QualityWatch

Closer to critical?

QualityWatch annual statement 2015

The Health Foundation | nuffieldtrust

About QualityWatch

QualityWatch is a major research programme providing independent scrutiny into how the quality of health and social care is changing. 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 draws 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 research reports, interactive charts and expert commentary.

This year's QualityWatch annual statement – our third since the programme began in 2013 – presents an independent view of how patterns of quality have changed over time.

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Foreword

Just over a year ago the *Five Year Forward View* (NHS England and others, 2014) set out how the NHS must adapt over the remainder of the decade to meet future need. At its heart was a welcome recognition that, in the long term, 'business as usual' for the NHS would not provide patients with the comprehensive and high-quality service they expect.

One year on and the NHS is still under intense pressure. Despite pledges of extra money, it is increasingly clear that the health service is in financial trouble, with almost four in five trusts ending the first quarter of this financial year in deficit. And despite the important focus on the need to monitor and improve care quality, a recent Care Quality Commission (CQC) report stated that patient safety remained their biggest concern across all health and care services (Care Quality Commission, 2015a).

In the midst of all this doom and gloom it can be difficult to assess how the NHS really is doing in providing patients with high-quality care. Our QualityWatch programme aims to help policy-makers and healthcare leaders make sense of quality across health and social care. Drawing on analysis of over 300 indicators of care quality – from waiting times to staffing levels – and several in-depth studies, we track how health and social care are performing at a time of huge challenge.

Each year we synthesise our analysis into an annual statement on care quality. In 2013 we highlighted some areas of concern, such as urgent care, but our verdict was that high-quality care was being sustained overall. Last year our assessment was less positive: while we acknowledged that things were still better than a decade ago, we pointed to several areas where historical gains in quality were starting to go into reverse, from waiting times for planned treatment, to access to mental health services.

This year, our annual statement focuses on three areas we consider to be critical to a high-performing health system: how easily patients can access care; how engaged and motivated the workforce is; and how well we look after the health of children and young people.

Taken in combination with the past year of QualityWatch analysis, it is clear that there are still many areas of excellent care – from the UK's high vaccination and screening rates, to reductions in unplanned admissions for children in England. Given the pressures it faces, the ability of the NHS to maintain and improve quality in such areas is to be celebrated, and is a testament to the efforts of staff across the country.

But this year there are clear signals that in some important areas quality is declining. The NHS has been unable to reverse the trends of deteriorating access to hospital, mental health and social care services, and has simultaneously suffered from growing staff disengagement and vacancy rates. On some key waiting times, for example, performance has deteriorated to the levels that were being achieved in the late 2000s.

Beyond these 'known knowns', QualityWatch also highlights our 'known unknowns' about the state of quality. Put simply, we lack the answers to many of the questions most fundamental to understanding the impact of financial austerity on quality. We do not know the impact on the health and wellbeing of individuals as a result of 400,000 fewer people receiving publicly funded social care. We know exceptionally little about patient safety in primary care, the point at which most people interact with the health service. We have virtually no data about the quality of services for children and adolescents with mental health problems. These data gaps are concerning – as is the lack of a plan in addressing them.

Given the areas of concern we highlight in this report, and the wider political and economic context in which the health service operates, a key question arises: what do we expect to happen next?

The *Five Year Forward View* proposes solutions to many of the challenges facing the NHS – from making clear the need for further funding, to outlining the ways in which NHS services need to adapt for the future. But in most cases these will not address the immediate challenges facing the NHS. The conditions for addressing the current financial challenge, maintaining quality and improving services do not appear to be in place. People working in the NHS want to deliver high-quality care, but they are increasingly battling against the odds to do so.

There needs to be greater realism about the level of quality the NHS can provide within the resources available to it. Currently policy for the NHS is focusing on additions to what the NHS can offer, for example seven-day working, or NHS England's strategy on cancer treatment. However, the NHS is struggling to preserve the quality of some existing services – let alone new ones. In the light of increasing demand for healthcare, policy-makers must focus on how to maintain and improve quality of care across all services and care settings, not just on new announcements. There is not yet a convincing plan for how the NHS will achieve the extremely challenging efficiency savings of at least £22 billion needed to prevent the £30 billion projected funding gap by 2020. With waiting times and staffing issues so closely linked to funding, it is likely that care quality will continue to decline in relation to these two areas. And on top of the tight and worsening financial position of the NHS, there will be further financial pressures as social care, staff training, public health and other related non-ringfenced budgets are subjected to further cuts.

