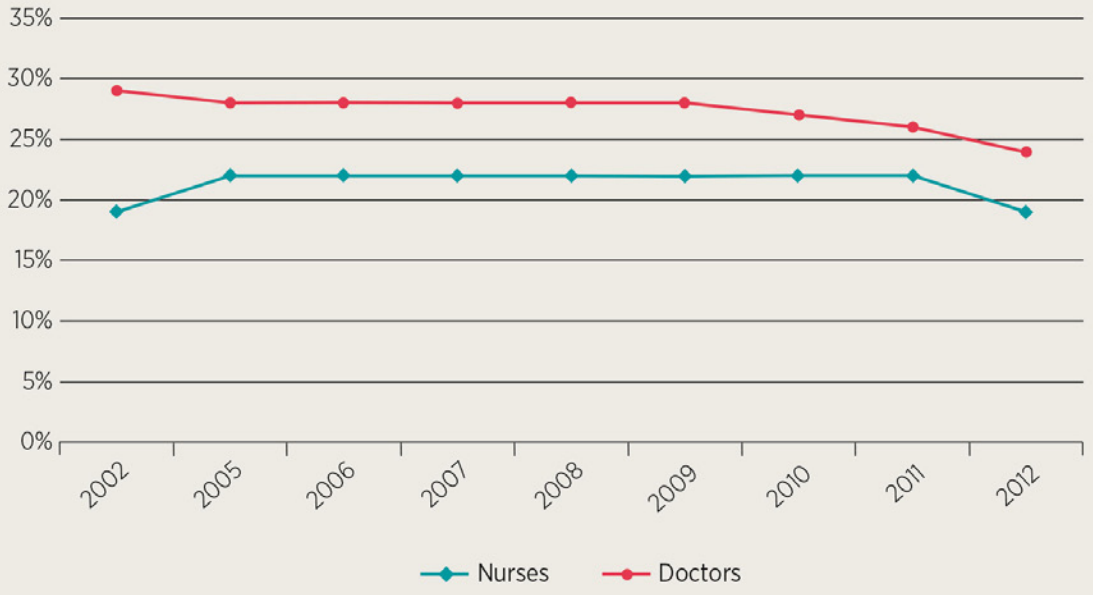
Table 3.5: Summary points from the CQC State of Care report 2011/12

NHS in 2011/12	Adult social care in 2011/12
91% of NHS hospitals and 86% of NHS mental health, learning disability and substance misuse services were treating people with dignity and respect.	93% of residential care homes and 95% of domiciliary care services were treating people with respect and dignity, compared to only 85% of nursing homes.
Three-quarters of NHS trusts had made changes to the way they provided services following the 'Review of dignity and nutrition for older people'.	Only 80% of nursing homes and 89% of residential care services were ensuring that people in their care were given the help with food and drink they needed.
85% of NHS hospitals were making sure patients had the right food, drink and help they needed.	Cooperation with other providers was good across all types of adult social care – 96% of nursing homes, 95% of residential care homes and 96% of domiciliary care agencies met this standard.
NHS staff were recruited effectively and checks were carried out to make sure they had the right skills and experience to do their jobs, but a number of services still struggled to make sure they had enough qualified and experienced staff on duty at all times.	A common problem among social care services was the lack of a good registered manager in place and, very often, a change of manager was followed by dramatic changes in the quality of care provided.
	There was varied performance around services' assessment and monitoring of the quality of care – only 80% of nursing homes, 84% of residential care homes and 87% of domiciliary care services met this standard.

Source: CQC, 2012b

The adult inpatients survey also asks patients if members of staff talked in front of them as if they weren't there. As shown in Figure 3.27, the proportion reporting this for doctors and nurses respectively decreased between 2005 and 2011. In particular, between 2011 and 2012, the proportion for nurses dropped from 22% to 19%, having been broadly constant for the previous six years, and fell from 26% to 24% for doctors. Despite this recent improvement, these proportions are large, pointing to the large scope for improvement needed.

Figure 3.27: Proportion of patients who said that doctors or nurses talked in front of them as if they weren't there (2002 to 2012)



Source: Care Quality Commission, Survey of Adult Inpatients.

Care environment

There are a number of different ways in which the quality of the healthcare environment is important to achieving good quality care, especially around the dimensions of safety and patient responsiveness. A good quality care environment can be defined in many ways. For example, in residential social care settings the size of rooms, range of amenities and the quality of their upkeep are especially important for the wellbeing of residents.

Up until 2011, the assessment of the environment of care in inpatient healthcare services was undertaken through Patient Environment Action Teams (PEAT). The process involved the healthcare provider (potentially with patient representatives) carrying out a self-assessment according to a set of standards. The standards included the quality of food, cleanliness, infection control and physical environment for care (including bathrooms, lighting, floors and areas that patients use).

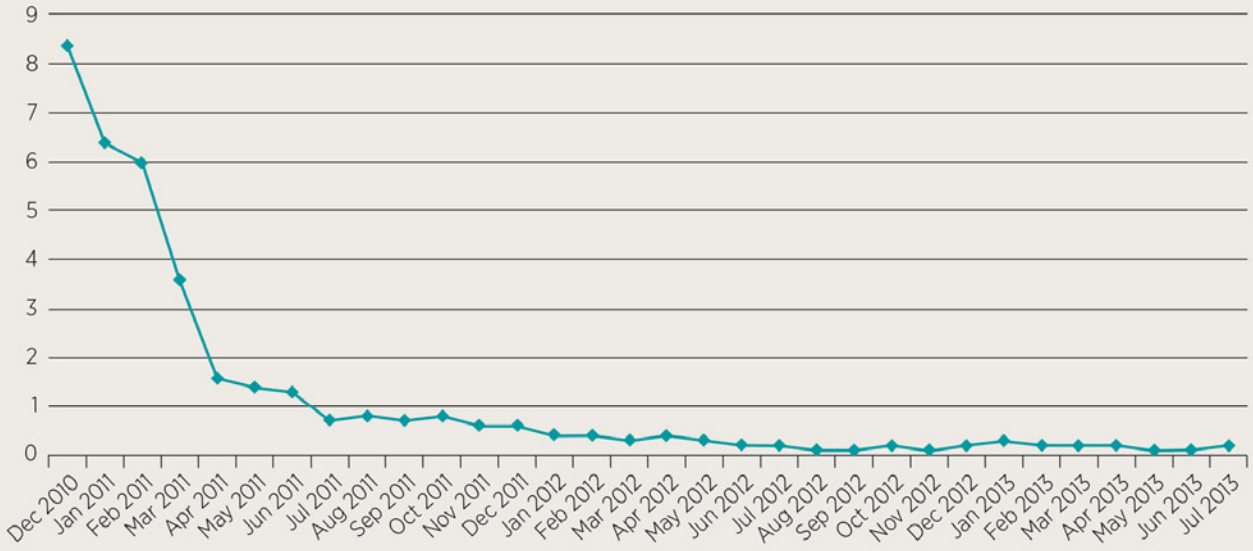
The PEAT process has recently been replaced by PLACE (Patient-Led Assessments of the Case Environment), which started on 1 April 2013. The programme applies to all providers of NHS-funded care in the NHS, independent and private healthcare sectors, including NHS treatment centres and hospices. All hospitals with inpatient facilities must participate, although participation is voluntary for very small providers of care which are closer to residential rather than inpatient facilities (these are, in the main, providers of care for people with mental health problems and learning disabilities).

A key change from the PEAT process is the increased involvement of 'Patient Assessors', who are individuals that represent users of healthcare services rather than

providers, with set guidance on numbers of representatives and proportions of the whole assessment team. The assessment process focuses on the environment in which care is provided, with particular emphasis on cleanliness, general condition, appearance and maintenance, privacy and dignity, and the provision of food and drinks.

One aspect of the care environment that is important to patients is mixed-sex accommodation, and there have been significant efforts to reduce it. A mixed-sex accommodation breach is classed as any unjustified mixing of sleeping accommodation. The breach rate (which is the number of breaches per 1,000 finished consultant episodes) has decreased from 8.4 at the end of 2010 and has remained very low (under 1.0) since July 2011 (Figure 3.28). These breaches were limited to 21 hospitals. This dramatic fall is a testament to the power of it being a national priority and being centrally performance managed, backed up by an investment fund to address issues of privacy and dignity (NHS Confederation, 2009).

Figure 3.28: Mixed-sex accommodation breaches per 1,000 finished consultant episodes, the breach rate (December 2010 to July 2013)



Source: Department of Health, Eliminating Mixed Sex Accommodation.