Furthermore, overall management of the NHS as a system seems to be in some disarray. Many within government believe that the NHS simply needs to become more efficient in order to save money. Since staff costs account for the biggest chunk of the NHS budget, the concerning result of a significant tightening of spending is likely to be fewer staff. Meanwhile contradictory guidance from regulators on staffing levels and the requirement to balance the books is creating confusion for those within the NHS. This may be one of the reasons why the health service is losing top leaders – just at the point when their contribution is most vital.

Given these multiple areas of concern, one would expect there to be a stronger sense of urgency from those in charge – whether that is the secretary of state, the heads of various regulatory bodies, or those responsible for managing and commissioning services. Greater clarity from regulators and ministers over their

approach to dealing with the problem of diminishing finances is urgently needed. Likewise, a more coherent approach to managing low morale in the workforce – an issue highlighted starkly in this report – might begin to alleviate concerns internally within the health service.

The warning lights on care quality that we observed last year now glow even more brightly. So far we have seen a gradual decline in some elements of quality. The problem with complex systems under high levels of stress is that they can suffer sudden and catastrophic collapse – often without a lot of warning. There have been examples of this in the past – for example at Stafford Hospital.

It is very difficult to predict whether crises in the quality or availability of services are likely to become more common – or even routine – or whether the gradual decline we are tracking through QualityWatch will continue. One thing that is clear is that patients cannot expect the speed at which they access care to improve anytime soon.

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Executive summary

The last year has been a momentous one for the NHS. The service has ambitious plans for change captured in NHS England's *Five Year Forward View* (NHS England and others, 2014) and recent moves towards regional devolution. Issues of quality, particularly those of access to care, have been constantly in the news, especially throughout the General Election campaign during which the NHS secured important funding commitments. Yet funding remains the critical issue across care services with almost four in five trusts ending the first quarter of this financial year in deficit (Monitor, 2015; Trust Development Authority, 2015). Faced with funding that is not keeping pace with cost, care services are under significant pressure.

Now is an opportune moment to step back and consider the quality of care provided to patients, service users and the public. This analysis from QualityWatch, a joint research programme from the Nuffield Trust and the Health Foundation, aims to add to the picture by considering a central question: is the quality of care getting better or worse?

Our aim is to help policy-makers, healthcare leaders, patient groups and others make sense of quality across health and social care, primarily in England. Drawing on analysis of over 300 indicators of care quality – from waiting times to staffing levels – and several in-depth studies, we track how health and social care services are managing at a time of huge change. Our programme looks at national-level, year-on-year changes and tries to place them in a wider long-term context, so that we can better understand which areas are performing well and which need attention. This enables our analysis to look beyond short-term spikes in performance, particularly when it comes to high-profile waiting time targets that attract so much attention.

Each year we publish an annual assessment of the quality of care provided in England. In our first year (2013) we found that the historic gains made by the NHS throughout the 2000s were, on the whole, being maintained, although problems were beginning to emerge in urgent care services. Last year (2014) our assessment raised concerns: while we acknowledged that things were still better than a decade ago, we pointed to a marked deterioration in many measures of access, raised questions about the quality of mental health services, and noted worsening conditions for NHS and social care staff.

Our focus in 2015

Describing the quality of services across all of health and social care is a complex task. In producing this year's statement we have drawn on a range of information sources to identify an admittedly limited, but priority, set of areas for consideration. Therefore, our annual statement this year focuses on three important areas of concern: (1) how easily patients can access care; (2) how engaged and motivated the workforce is; and (3) how well we look after the health of children and young people. Our view is informed by the ongoing analysis we undertake throughout the year, including of the many indicators we are regularly tracking as well as help from a number of national experts.

The analysis provided in this report situates the performance of the health system in 2015 in the wider context of progress made over the last decade. Our key findings are the following.

Access to care

Measures of access to services are declining, and continuing a trend that we reported in 2014. For example, people are spending longer in Accident & Emergency (A&E) and experiencing delays to planned treatment. This is likely to lead to worse outcomes and poorer experience in many services. The decline has been consistent over several years, and there is no reason to expect that services will in future hold to the level of performance that they deliver today. Yet the public is clear that better access is expected.

Mental health and ambulance services appear consistently throughout the themes we highlight this year – both in terms of growing waiting times and workforce issues (see below). The ambulance service is under significant strain, with falling performance on its eight-minute targets and high turnover. Yet the ability to rely on a prompt emergency response when needed is critical in terms of public expectations of the health service.

Though there is less information about quality in mental health services, we can see problem areas, especially around access to services. In last year's report we highlighted the disparities in waiting times between people waiting for planned treatment for physical and for mental health care. Provisional figures analysed for this report suggest this gap has widened yet further. Looking at emergency hospital care, our own study on disparity in physical health service use for people with mental ill health (Dorning and others, 2015b) found that people with mental ill health use much more emergency hospital care than those without. While the area received a substantial amount of policy attention in 2015, it is too early to see whether that will translate into improvement.

Staff and working environment

There are a number of indications that staff in both the NHS and social care services appear to face pressures that lead to work-related stress and high vacancy rates. Proxy measures for staff wellbeing (complaints and reports of bullying) have risen since 2010. Many organisations are relying increasingly on contract and agency staff to fill the gaps, despite policy moves to reduce reliance on these. On top of this, providers are being required to address a range of new priorities including plans for seven-day services. Given the relationship between engaged staff and good-quality care, there is a substantial risk that the current staffing situation in both health and social care may be reducing the quality of care received by people who use services.

Child health

It is well established that events in early life affect health and wellbeing later in life, with associated increased care needs (Wanless, 2002). There are some positive signs – for example, the rate of unplanned hospital admissions for long-term conditions in children is steady, and broader societal trends (in which health services play a part) are reducing the potential harm to which young people are exposed. However, three issues remain:

1. While it is good practice that children and young people receive care separately from adults, it is not always the case that the services are of the equivalent quality. For example, when it comes to diabetes there is a discrepancy between the completeness of the care received by adults compared with children – this should be examined further.

2. The need for more appropriate support for children and young people with mental illness remains a key issue. Waiting times for outpatient children and adolescent mental health services (CAMHS) have increased, and young people and their parents have described "battles" to get access to this vital service. Major problems have also been reported with access to inpatient mental health services for children and young people.

3. The problem of obesity in childhood continues to cause concern. There is a consistent upward trend in the proportion of children aged 10–11 classed as obese, while the proportion of children eating the recommended five portions of fruit or vegetables every day and who have at least an hour of moderate intensity activity a day is falling.

The essence of these three challenges is prevention: care services stand to save a large amount of money in the future by investing a relatively small amount now, not to mention vastly improving quality of life for many people. However, with constrained funding and pressing immediate problems, it is not always easy to take a long-term view.

Data gaps

The NHS still lacks vital information to provide a full picture of the quality of its services. This impairs its ability to plan properly, which will make it even harder for it to achieve the £22 billion in efficiency savings it has been tasked with achieving by 2020/21. Improving the visibility of quality is crucial, as sustained financial constraint brings the debate of quality versus cost more to the fore than it has been for some time. Financial performance is relatively easy to measure, so it is vital that care services have access to comprehensive quality information to match. If they do not, the lessons of the Francis Report may be forgotten.

Conclusions

In considering whether the quality of care for patients, service users and the public is getting better or worse, this report presents an independent view of how patterns of quality have changed over time. It draws three main conclusions:

1. Care services are improving in many markers of quality. We are seeing sustained improvements in the prevention of harm to children; reductions in unplanned admissions for children and young people with chronic conditions; and high vaccination and screening rates. In addition, there have been continued improvements in both the measuring and delivery of safety in hospital settings.

2. However, there are clear signals that performance in many areas is declining, and it seems that the NHS has been unable to reverse the trends of deteriorating access to hospital, mental health and social care services we identified in last year's report. Some key waiting times have deteriorated back to the levels of performance that were being achieved in the late 2000s. Even more concerning is that access to some services now appears to be on a consistent downward trend. Policy interventions that have tried to improve the situation have had limited success. The question is not whether we should accept today's levels of access as the 'new normal', but how much further access might decline by 2020. There is no reason to expect that services will in future hold to the level of performance that they deliver today.

3. Given the relationship between engaged staff and good-quality care, there is a substantial risk that the current staffing situation in both health and social care may be reducing the quality of care received by patients and service users. There are worrying indications of stress, high vacancy rates and increases in instances of bullying, which should be of major concern to managers and policy-makers.

1

Introduction

The last year has been a momentous one for the NHS. The health service has seldom been out of the news, and in October 2014 NHS England published its *Five Year Forward View* (NHS England and others, 2014), which sets out a radical vision of how the NHS will use different approaches to adapt to deliver care in England in the future. This was followed by a long campaign for the UK General Election, in which the NHS was one of the key battlegrounds (Ipsos MORI, 2015).