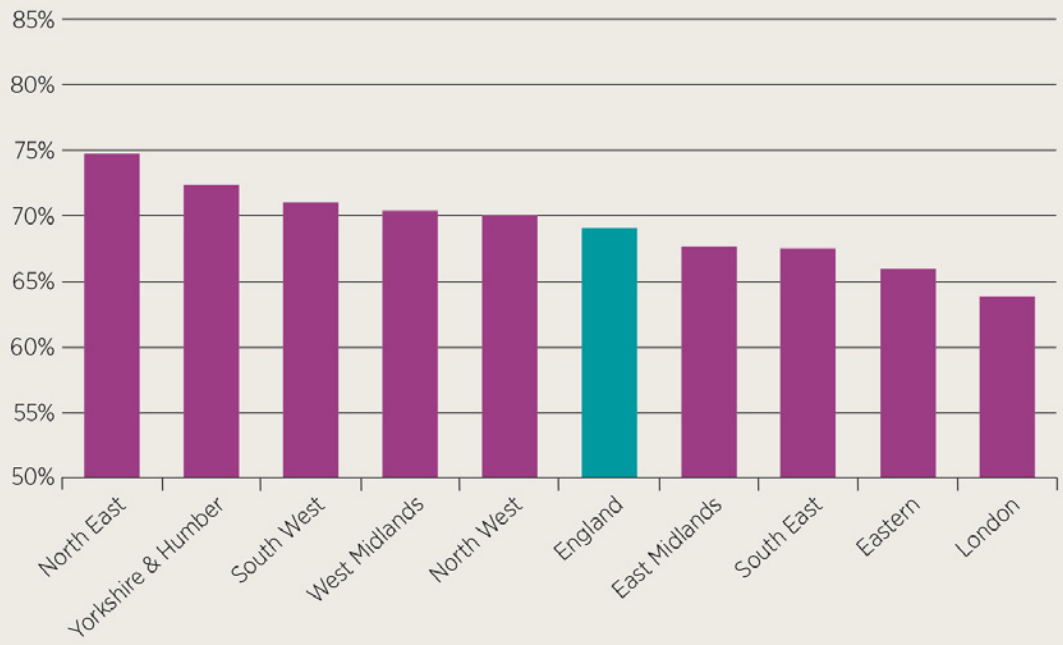
Engaging with patients and open information

The personal social care survey of adults asks people over the age of 18 who use services wholly or partly funded by social services about their experiences of care. The questionnaire is conducted yearly and looks at quality through patient experience to understand if services are helping people to live safely and independently.

For example, it reports on the proportion of people who found it very or fairly easy to find information about social care services, which was 70% in 2011/12 and 2012/13. There is also a survey of carers which reported a 4.7% decrease in the proportion who

found it very or fairly easy to find information and advice about support, services and benefits from 2009/10 to 2012/13. There is also large regional variation, as shown in Figure 3.29.

Figure 3.29: Proportion of carers who found it very or fairly easy to find information and advice about support, services or benefits by region (2012/13)



Source: Health & Social Care Information Centre, Personal Social Services Survey of Adult Carers in England.

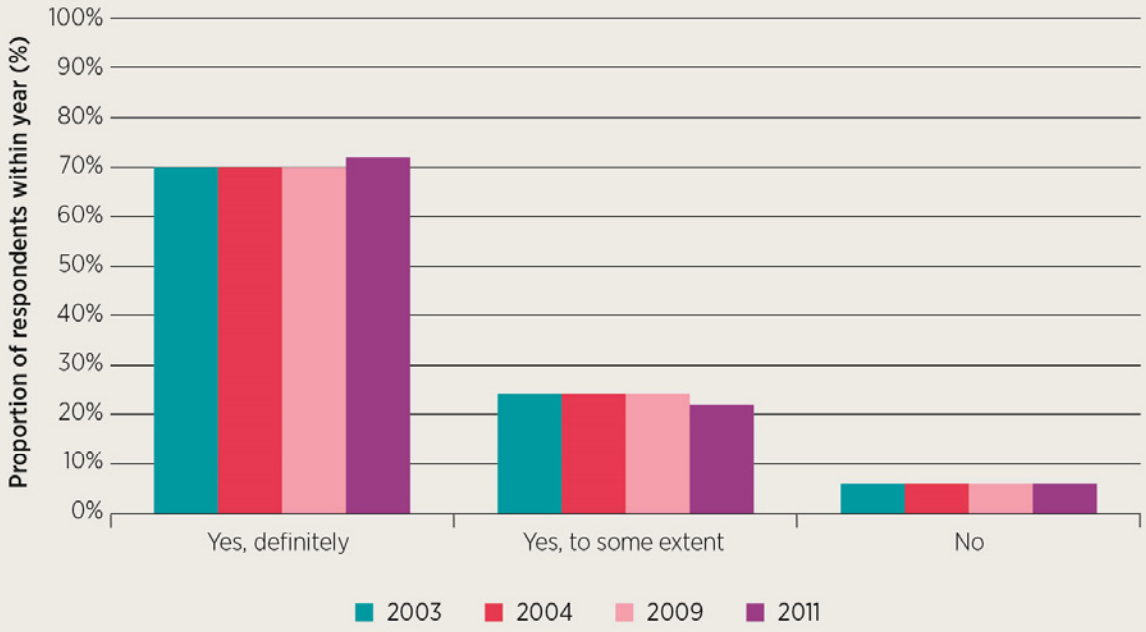
London had the lowest proportion of carers (63.8%) who found it very or fairly easy to find information. This is 10.9% below the highest seen in the North East and 5.2% below the national average of 69.0%.

For healthcare, the adult inpatient and outpatient surveys commissioned by the CQC also contain questions about the extent to which people were involved in decisions affecting their care.

Figure 3.30 shows that the majority (72%) of people surveyed in the 2011 outpatient survey report that they were involved as much as they wanted to be in decisions about their care and treatment when they had been to the outpatients department. This was a small increase on the 2009 result (70%), which is a level that has not changed since the first time the survey took place in 2003. This increase is offset by a decrease in the percentage of patients reporting they were involved as much as they would like 'to some extent' and there has been no change across all years in the percentage of patients reporting that they were not involved as much as they wanted to be in decisions about their care and treatment.

NHS organisations could perhaps do more to address the almost one quarter of patients (which would equate to over 15,000 respondents) who said they were involved to some extent, because the nature of the response suggests that more could have been done to involve them fully.

Figure 3.30: Outpatients' view on whether they were involved as much as they liked to be in decisions about their care and treatment (2003 to 2011)



Source: Care Quality Commission, Survey of Outpatients.

Managing complaints well

Using the level of complaints about care as an indicator of the quality of service must be interpreted with caution. First, it is widely recognised that formal written complaints are only the tip of an iceberg of dissatisfaction that service users may feel. Second, the level of complaints may be influenced by how easy it is to complain, and healthcare providers are being encouraged to make the process easier. Third, there may be differences in the ability to achieve local resolution of complaints (before they become formal) between providers and over time.

In 2012/13, there were about 3,000 written complaints about NHS services per week. Around one third relate to family health services (FHS; GP services including dental care) and the other two thirds to hospital and community health services (HCHS). Of these complaints, over half of them were upheld locally (Table 3.6). Interpreting long-term trends in written complaints about HCHS is difficult as until 2010/11 foundation trusts only reported data on a voluntary basis. The picture presented up to the end of 2012/13 was that complaints about HCHS had increased slightly compared with 2011/12 (by 1.9%).

For FHS in 2012/13, 65 primary care trusts (out of 150) indicated that they were unable to provide complete returns for all practices within their area; compared to 36 (out of 150) in 2011/12, which means that comparisons between years are not possible.

Table 3.6: Written complaints received and percentage locally upheld by service area (2011/12 to 2012/13)

	2011/12		2012/13	
	Written complaints received	Percentage upheld	Written complaints received	Percentage upheld
All HCHS areas	**107,259**	**49.2**	**109,316**	**50.2**
Ambulance services	5,173	16.0	5,332	39.6
Community hospital services	1,328	48.8	1,315	52.4
Elderly (geriatric) services	1,051	57.3	880	53.6
Hospital acute services: A&E	9,362	54.2	9,680	52.2
Hospital acute services: Inpatient	33,873	54.8	34,872	53.9
Hospital acute services: Outpatient	29,559	57.1	30,019	55.6
Maternity services	3,240	58.6	3,427	56.7
Mental health services	10,439	32.6	11,749	35.5
NHS Direct	163	67.5	193	50.8
Other community health services	6,407	46.8	6,840	49.8
Primary care trust commissioning	3,114	26.3	2,507	26.8
Walk-in centres	472	41.7	457	46.4
Other	3,078	24.2	2,045	30.0
All FHS areas			**52,703**	**35.2**
Medical			27,711	36.0
Dental			6,729	34.4
General practice administration			13,933	36.3
Other			4,330	28.0

Source: Health & Social Care Information Centre, Data on written complaints.

If people are unhappy after the NHS has tried to resolve their complaint locally, they can go to the Parliamentary and Health Service Ombudsman. In 2011/12 the Ombudsman's office received 16,337 complaints from the public about the NHS or NHS-funded services. This was an 8% increase on the year before (Parliamentary and Health Service Ombudsman, 2012). Not all of these complaints represented problems in the quality of care, as many related to problems that had not yet been through the local complaints process, and others did not fall under the jurisdiction of the Ombudsman or were withdrawn by the complainant. For 3,339 complaints, the Ombudsman felt that there was no case for the NHS to answer, or explained how the NHS had already put things right. However, 351 complaints were accepted for formal investigation, of which 79% were wholly or partially upheld. The two most common reasons for complaints were the quality of clinical care and treatment, and poor communication with patients.

Capacity

Care systems should be sufficiently well resourced and with adequate distribution to enable delivery of appropriate services.

The comparative level of spending in healthcare was famously an incentive for changes in NHS funding from 2000 onwards. Figure 3.31 summarises OECD figures on health spend in US dollars per head in 2011. These estimates suggest that the spending increases have resulted in the UK now being at approximately the OECD average; higher than Spain or Italy, but less than France, Germany, Ireland and the Netherlands, and much less than the US.