Funding remains a critical issue across health and care services. Although the NHS was able to secure a commitment to maintaining spending as flat real per person during the election campaign (worth £8 billion a year in real terms in England by 2020/21), NHS England's own analysis suggests that this must be accompanied by £22 billion in efficiency savings just to maintain the current quality and range of NHS services. Political leaders have been explicit that the NHS is expected to deliver this before any further funding increases (Hunt, 2015a), especially at a time when the budgets of other government departments are being cut. Some of these cuts impact on services that are intertwined with the NHS – for example, social care and aspects of public health – potentially placing further calls on the NHS budget.

This situation is complicated by a continuing rise in the demand for health and social care services, driven partly by changes in the health needs of the population but also by changing expectations of what services can and should deliver. These factors – organisational change, constrained funding and rising demand – present significant risks for quality of care. There is a real danger that the only way to deliver financial or political imperatives is seen as cutting quality: saving money through reducing access, staffing or changing the way that services are delivered. This report presents an independent view of how patterns of quality have changed over time.

Putting quality into context

The QualityWatch programme was established in 2012 to provide authoritative and independent analysis of the ways in which the quality of health and social care in England is changing over time. It looks at national-level, year-on-year changes and tries to place them in a wider context, so we can better understand which areas are performing well and which need attention. The programme aims to highlight where there are clear and compelling gaps between existing standards of care and what is possible, and to help develop the way that quality of care is measured.

Quality of care is a complex, multidimensional concept and can be viewed through many different lenses. The QualityWatch team uses an extensive range of indicators to assess the quality of health and social care services in England. This range of indicators continues to develop over time to provide an increasingly broad assessment of quality (see www.qualitywatch.org.uk/indicators).

To supplement these indicators, we also carry out a number of in-depth analyses into specific topics in health and social care, using a range of methods (see www. qualitywatch.org.uk/focus-on). The topics chosen so far have reflected the programme's desire to:

- add something new to high-profile debates, such as the time spent in Accident & Emergency (Blunt, 2014)

- highlight gaps in care – for example, our work on international comparisons (Kossarova and others, 2015)

- improve the quality of measurement (Dorning and Bardsley, 2014; Smith and others, 2015).

Each year we compile our analysis into a summary document. Our first Annual Statement, *Is The Quality of Care in England Getting Better?* (QualityWatch, 2013) found that the historic gains made by the NHS throughout the 2000s were, on the whole, being maintained, although problems were beginning to emerge in urgent care services. Our second Annual Statement, *Cause for Concern* (QualityWatch, 2014), highlighted a marked deterioration in many measures of access to care, raised questions about the quality of mental health services, and noted worsening conditions for staff in the NHS and social care. Both statements also point out the lack of progress that the NHS has made in reducing health inequalities.

Patterns of quality in 2015

The central question for the QualityWatch programme is very simple: is the quality of health and social care getting better or worse? In this statement we have selected a limited number of key themes to summarise what we have found over the past year. We have deliberately sought to identify a limited set of summary points for discussion, rather than to review all aspects of quality. Our intention is to highlight some key issues where there is a distinctive pattern of change, which may be for the worse (suggesting that more immediate action is required), or for the better (indicating success for the health and care services).

Despite the simplicity of the above question, describing the quality of services across all of health and social care is a complex task. In producing this summary we have drawn on a range of sources of information, including more than 300 indicators on the QualityWatch website, our own in-depth studies and the very many reports produced about the NHS and social care services by other organisations. These were brought together and analysed with the help of a number of national experts.
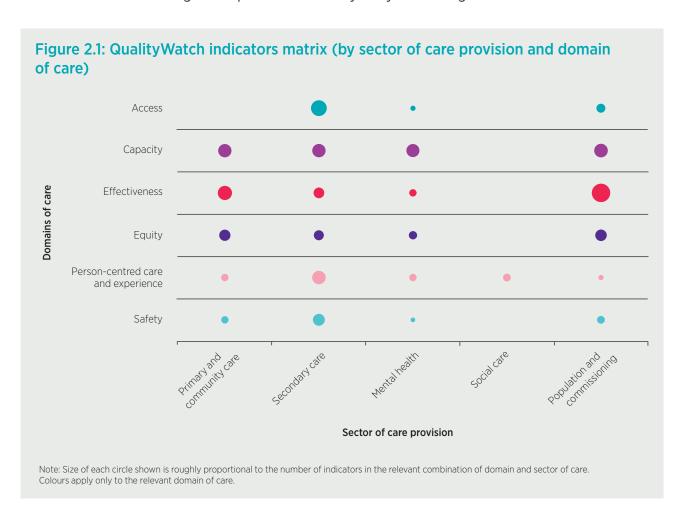
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Understanding quality