Having the right numbers of staff

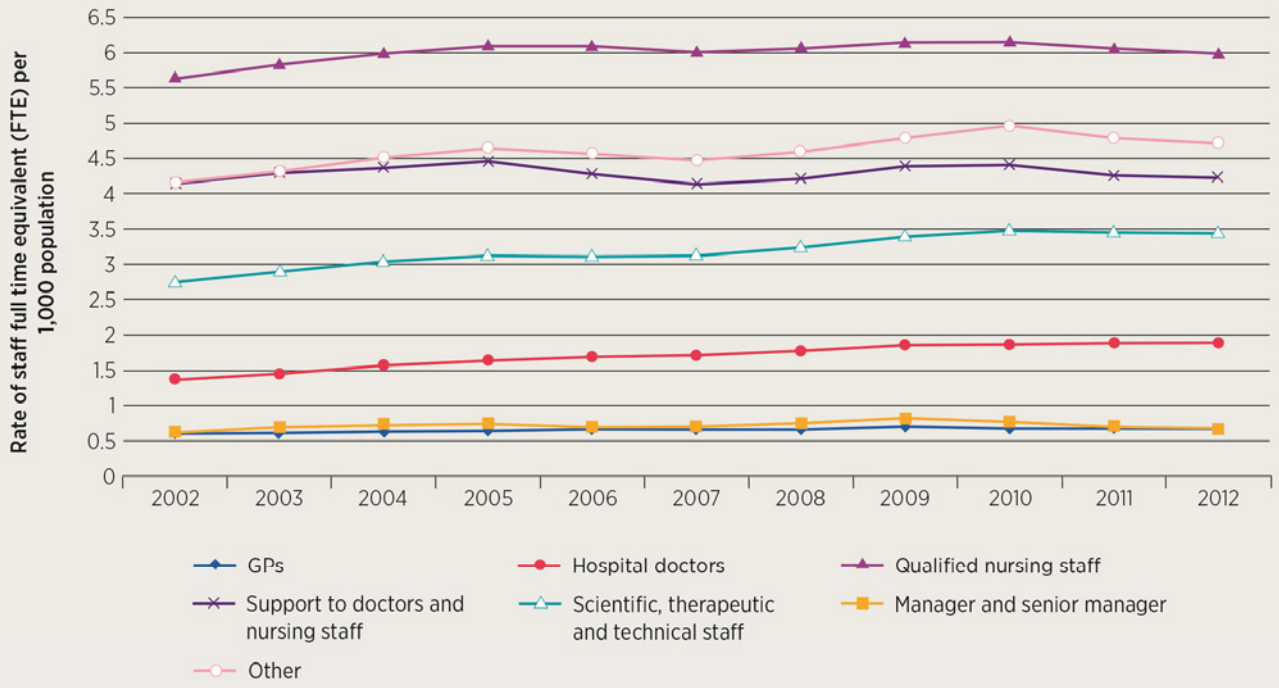
Having the right numbers (and quality) of staff is clearly key to good quality care. A number of studies have shown that higher numbers of nurses are associated with better outcomes for patients and greater patient satisfaction. In particular, a higher proportion of hours of nursing care provided by registered nurses is associated with better care for hospitalised patients (Needleman and others, 2002). However, staff costs make up approximately 70% of the NHS budget and are therefore vulnerable to cuts when finances are strained.

Between 2002 and 2012, activity within the NHS increased and the number of staff working (in terms of full time equivalents; FTE) in the NHS increased by just over 20%. The increase was seen in all staff groups but some increased more than others, such as hospital doctors (40%) compared with qualified nursing staff (14%). Figure 3.32 shows the crude rate of FTEs per 1,000 population. The provision of GPs appears to have matched population growth (although not accounting for population ageing or changes in morbidity), while other staff groups grew more. The number of managers compared with the population fell by nearly 20% from 2009. The figures do not include the number of staff working in the NHS who may be temporary staff. Historically, as much as 29% of total workforce cost is spent on temporary and flexible working, including overtime, bank staff and expensive agency workers in some trusts (National Audit Office, 2006). This is a limitation of these datasets, especially where temporary and locum staff are an important part of the workforce.

Figure 3.31: Total expenditure on health in US dollars ($) per head by country (2011 or nearest year)

Source: Office for National Statistics, Health Data 2013.

Figure 3.32: Rate of staff full time equivalent (FTE) per 1,000 population for major staff groups (2002 to 2012)



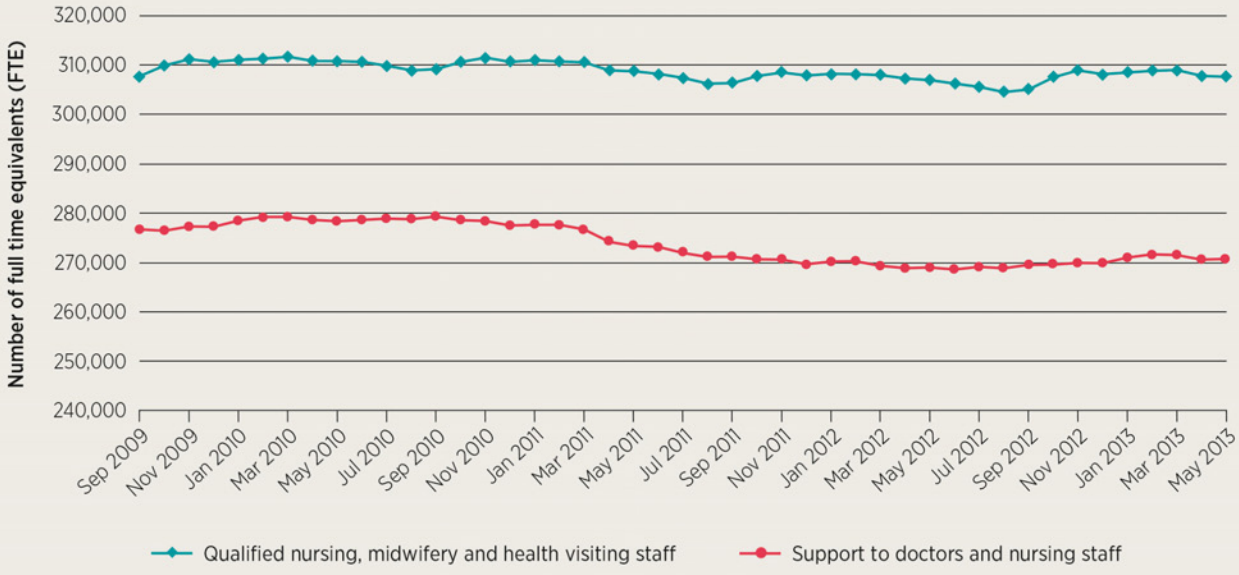
Source: Health & Social Care Information Centre, NHS Hospital & Community Health Service and General Practice workforce.

Figure 3.33 shows the number of qualified nurses by month from September 2009 to May 2013. The absolute numbers show an annual fluctuation as new nurses graduate. Nevertheless, the numbers show a slight decline up to mid-2011 and are stable since then. These data do not specifically identify healthcare assistants, but do provide a category for 'support to doctors and nursing staff', which is also shown.

The most recent position across all staff groups for hospital and community health services is shown in Table 3.7 and indicates a small overall reduction in staffing of 0.2% in the year up to May 2013. The groups showing the greatest reduction are in the NHS infrastructure and support.

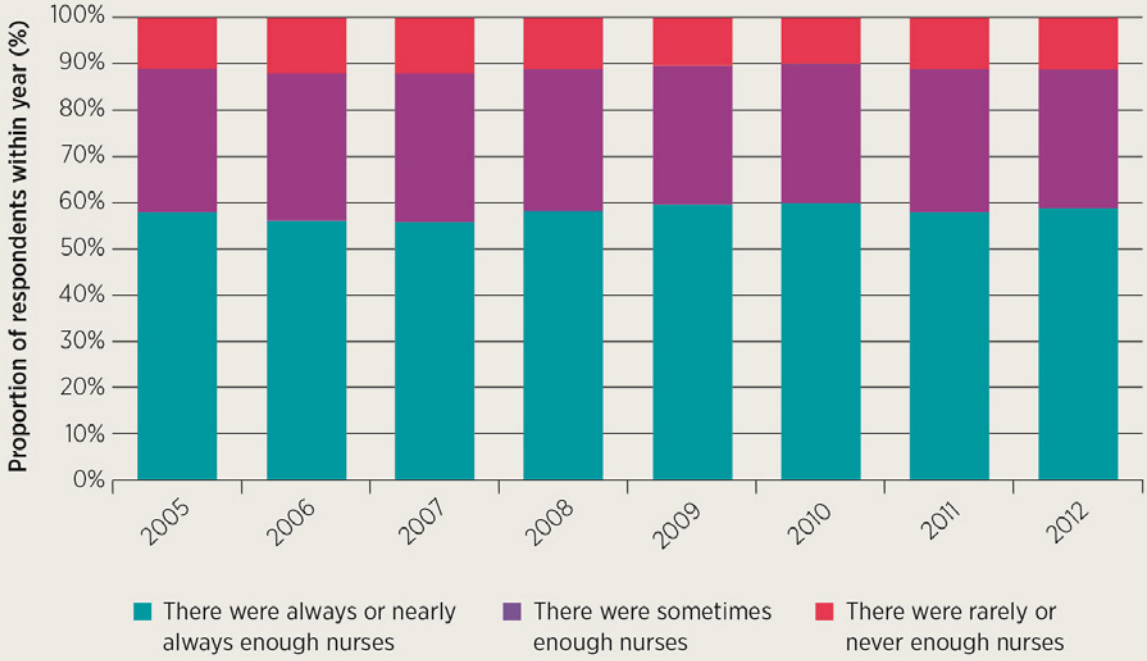
The annual inpatient survey (referred to earlier) includes the question: 'In your opinion, were there enough nurses on duty to care for you in hospital?'. The distribution of responses to this question by patients has remained broadly stable since 2005 (despite the increases in nursing staff shown). Overall, in 2012, 59% of respondents felt there were enough nurses on duty to care for them in hospital, while 11% felt there were not enough nurses on duty.

Figure 3.33: Trends in the number of qualified nursing, midwifery and health visiting staff, and support to doctors and nursing staff (September 2009 to May 2013)



Source: Health & Social Care Information Centre, NHS Hospital and Community Health Service (HCHS) Workforce Statistics.

Figure 3.34: Patients' responses to the question "In your opinion, were there enough nurses on duty to care for you in hospital?" (2005 to 2012)



Source: Care Quality Commission, Survey of Adult Inpatients.

Table 3.7: Summary changes in staffing levels for selected staff groups, FTE for hospital and community health services in England (May 2013)

	May 2013	Annual change	Annual change (%)
Total	**1,032,044**	**-2,468**	**-0.2**
Professionally-qualified clinical staff	**559,388**	**1,035**	**0.2**
All HCHS doctors (including locums)	**101,781**	**576**	**0.6**
Consultants (including directors of public health)	38,387	731	1.9
Registrars	37,184	-46	-0.1
Other doctors in training	13,806	-61	-0.4%
Other medical and dental staff	10,039	56	0.6%
Qualified nursing, midwifery and health visiting staff	307,634	635	0.2%
Qualified midwives	21,458	404	1.9%
Qualified health visitors	8,840	650	7.9%
Qualified allied health professionals	63,631	734	1.2%
Qualified diagnostic radiography staff	12,789	335	2.7%
Qualified speech and language staff	6,095	62	1.0%
Qualified healthcare scientists	27,179	-1,702	-5.9%
Other qualified scientific, therapeutic and technical staff	41,315	813	2.0%
Qualified ambulance staff	**17,848**	**-21**	**-0.1%**
Support to clinical staff	291,366	2,157	0.7%
Support to doctors and nursing staff	227,513	2,895	1.3%
Support to scientific, therapeutic and technical staff	51,320	-621	-1.2%
NHS infrastructure support	**181,291**	**-5,660**	**-3.0%**
Central functions	91,849	-3,686	-3.9%
Hotel, property and estates	55,511	-309	-0.6%
Senior managers	10,535	-162	-1.5%
Managers	23,395	-1,503	-6.0%

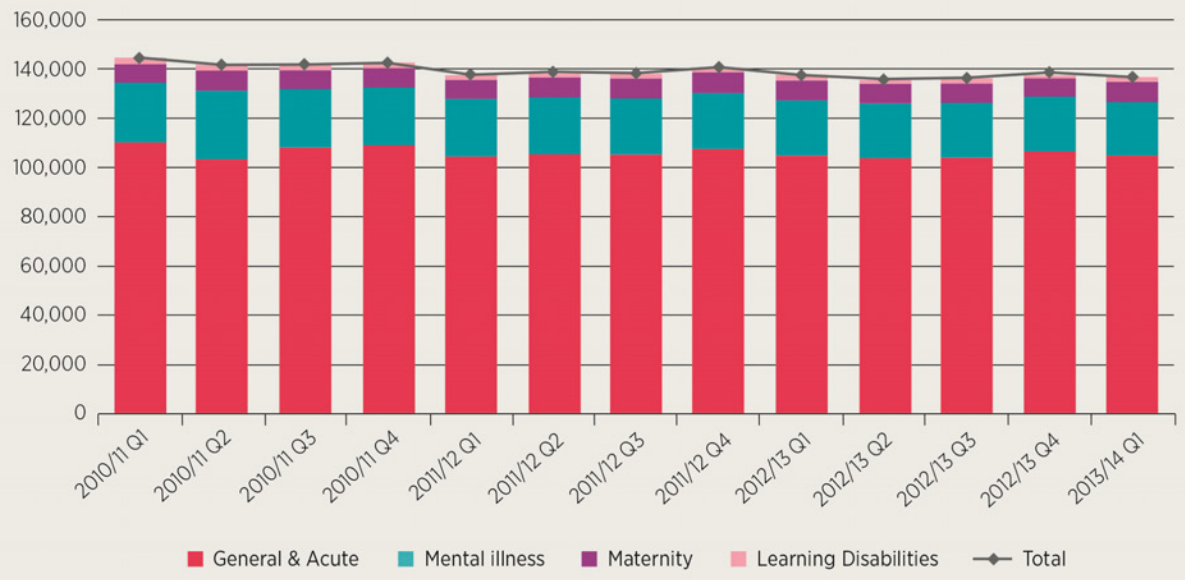
Source: Health & Social Care Information Centre, Monthly NHS Hospital and Community Health Service (HCHS) Workforce Statistics in England – May 2013, Provisional statistics.

Having the right amount of service facilities

Having enough beds available for the care of NHS patients is clearly important to achieving good quality care. There is a long-term trend across health systems in OECD countries of a decline in hospital beds as new treatments and care reduce the need for dependency in hospital. There has been an approximate 30% drop in the number of beds in the NHS over 30 years.

Figure 3.35 shows the number of beds available over the last three years for various areas of care. Although total hospital activity is generally rising, there has not been a commensurate rise in hospital beds. Between April 2010 and June 2013, there has been an overall decrease of over 5.5% in the total number of beds available overnight. During this period, occupancy increased, day activity increased and lengths of stay continued to fall as acute hospital beds are used more intensively.

Figure 3.35: Average daily number of available overnight beds (quarter 1 2010/11 to quarter 1 2013/14)



Source: NHS England, Bed Availability and Occupancy.

There is probably no 'right' number of beds in the NHS. However, it is important to monitor the pressure on beds and to come to a judgement as to whether the pressure warrants investment in more beds (and associated staff) or other forms of care. One indicator of pressure is the number of operations cancelled. For urgent operations, the trend is upwards: the number of urgent operations cancelled was 330 in May 2013, which compares to 283 in May 2012 and 205 in May 2011, although the absolute numbers are very small. For elective operations the absolute number of cancellations increased from 1994/95 (48,129) to the end of 2012/13 (63,517). But this was in the context of higher levels of elective surgery, so cancellations fell as a percentage of elective admissions (from 1.1% to 0.9%).

Equity

Care should be provided on the basis of need, regardless of personal characteristics such as age, gender or ethnicity; and in such a way as to reduce differences in health and wellbeing status and outcomes across sub-groups.

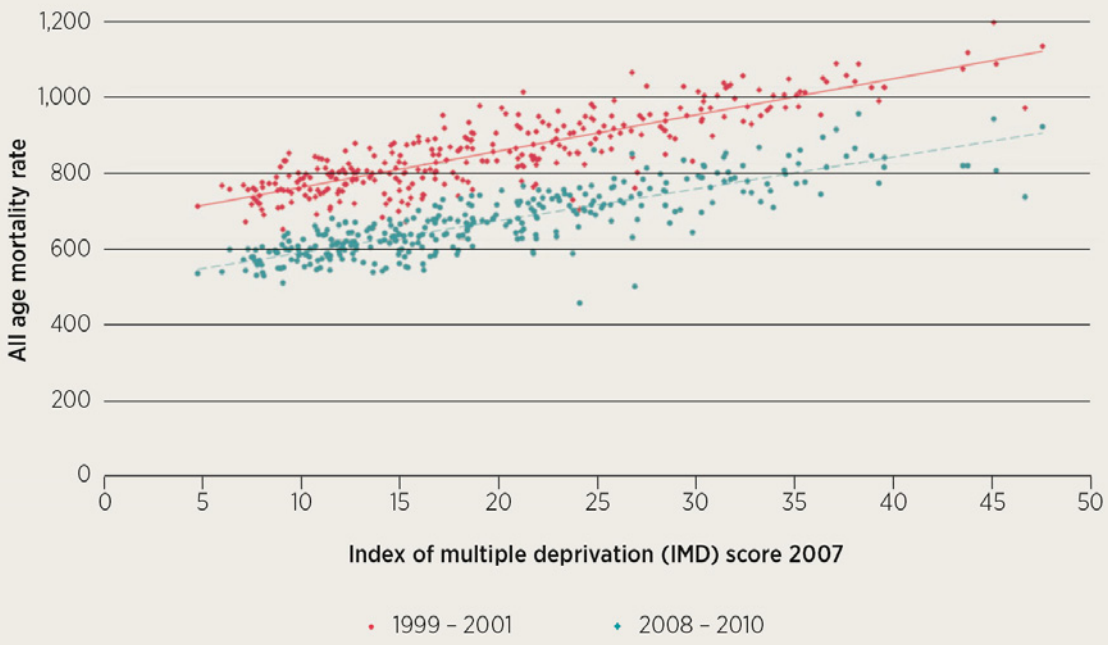
Equity of access to care for people of equal need is clearly a founding principle of the NHS. A large number of indicators could potentially be considered here, but for simplicity we have selected only a few topics to explore. Future reports will examine this domain in greater detail.

Our current legislative framework for equality identifies a number of different attributes of an individual where the law seeks to protect from discrimination, for example, age, sex, sexual orientation, disability, race, religion and sexuality. Good quality care should not discriminate against these characteristics through the way it is organised and delivered. The most relevant aspects of the organisation and delivery of care include: workforce training, allocation of resources for care (access to care) and some physical aspects of services (whether disabled access or multi-faith chaplaincies). In times of austerity, the concern is that services for minority groups, or those whose voices are less heard, may suffer. Unfortunately the information available to assess care in these areas is weak.