There are many challenges for anyone wishing to formulate some shared measure of the 'quality' of care services. Many different factors have to be considered, many of which will be subjective and can mean different things to different people. Some may even involve conflicting perspectives, including those of professionals, care users, their friends and relatives. The quality of care will vary between and within organisations, services and even from event to event. Moreover, the outcome of better quality care may not be immediately visible – for example, in the implementation of appropriate preventive care. Most sets of indicators give only selected slices of reality (Pencheon, 2008). Yet the importance of maintaining and improving the quality of health and care services is so fundamental that it is essential that we continue to describe trends in quality as best we can.

Measuring quality

Given these challenges, the QualityWatch programme draws on the large library of existing quality indicators available for the NHS and adult social care services in England to present a summary analysis of change over time. There have been

Figure 2.1: QualityWatch indicators matrix (by sector of care provision and domain of care)

Note: Size of each circle shown is roughly proportional to the number of indicators in the relevant combination of domain and sector of care.
Colours apply only to the relevant domain of care.

many different ways of defining and categorising elements of quality of care. We have chosen the framework used by Leatherman and Sutherland (2008) 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 with which to describe quality. This is described in Figure 2.1.

Which aspects of quality matter most?

The QualityWatch indicators provided a pragmatic list of measures, but we were conscious that the list would benefit from a broader view of the relative value of the indicators – specifically, the differing perspectives of clinicians, managers and service users. In 2014 we began a study to gather these views.

Our study (Dorning and others, 2015a) found that there were no appreciable differences in what was important to people between the domains, although statements relating to safety did score particularly highly. This suggests that using a wide range of indicators is a good approach for covering the 'many things to many people' nature of quality.

The impact of gaps in our information

We know that we have much more information in some areas than others. For example, we are well served for measures of acute services, yet know very little about social care or community services. This in itself can distort our view of quality, in that we can only report what is known. In this way, highlighting gaps in information (with the aim of encouraging new data collection) is just as important as highlighting areas where quality is known to be good or bad.

Existing measures tend to reflect the particular priorities of the time that they were created (Pfleuger, 2015). That could mean that, by basing our partial view of quality on what is already available, we are implicitly restricted to looking at areas where there is more likely to have been progress. This does not mean the quality measures we use are 'wrong', but that we must remember to ask the question: 'What other themes might our programme have highlighted if we had better information?'

Changing information needs

The value of good information to quality management has been recognised for a long time (Griffiths, 1983), yet the NHS still struggles to maintain good data on the services that it provides (House of Commons Health Select Committee, 2013). Of most concern are the services where national data simply do not exist, and there have been many efforts to improve the quality of information in these 'dark' services (Dorning and Bardsley, 2014; National Information Board, 2014). Without this information the NHS cannot plan its services effectively, and this will have a substantial impact on its ability to realise the required £22 billion efficiency savings by 2020/21.

Measuring quality in health and care services is a complex task. We believe that it is best done by using a wide range of information, and a consensus study has confirmed the importance of this multidimensional view. Lack of information can distort our view of quality, and the likely future configuration of care services means that the NHS will need to fundamentally change its approach to data collection.

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Findings

Our annual statement focuses on three areas that emerged from our analysis as important areas of concern: (1) how easily patients can access healthcare; (2) how engaged and motivated the workforce is; and (3) how well we look after the health needs of children and young people. Our view is informed by the ongoing analysis we undertake throughout the year, including of the many indicators we are regularly tracking. The analysis provided situates the performance of the health system in 2015 in the wider context of progress made over the last decade. This section presents our key findings.