One of the most important dimensions of NHS care is that it is available regardless of the social or economic disadvantage of people who need it. It has been recognised for a long time that the people who live in more affluent areas, or are in more affluent social groups, have better health. So, for example, in terms of life expectancy, male life expectancy at birth was highest in East Dorset (83.0 years); 9.2 years higher than in Blackpool, which had the lowest figure (73.8 years). For females, life expectancy at birth was also highest in East Dorset at 86.4 years, and lowest in Manchester where females could expect to live for 79.3 years. The reasons for these differences are complex, but it is clear that the government can act to reduce these differences, including via healthcare (Marmot, 2010).

Figure 3.36 gives an example using a different indicator, standardised mortality rates (under age 75), and compares the relationships at local authority level between premature mortality and deprivation for two time points. These studies provide a compelling case for monitoring inequalities in life expectancy, with a view to narrowing the gap between different areas. As noted by Marmot (2010), reducing health inequalities would benefit society in many ways. There would be economic benefits in reducing losses from illness associated with health inequalities, which currently account for productivity losses, reduced tax revenue, higher welfare payments and increased treatment costs.

Figure 3.36: Comparing all age all cause mortality rates for local authority area versus deprivation for two time periods (1999-2001 and 2008-2010)



Source: Office for National Statistics, Mortality data by cause and mid-year population estimates.

It is difficult to link poor quality care to poor health outcomes at the population level for different population groups. Instead there has been a wealth of analysis over several decades looking at access to healthcare for different socioeconomic groups. Typically, utilisation rates of care, such as admission rates and vaccination rates, for different population groups have been examined.

Chapter 4 shows how emergency admissions for conditions amenable to treatment in primary care are related to measures of social and economic deprivation. Moreover, these differences appear to have remained largely constant over time.

Over the next few years we will be selecting key indicators of equity, building on the findings of our in-depth studies.

4

A focus on specific topics

In this chapter we pull together some findings from the in-depth analyses we have been undertaking. The ability to conduct such in-depth studies of specific areas is an important part of the QualityWatch programme. It allows us to use a wider range of methods and draw on different forms of evidence than those used for simple indicators. It also allows us to explore better ways of measuring and assessing changes in quality and in time may inform the work on indicators.

Each project is designed to take around six months to generate its particular analysis and individual report. The selection of topics is informed by our advisory group and uses the following criteria. The topic:

- addresses important aspects of quality
- is an issue that is significant to patients, service users and/or clinicians
- is remediable/actionable
- has the potential to develop new/innovative perspectives on health issues
- will generate policy-relevant findings/tools for implementation.

The projects we have started to date include work on emergency admissions, which is a key policy concern in terms of the organisation of health and care services, as well as representing a quality issue for individual patients if emergency care can be avoided by better prevention. We are also undertaking work to look at access to emergency care, and in particular about the distribution of acute emergency care, which is an area where the concerns of the public and the need for economies often conflict. Of particular concern is the care of older people, which is addressed in our study of hip fractures over the past decade. Care for older people is also a key issue in social care where constrained funding was implemented before that for health services, and our work on social care explores the impact that this may have had. Finally we have undertaken a project that links with the possible impacts of austerity itself, where more unemployment and deprivation can increase the prevalence of mental health problems seen in primary care. We are looking at the factors associated with the increasing number of prescriptions for antidepressants in primary care.

The following sections give brief summaries of two topics where reports are completed and three other areas on which reports will be published in due course.

Changes in the prevention of emergency hospital admissions

The full report of this work is available at **www.qualitywatch.org.uk/focus-on/preventable-admissions**.

As noted in the previous chapter, one of the most challenging areas for healthcare is providing good quality emergency and urgent care. The number and rates of

emergency admissions are rising. One of the keys to managing demand is felt to be offering good quality preventive care outside hospital that reduces the risk of emergency admission. The most commonly used indicator in this area is rates of emergency admission for people with 'ambulatory care sensitive' (ACS) conditions, which currently appears in the Outcomes Framework (Department of Health, 2012b).

In this topic we built on earlier work (Bardsley and others, 2013) to explore patterns of change in admission rates. We were interested in how these rates varied across areas, and how they have changed over time – particularly in relation to the tougher financial constraints introduced in the NHS since 2010. To do this we used an anonymised record of all hospital admissions in England between April 2001 and March 2013; nearly 200 million episodes of care. Nationally we found that 20% of emergency admissions were for ACS conditions (therefore potentially preventable), and these admissions were dominated by a relatively small number of conditions that disproportionately affect older people and children. Overall rates of admissions for ACS conditions (standardising for age and sex) had grown by 26% since 2001/02. This increase was similar to that seen for emergency admissions in people with any clinical condition, and we did not find any evidence to suggest that these trends had changed significantly since the introduction of the current financial constraints.

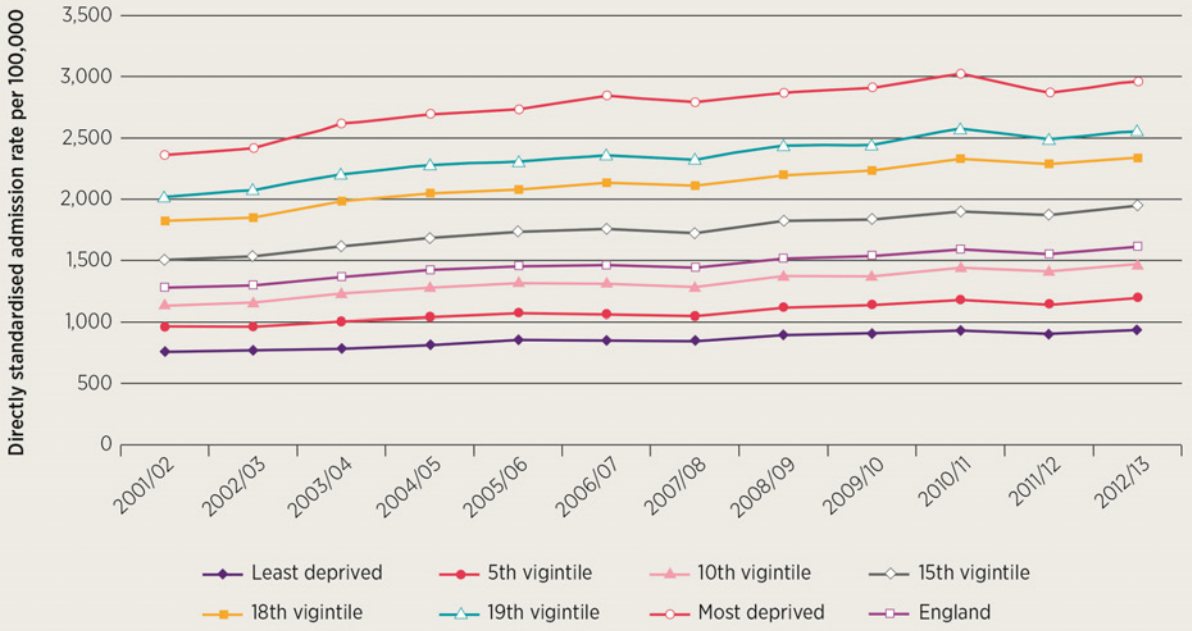
For some ACS conditions, emergency admission rates have actually fallen. So, for example, there have been improvements in the treatments for people with angina and peptic ulcers, and subsequently emergency hospital admissions for these conditions have reduced. In general, emergency admissions for people with chronic ACS diseases did not increase as much as those with acute ACS conditions, including two common health problems for older people – pyelonephritis/urinary tract infections (UTI) and pneumonia.

In general, rates of emergency admissions for ACS conditions are higher for people living in areas with higher levels of deprivation; as Figure 4.1 shows, the admission rate for the most deprived twentieth of the population is over twice that of the least deprived areas. Moreover, there is no evidence that this gap is changing over time; in absolute terms it is increasing. In fact we noted that a substantial amount of the variation in rates of admission between populations residing in geographical areas was 'explained' by the effects of socioeconomic deprivation, and this was particularly marked for certain conditions such as chronic obstructive pulmonary disease (COPD).

However, there were still differences between areas even when standardising for age, sex and deprivation of the population. Figure 4.2 shows the variation between areas for the 10 most common (by volume of admission) conditions. The variation between the 90th and 10th percentiles of rates for people with ear nose and throat (ENT) infections is 3.6-fold (a variation of 211 admissions per 100,000). The variation between the 90th and 10th percentile in rates for pyelonephritis/UTI, COPD and pneumonia is greater than 100 admissions per 100,000 of the population.

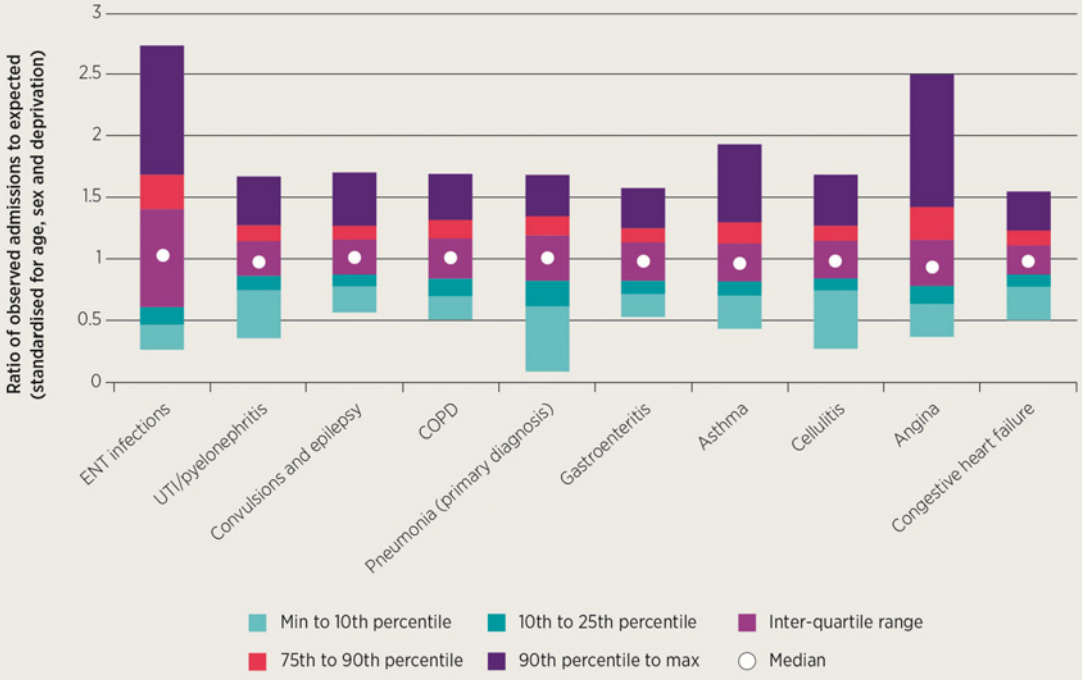
A big challenge is assessing how much of this variability is tractable through health service action in the short term. The significant variation in rates of admission between areas, over and above that associated with the socioeconomic deprivation and age structure of the population, suggests that reductions in ACS admissions may be achieved through action by health services, perhaps learning from areas with lower rates.

Figure 4.1: Overall ACS admission rate by vigintile (a slice of one twentieth of England, just over 2.5 million people in total) of deprivation (2001/02 to 2012/13)



Source: Health & Social Care Information Centre, Hospital Episode Statistics (Copyright © 2013, Re-used with the permission of the Health & Social Care Information Centre. All rights reserved).

Figure 4.2: The extent of variation between local authority areas for the 10 most common ACS conditions (2012/13)



Source: Health & Social Care Information Centre, Hospital Episode Statistics (Copyright © 2013, Re-used with the permission of the Health & Social Care Information Centre. All rights reserved).

Trends in hip fracture

The full report of this work is available at **www.qualitywatch.org.uk/focus-on/hip-fracture.**

Hip fracture is one of the most common and serious health problems affecting older people and leads to over 50,000 hospital admissions per year. Providing good quality care for people with hip fractures will become increasingly important due to an ageing population and the corresponding rise in the incidence of hip fracture. In this analysis, we explored the quality and outcomes of treatment by looking at 10 years of hospital inpatient activity data.

In our analysis we looked at patterns of admission, readmission and deaths in patients following a hip fracture. The number of admissions for people with hip fracture increased by 15.5% over a decade; from 46,495 admissions in 2001/02 to 53,694 admissions in 2010/11. This increase appears to be mainly due to the general ageing of the population, as age- and sex-standardised rates have been more or less stable since 2002/03 (despite significant action across the NHS and social care to prevent falls in older people).

Care for people with a hip fracture appears to have shown some marked improvements. The proportion of admissions in which an operation was received within 24 or 48 hours (a marker of good practice) has been steadily increasing since 2005/06. Standardised 30-day mortality rates decreased by 22.9%, from 97.2 to 74.9 deaths per 1,000 admissions between 2001/02 and 2010/11.

The management of people with hip fractures in the NHS changed over the decade studied, generally for the better, with reductions in 30-day mortality rates and length of hospital stay, and an increase in the proportion of people undergoing surgery within 48 hours of admission. These are indications of improved quality in the acute response to hip fracture and provide a valuable benchmark to assess changes over the next few years.

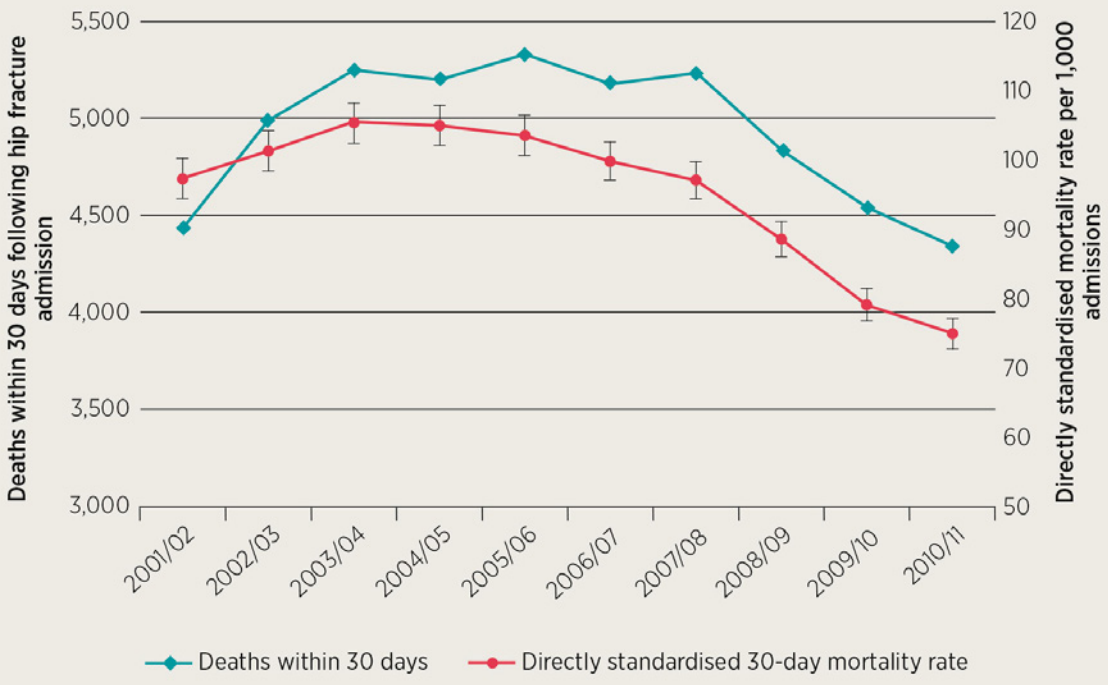
In addition, we noted over the decade changes in patterns of care for older people admitted to hospital with hip fracture – they experience a shorter time in hospital but more readmissions. These changes are consistent with patterns of acute care found elsewhere and are an indication of changes in wider health and social care systems.

These data also point to changes in the population with a growing community of people surviving hip fracture, with increasing frequency of admission. This group of people will most likely have significant health and social care needs.

There is room for improvement in primary and secondary prevention services for hip fracture as the rate of hip fracture across the population has not decreased. It appears that some parts of the country buck the national trend with reductions in admission rates. Further exploration of this would be worthwhile.

Finally, we observed that people living in the most deprived parts of the country are more likely to have a hip fracture and exhibit worse outcomes than those in the least deprived. These gradients have not reduced over time.

Figure 4.3: Total annual number of deaths within 30 days following admission for hip fracture (left axis) and age and sex-standardised mortality rate per 1,000 hip fracture admissions with 95% confidence intervals (right axis) (2001/02 to 2010/11)



Source: Health & Social Care Information Centre, Hospital Episode Statistics (Copyright © 2013, Re-used with the permission of the Health & Social Care Information Centre. All rights reserved).

Other current work on specific topics

Currently we are also working on three further projects:

Social care: scale and scope of reductions in budgets for publicly-funded social services for older people in England 2010–2013.

Local authorities are responsible for providing support for eligible* older adults needing help with activities of daily living, either in the home or in institutions. However, budget allocations from central government to English local authorities were reduced by 14% in real terms between 2011/12 and 2014/15. This project investigates how local authorities have responded to this decline in income (in terms of reductions in social care spending and services delivered to older adults) and explores the possible impact on older adults' health and wellbeing.

This project uses expenditure and service use data from the National Adult Social Care Intelligence Service to explore trends from 2009/10 (which we established as a

* Local authorities assess eligibility based on physical needs and a means test.

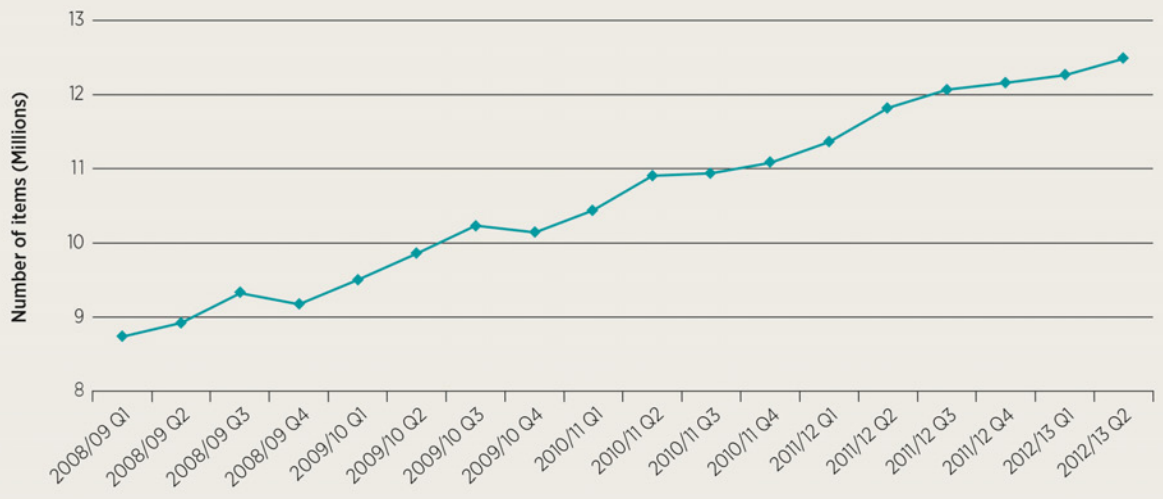
baseline year) to 2012/13. For contextual purposes we are also exploring survey data from service users and directors of adult social services.