Access

As highlighted by last year's QualityWatch annual statement (QualityWatch, 2014), there is a continuing sensitivity to indicators of timely access to care. Whether in the form of longer time spent in A&E or delayed ambulances, these indicators grab the headlines and strike a chord with politicians and the public. The trend of declining performance for this year is a continuation of what we reported last year (Figure 3.1).
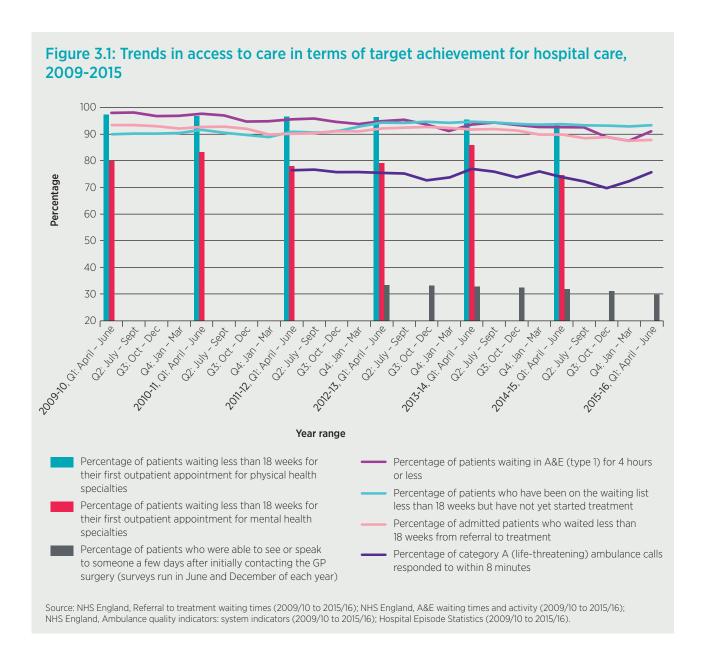
Access to physical health services

The highest-profile access measures tend to be those for people waiting for hospital care. The percentage of patients spending less than four hours in major A&E units fell from 95.6 per cent in 2011/12 Q1 to 91.1 per cent in 2015/16 Q1 (Figure 3.1). This measure has now been well below the overall target of 95 per cent for nearly three years, and reached its lowest value in more than 10 years in 2014/15 Q4 (87.5 per cent) (NHS England, 2015a).

Another measure of access from A&E units is the number of patients who wait more than four hours between the decision to admit and arriving on a ward ('trolley-waits'). Where full financial year data are available, we continue to see the rise in this measure that we highlighted in last year's annual statement. In 2013/14 there were 167,941 patients (3.2 per cent) waiting more than four hours and in 2014/15 there were 304,276 patients (5.5 per cent). This trend also continues on into 2015/16 with the number of patients rising from 48,567 (3.6 per cent) in 2014/15 Q1 to 70,584 patients (5.1 per cent) in 2015/16 Q1 (NHS England, 2015a).

Similarly, the percentage of people waiting less than 18 weeks after a referral for planned inpatient care fell from 91 per cent in 2011/12 (inpatient treatment) to 89 per cent in 2014/15 (NHS England, 2015c) (Figure 3.1). The average (median) waiting time for inpatient treatment has also increased by more than a week (9 days) in this time, from 7.7 weeks in April 2011 to 9 weeks in April 2015. Moreover, all these measures have deteriorated across the majority of providers, indicating that these pressures are universal (Dorning and Blunt, 2015).

There are also questions about access to hospital care for residents of care homes. Our study *Focus On: Hospital admissions from care homes* (Smith and others, 2015) found that older people living in a care home postcode had 40–50 per cent more emergency admissions and A&E attendances than the general population

Figure 3.1: Trends in access to care in terms of target achievement for hospital care, 2009-2015

Percentage of patients waiting less than 18 weeks for their first outpatient appointment for physical health specialties

Percentage of patients waiting less than 18 weeks for their first outpatient appointment for mental health specialties

Percentage of patients who were able to see or speak to someone a few days after initially contacting the GP surgery (surveys run in June and December of each year)

Percentage of patients waiting in A&E (type 1) for 4 hours or less

Percentage of patients who have been on the waiting list less than 18 weeks but have not yet started treatment

Percentage of admitted patients who waited less than 18 weeks from referral to treatment

Percentage of category A (life-threatening) ambulance calls responded to within 8 minutes

Source: NHS England, Referral to treatment waiting times (2009/10 to 2015/16); NHS England, A&E waiting times and activity (2009/10 to 2015/16); NHS England, Ambulance quality indicators: system indicators (2009/10 to 2015/16); Hospital Episode Statistics (2009/10 to 2015/16).

of the same age, but significantly fewer planned admissions and outpatient appointments. We also found that areas containing a care home had a greater proportion of instances where patients had multiple admissions in a relatively short time period. While hospital admission is an ambiguous indicator in this context, it can suggest that care is not being managed as well as it could be.