Depression and recession: how has the economic downturn affected the prescribing of antidepressants?

The strong relationship between a person's economic circumstances and their health and social status is well documented. Growth of unemployment, poverty and inequality is likely to result in increased demands for health services. One area where change may be more visible in the short term is the prevalence of mental health problems in a population, particularly depression associated with unemployment. Such health problems are most likely to be seen in primary care. Depression is the third most common reason for consultation in general practice in the UK and is the most common psychiatric disorder. The quality of care for people with this condition is therefore of critical importance.

We have noted reports (Health & Social Care Information Centre, 2012) of increased primary care prescribing of antidepressants (see Figure 4.4). In this study we are looking at trends in prescribing and are developing a series of models to explore the factors that lie behind these changes. How much is related to the organisation of health and care services? How much is due to underlying changes in social and economic circumstances?

Figure 4.4: Trend in prescribing of antidepressants in England, expressed as a total count (quarter 1 2008/09 to quarter 2 2012/13)



Source: Health & Social Care Information Centre.

We have worked to develop a statistical model that looks at the factors that are associated with high levels of antidepressant prescribing at practice and area level. We believe the use of this type of model can help local areas understand the absolute level of prescribing of antidepressants and whether this matches to local needs. It will also help us to track the extent to which the economic recession impacts on local practice.

Changes in the distance people travel for emergency admissions

The accessibility of emergency care in hospital is often seen by the public as a critical marker of the quality of healthcare. Yet, although there is often public outcry in response to debates about closures of A&E departments, there is little systematic information on how the typical distances that people might have to travel for emergency care has changed. In this project we are undertaking some basic analysis using hospital data from the last decade to look at the actual distances from people's home area to the hospital providing A&E care or emergency inpatient care. The analysis will also look at changes in provision and the impact on changes in distance over time, as well as the degree of variation between areas within England.

Next steps

These analyses are the first stage in our programme of in-depth studies on specific quality issues. They provide examples of the different perspectives and methods that we can apply when looking at the quality of care. These projects also provide some precise ways on which we can develop new and better metrics for looking at change – at both a national and local level.

The full reports on emergency admissions for ACS conditions and trends in hip fracture rates were published on the QualityWatch website in October 2013, and further reports from existing projects will be published in the coming year. We will also embark on a rolling programme of new projects for the next 12 months.

5

Discussion

The overarching purpose of the QualityWatch programme of work is to monitor over time a series of markers of the quality of NHS and social care. One impetus to starting this work is because of the tightening of funding constraints in the NHS and in social care, which look likely to be continued in the future (Roberts and others, 2012), increasing the need for vigilance in terms of timely access to safe, effective and individually responsive care.

Measuring quality

Acknowledging the many challenges of quality measurement, our intention is to provide an independent and dispassionate analysis of how the quality of NHS and local authority funded care is changing over time. We want to use both new and existing indicators and to conduct deeper level investigation in some areas. In doing so we expect to augment and inform other national initiatives and commentaries.

Our focus in this first year has been to explore changes across England at a national level. Very often this means using an average or other summary measure across the whole population. One problem with this aggregate level is that it will not show the extent of variation between providers and is not designed to necessarily highlight significant lapses within an individual provider.

The same is true of data drawn from national surveys which summarise the average experiences of patients as such averages do not reveal the number of times individual patients suffer unacceptable levels of care. Yet it is the individual patient or service user that is so very important and often (rightly) highlighted in the media. It is possible to draw false comfort from looking only at aggregated or average figures, which by themselves do not give a complete picture of the quality of care. In addition, we need metrics that are able to detect the extremes, especially when things are going wrong. One example of this is in the way we use breaches against a target, say in the case of waiting times or mixed-sex accommodation. Similar approaches are needed to monitor other unacceptable exceptions in future.

A further key challenge for quality assessment and measurement is the fact that our information systems are stronger in some areas than others. For example, in areas such as acute care there are many more indicators than for, say, social care. Likewise, primary care has a wide array of data linked to the QOF, but much less on the many aspects of community-based care not covered by the QOF. Although the measurement of quality has come a long way in the past 20 years, there is still a long way to go if we are to have comprehensive coverage across care sectors using reliable and valid indicators.

Summary progress on the domains of healthcare

Even with the caveats identified above, we have identified some themes and patterns. The overwhelming message from our findings, as outlined in this report, is of gradual improvement in the quality of NHS-funded care over the past decade. Our website contains analysis of many more indicators than covered in this report, as well as detailed reports on specific topics: **www.qualitywatch.org.uk**.

Access

A clear message is that the time patients wait for care in 2013 remains low after the dramatic improvements in the mid-2000s, despite the reduction in direct central performance management (although perhaps with a rise in scrutiny by Monitor and the CQC). In general, the gains that were made have been consolidated and waits for elective care, diagnostic tests, ambulances and cancer treatment are low overall compared with five or 10 years ago. This is significant as waiting is an iconic issue for the public and one key litmus test for the performance of the NHS. It will be important to monitor if the hard won gains in the past decade are to be maintained, and this will be a key focus of our and others' work in future.

We noted that access to certain specially designed forms of care that are more responsive to people's needs also seem to be improving. Two areas that have received some national policy attention are increasing numbers of people being supported to die in their usual place of residence and people receiving psychological therapies for anxiety and depression through the IAPT programme.

There are some areas where progress is not so clear. There are signs that some patients appear to be waiting longer for transfers to care from acute hospitals for reasons solely due to the NHS. This merits further scrutiny, although absolute numbers are small in relation to the total number of discharges. For primary care, about a quarter of people report that it is not easy to make a GP appointment by phone, and a similar proportion report having to wait 'a bit too long' for the appointment. Many more people would also prefer to book their appointment online than do so at the moment.

One area where the record is not positive has been the recent deterioration in the number of people waiting more than four hours for care in major A&E departments. This measure had been consistently around 95%, but started to decline in autumn 2012 and in April 2013 it reached just 90% – the lowest level since the introduction of the four hour target in January 2004. A combination of factors may be contributing to this, including:

- problems in staffing A&E departments, and in particular the difficulties in recruiting certain grades of doctors
- public confusion about accessing other urgent care options, such as their local out-of-hours service or minor injury unit, and the widely-criticised introduction of the new telephone advice service, NHS 111
- lack of public confidence in other urgent care options in the face of perceived need for urgent care

- the cumulative effects of an unusually long winter in 2013, which lasted well into April.

However, this has been the focus of attention in the NHS, and the most recent figures from May 2013 suggest that performance has returned to levels closer to the 95% level (NHS England, 2013a). In addition, the Department of Health has made £500m available to ease winter pressures on A&E over the next two years. It will be important to monitor closely if this improvement in performance (and increase in funding) is sustained in the long term in such an important area.

It is against this background that current proposals for service reconfigurations involving urgent care will need to be carefully assessed. Major A&E units are expensive to run (because they need to provide 24-hour care, supported by an appropriate number of trained specialist staff and facilities) and evidence suggests fewer, larger centres produce better outcomes. Yet this may reduce access for patients who find they need to travel further for urgent care, prompting public outcry. We have analysed this issue in more depth and will publish the findings shortly. In response to the short-term concerns and longer-term trends, as well as the challenges of delivering service reconfiguration locally, NHS England is conducting a major review of emergency care services in England (the first part of which has been published; NHS England, 2013b). Urgent care services in England are facing profound challenges which will need clear solutions.

Safety

Our limited analysis in this report shows that in some important areas NHS care is safer than in the past, particularly with respect to the healthcare-acquired infections MRSA and *C. diff.* We have also noted improvements in other areas such as screening for VTE.

As many have noted (Vincent and others, 2013), it is not easy to assess safety as very often safe care is based on a myriad of different elements of care, such as the behaviour of staff and even the culture of the organisation. This does not lend itself to simple indicators. So it is important to consider other forms of assessment by agencies such as the CQC or the NHS LA, whose CNST offers a potential reduction on insurance premiums based on the completeness of safety management systems and processes. Achievements in this scheme show a significant degree of variation between NHS providers in terms of their approach to managing safety issues.

Clearly there has been much analysis and debate over the past year on the safety of care, not least arising from the inquiries into Mid Staffordshire NHS Foundation Trust by Robert Francis QC. Changes in the regulatory system are being introduced, along with other developments recommended in the Francis Report. The government has also focused attention on the 'Friends and Family Test' whereby patients and staff are surveyed to see if they would recommend treatment in a hospital to their friend or family if they needed similar care or treatment. However, as the Berwick report (National Advisory Group on the Safety of Patients in England, 2013) made clear, there are unlikely to be simple off-the-shelf solutions for delivering harm-free care. The reasons for safety lapses are often complex, and there needs to be a systematic, continuing programme of learning and diffusion of knowledge about safety in practice.