There is more diversity in the measures used to gauge access to primary care, but many of the access measures in the general practitioner (GP) patient survey have declined (NHS England, 2015d). For example, in 2014/15, 71 per cent of patients reported that they found it easy to get through on the phone, compared with 78 per cent in 2011/12. The percentage of patients seeing their GP on the same or next working day continued to fall to 48 per cent (compared to 51 per cent in 2011/12), and 18 per cent reported waiting more than a week (up 5 per cent since 2011/12).

Over the past two years there has been a steady decline in the proportion of life-threatening emergency calls attended by an ambulance within eight minutes (shown in Figure 3.1). At a national level the 75 per cent standard for both red 1 and

red 2 calls was regularly missed throughout 2013/14 and 2014/15, reaching a low point of just 61 per cent in December 2014 (NHS England, 2015b).

Turning to preventive care, which is measured for the UK as a whole rather than for England specifically, it is well known that the UK has good access to care in this area, reflected by some of the highest rates of cancer screening in the OECD (Kossarova and others, 2015). Nonetheless, there are now concerning signs that screening rates for breast and cervical cancers are falling – caused both by fewer women being invited for screening, and fewer women attending (QualityWatch, 2015a).

Yet it is not the case that access is worsening in all physical health services. For example, there are several indicators around urgent cancer referral which show that performance in this area for England is fluctuating, but remaining broadly steady (QualityWatch, 2015b). Also, the proportion of respondents to the GP patient survey who were able to get an appointment successfully with an NHS dentist has remained steady at around 93 per cent since 2011/12 (QualityWatch, 2015e). The proportion of patients seen by ambulance crews that receive an appropriate care bundle in cases of suspected stroke increased from 94.2 per cent in 2011/12 to 97.1 per cent in 2014/15 (NHS England, 2015b).

Access to mental health services

The established measures of referral-to-treatment times largely exclude activity related to mental ill health. While this is changing (Department of Health, 2014), the relevant data are not yet available. However, we have undertaken specific analysis using the Hospital Episode Statistics database (Health & Social Care Information Centre (HSCIC), 2015c) to calculate equivalent figures, shown in Figure 3.1. This shows that people attending a first outpatient appointment for a mental health specialty continue to wait longer than those attending under a physical health specialty.

We saw some improvement for outpatient waiting times for mental health in 2013/14 compared to earlier trends, where 86 per cent waited less than 18 weeks for a mental health specialty, compared with 96 per cent for physical health. The most recent (provisional) 2014/15 figures suggest that this proportion has now fallen to 75 per cent for mental health, and 94 per cent for physical health. Looking at emergency hospital care, our own study on disparity in physical health service use for people with mental ill health and those without (Dorning and others, 2015b) found that people with mental ill health had five times more emergency hospital admissions and three times more A&E attendances than those without in 2013/14. We also found evidence that people with mental illness are being treated less efficiently by the system. For some common inpatient procedures, people with mental ill health were more likely to have an emergency rather than a planned admission, stay longer in hospital or be admitted overnight.

A review of crisis care for people with mental ill health (Care Quality Commission, 2014a) found that national standards were not being met in a range of areas. Often, people were turned away because services were full, or because they operate policies that exclude young people, the intoxicated or people with disturbed behaviour. Poor supervision by commissioners and a lack of basic information from providers means that there is no way to understand the quality of services.

Even when people are able to access mental health services, accessing evidence-based treatments can be challenging. It is estimated that up to 35,000 adults with a learning disability are prescribed antipsychotic or antidepressant medication

without appropriate clinical justification (Public Health England, 2015). However, it is positive that the Improving Access to Psychological Therapies (IAPT) programme has increased the number of people receiving evidence-based psychological therapies for people with depression and anxiety. It is nearing its target to reach 15 per cent of eligible people, and continues to expand access to these treatments (QualityWatch, 2015d).

Access to social care services

The amount of money that local authorities spend on adult social care fell again in 2014/15 to £17.1 billion, representing an eight per cent real-terms decrease from 2009/10 (HSCIC, 2015i). This reduction in spending is compounded by the increase in the number of people aged over 65 in the population. While current data for the number of people receiving services are not directly comparable to previous years, it is likely that the established pattern of large reductions in the number of people receiving domiciliary and community care services (QualityWatch, 2014) has continued in line with spending reductions. These trends have also been associated with a decrease in satisfaction with services reported by unpaid carers. In 2012/13, 66 per cent of unpaid carers were satisfied with the support that they had received from social services in the last year. In 2014/15 this number fell to 62 per cent (HSCIC, 2015h).