Very often the focus of safety programmes is on hospital care – yet there is also a need to engage other areas of care, for example primary care, where the nature of the service inevitably means it will be harder to develop such programmes. QualityWatch has identified safety in primary care as an area to focus on for development of data sources and measures.

Effectiveness

There are a number of metrics indicating that more effective care is being provided in certain cases. For example, emergency admissions for some conditions (for example angina and peptic ulcer) are declining due to better treatment and diagnosis. Similarly, in other areas we see increasingly efficient and effective care, for example there are marked reductions in the time it takes for a person with a hip fracture to receive surgical treatment, as well as increased survival rates. For people with stroke, cardiovascular disease and renal disease there have been significant improvements in care (for example time to specialised treatment resulting in improved survival and functioning of patients) and survival.

The best indicators of effectiveness tend to be partial and identify only subsets of patients or treatment types. This means that it is especially difficult to make summary statements on overall improvements in effectiveness. One possible exception is in primary care where many indicators looking at how general practices perform against a series of standards of effective care are combined through the QOF. Performance against the framework, through a points system, in part determines the pay of general practitioners. Practices across the country generally perform very well against the expected benchmarks so it is difficult to discern any significant improvements. There is also little meaningful variation between practices with so many reaching the upper thresholds. There is a case for developing more sensitive markers in relation to primary care that allow for more challenging benchmarks and provide tools to show what the very best care looks like, and indicate where it is being achieved.

In other areas it can be difficult to identify improvements in effectiveness as data are not routinely collected across the country outside of the clinical audit programmes.

Person-centred care and experience

Patient and public perceptions about the care they receive are important sources of intelligence on quality of care. Different sources sometimes present a varying picture. Despite the many reports and media stories about failings in care, the annual inpatient survey consistently records that about four out of five people treated in hospital report that they were always treated with dignity and respect – a consistent finding over the last decade – with only 3% answering that they were not. The proportion of people reporting that they were not treated with dignity and respect by providers of social care was even lower.

The majority of hospital patients surveyed (70%) reported they were as involved as much as they wanted to be in decisions affecting their care, with only about 5% reporting that they were not. However, other measures of the patient experience of care have greater room for improvement: in hospitals, a quarter of patients report that doctors talked in front of them ‘as if they weren’t there’, and one fifth of patients report that nurses did the same.

The NHS has a strong track record by international standards in using large national patient surveys. However, as noted earlier, although these surveys are good at capturing the 'average' for many patients, they do not help us identify instances where serious lapses lead to unacceptable care for a minority of patients. We need better mechanisms to identify and learn from those. Complaints data (discussed in Chapter 3) can supplement the national surveys. Although a limited indicator of quality, the number of complaints made to the Health Service Ombudsman has increased by 8% in the past two years (now just over 16,000 per year). The most common reasons for complaints were poor quality of care and communication with patients.

Capacity

Our analysis to date concerns only the staffing levels of doctors and nurses, and the number of beds. Across most developed countries there has been a long-term, gradual decline in the number of beds available, and the NHS is no exception.

The number of doctors has grown at the fastest rate of any staff group during the last decade, and continued to increase in 2011 and 2012. Although the number of full time equivalent doctors increased by over 40% from 2002, the equivalent increase in qualified nursing staff was more modest (up by around 15% from 2002) and since 2010 there has been a very slight decline. There has been much debate about the relationship between care quality and nurse staffing levels, and some research showing staffing levels do affect quality of care (Aiken and others, 2003). Although the Royal College of Nursing (2012) has called for using explicit nurse:patient ratios, such normative standards are not currently applied in the NHS. In this context, we also note that in the annual inpatient survey, 60% of patients report that there were 'always or nearly always' enough nurses involved in their care. While that suggests that a large minority of patients (two in every five) did not feel there were enough nurses, this figure seems to have been consistent over a number of years and is not associated with the changing numbers of nurses or the introduction of healthcare assistants.

Numbers of NHS management and administrative staff have seen falls in recent years. We also note that in the staff surveys, the degree of stress felt by NHS staff appears to have increased.

Equity

Our analysis to date in this area has been limited and we will return to it in more detail over the coming year. We noted the well-known longer-term trends in inequalities in health and life expectancy, particularly between population groups of different socioeconomic status. Measures of socioeconomic deprivation are linked with a range of ways that health services are used. People in more deprived areas, for example, tended to have higher levels of admission for ACS conditions, more hip fractures, higher mortality and higher levels of antidepressant use in primary care. Moreover, there is no evidence to suggest that these inequalities were narrowing over the past decade and it may be that the economic downturn itself will exacerbate these differences (Bloomer and others, 2012).

These changes need to be seen within the context of the underlying inequalities in healthcare within many countries including the UK. Many studies over the past

20 years have outlined the extent of health inequality and the Marmot review encapsulates a range of policy responses (Marmot, 2010). Although there have been targets to reduce inequality, these have proved difficult to achieve – health status across the population as a whole may be improving, but the gap between rich and poor seems to have been stubbornly persistent.

Conclusion

The ability of the health system in England to monitor quality is increasing and, partly in response to the Francis Inquiry, there have been large changes in the range of ways that quality is assessed and measured.

However, our work in the first year of the QualityWatch programme has highlighted that there are some trends worth watching more closely over the coming years, in particular the quality of, and access to, urgent care and primary care. The urgent care system provides, arguably more than any other area of care, the security to the population that when individuals really need care, the NHS can be relied upon to provide good quality care. Thus any shortfalls against that expectation will be widely reported. Not only are urgent care providers exposed to challenges of delivering their own services in times of increased demand and financial constraint, but failures in other parts of the health and social care system (such as poor access and care planning, or provision of preventive care to manage ACS conditions) will increase pressure on urgent care services.

The total level of both emergency admissions and A&E attendances in England has increased substantially over the past decade. This has been continuing for at least several decades and is also documented in many other countries. However, the capacity of the health system (in terms of basic facilities such as staff or beds) has not increased and in some areas has dropped (see Chapter 3). The addition of new services aimed at diverting demand away from hospital (such as minor injury units, walk-in centres and NHS Direct) do not appear to have reduced demand on hospital services.

This does not mean that the increase should be seen as inevitable, however. Indeed, the analysis summarised in Chapter 4 on emergency admissions for people with ACS conditions notes that there have been some successes in reducing emergency admissions for some conditions. However, for many more ACS conditions, rates of emergency admissions are rising, especially in older people, and many admissions result in a very short stay in hospital (raising questions as to whether alternative forms of care may be more appropriate). This in part suggests that the quality of preventive care which led up to the admission needs to be investigated.

The main regulatory body assessing quality of care, the CQC, is developing its approach, and has consulted widely on this in the past year. For example, the CQC is developing a system of comparative and public quality ratings of providers of health and social care, and will be modifying its inspection regime with increased ability to spot and predict risks of poor quality care. Yet a national regulator can only ever have a limited view of the quality of care provided locally. It is for local providers to improve their ability to monitor quality, and improve their ability to predict lapses, using better data and, critically, information from patients and carers.

Some initiatives introduced this year (such as NHS England's care.data programme) have the potential to shine a light on quality, particularly in ways of accessing data from different sectors of care and linking data for individual (anonymised) patients to illustrate the quality of a care pathway over time and across different providers (Dixon and Bardsley, 2012). Yet there is a long way to go and we suggest the following areas should be priorities for further development nationally:

- Improve the scope and robustness of existing data flows through:
  - clinical markers of quality that extend beyond the basic information in Hospital Episode Statistics towards more detail about the process of care
  - information on patient outcomes, measured through patients themselves or through clinical proxies; although PROMS are being used for selected elective conditions, these types of measures are needed in the management of chronic disease too – a much more difficult challenge
  - information on care provided in community settings, including the range of social care services
  - a reduction in the time lag in availability of information, particularly at national level
  - greater assurance about the quality of the data.
- Develop measures of quality across care pathways via:
  - information that spans a patient's journey through care sectors, teams and services through data linkage
  - data to capture what is happening to people who, for whatever reason, are not accessing care.
- Produce more complete information about patients' experiences of care. In recent years there have been developments in the way that patients' views of services can be captured, such as people contributing their views on web forums (as in Trip Advisor). For example, NHS Choices includes free text comments directly from service users. The challenge is whether these can be transformed into a meaningful measure of quality.

Finally, we would note that as well as better data, we also need to support the appropriate analysis of the data; at times the rate limiting step is not the data, but access to the people with the right skills to undertake the analysis.

QualityWatch programme for the coming year

Over the coming year the QualityWatch programme will continue to develop. Our plans include work to develop and refine new indicators and quantitative methods of analysis. We are aware that the indicators used on our website, and the nature and level of analysis shown there (and outlined in this report), are starting points. We will be actively seeking feedback from experts in the field and users of the website on a number of issues including:

- which indicators are the best markers of changing quality

- what is the best way to display and report indicators and groups of indicators for maximum clarity
- which indicators do we need to remove or add to our list.

We also expect indicator areas from our focused work to be added to our library of information, as well as updating selected indicators where data are available.

We will also publish a series of in-depth analyses on specific topics ('Focus On' reports). We have in train a series of reports and plan to undertake other studies in the coming year. See **www.qualitywatch.org.uk** for further updates.

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