Explaining these trends

The high profile of access measures has led to substantial debate over the last few years regarding the causes of the decline, and there is no single explanation (Blunt and others, 2015). Often, access to services is felt to be particularly sensitive to funding constraints and the impacts of rising demand with constrained or reduced capacity. In addition, issues of flow and system efficiency are being increasingly raised as ways to improve access. This applies to both acute inpatient beds (Nuffield Trust, 2015c), and for inpatient mental health services (Crisp, 2015), where 16 per cent of beds are estimated to be occupied by people who are well enough to be discharged but are waiting for other services such as appropriate housing. The importance of maintaining the right flow through services is seen in how the availability of social care options – care home beds or local authority intermediate care facilities – appear linked to shorter hospital stays (Kasteridis and others, 2015).

This implies that there should be a change of emphasis away from increasing the volume of services delivered, and towards adjusting the way in which they are delivered. One example of this being applied is the success of Regional Major Trauma Networks, which have been associated with a 50 per cent increase in the odds of survival for trauma patients since they were set up three years ago (NHS England, 2015e; Trauma Audit Research Network, 2015). This is echoed in the hope that the new emergency care vanguard pilot sites will be able to improve urgent care performance by breaking down the barriers between primary care and hospitals (NHS England, 2015e).

In addition, ambulance services are continuing to adapt to new ways of delivering care. The percentage of cases dealt with through telephone advice or 'see and treat' continues to rise. While ambulance services bear a higher share of risk in these situations than if they had transported to A&E, there has been little change in the rates of patients treated who re-contact the ambulance service within seven days (NHS England, 2015b). This suggests that these cases have been dealt with appropriately.

Implications of waiting longer for care

One response to declining levels of access has been to question the significance of some of these targets, and to ask whether they really reflect the quality of services. Underneath, the observed rise in waiting times for planned treatment is likely to be due to a large number of people waiting slightly longer for treatment (NHS England, 2015c). Although such a situation is not desirable, it is hard to argue that this has had a significant impact on the quality of care that most individuals receive. However, there are other instances where such differences are more important. For example, it is well established that waiting longer to conclude care in an A&E unit is associated with worse outcomes, including increased mortality (Carter and others, 2014). The lack of availability of mental health inpatient beds leads to more out-of-area placements, which are associated with an increased risk of suicide (Appleby and others, 2015). The number of suicides for people discharged from non-local wards increased from 6 per cent between 2003 and 2007 to 11 per cent between 2008 and 2012, although this may reflect increasing numbers of non-local admissions.

Policy responses

Policy interventions on key performance measures in England seem to have done little to stem the decline. In August 2014, the secretary of state suspended the 18-week referral-to-treatment target, with the intention of allowing acute trusts the space to address the small number of people who had been on the waiting list for more than 52 weeks – which was 1,073 at the time of the announcement. Despite these efforts, the number of people waiting more than 52 weeks for treatment in May 2015 was 915 (NHS England, 2015c). The Department of Health supplied £700 million in additional funding to ease winter pressures in the urgent care system, but whether this was spent effectively is a matter of some debate (Nuffield Trust, 2015c), and performance against the four-hour target reached its lowest level in more than 10 years (NHS England, 2015a).

The other nations of the UK are grappling with similar issues. The challenge of meeting established performance standards for ambulances has resulted in changes to the definition of targets in both England and Wales. In February, NHS England announced a pilot scheme in two trusts to give call handlers more time to assess calls before triggering an ambulance. This was in response to fears that pressure to meet the eight-minute target had resulted in ambulances being sent to calls before the problem had been determined (Willett, 2015).

In July, the Welsh Government announced that response-time targets for all but the most serious calls were to be replaced by a one-year pilot, in which performance for less urgent incidents will be assessed by clinical outcomes (Welsh Government, 2015). However, Scottish A&E departments recently met their four-hour target for the first time (ISD Scotland, 2015).

In summary, performance on measures of access to services is continuing to decline. While some are tempted to limit expectations of what care can be delivered in the current financial situation, this will have a real quality impact in many services. Another argument against accepting current levels of access as 'the new normal' is that the decline has been consistent over several years: there is no reason to expect that services will hold to the level of performance that they deliver today.

If the new models of care set out in the *Five Year Forward View* are not successful, it looks likely that levels of access will continue to fall. Yet the public is clear that more access is expected, not less. A recent survey found that two-thirds of people thought it was important that GPs and hospitals offer a full seven-day service (Jordan, 2015).

Staff and working environment

Approximately 1.4 million people work in the NHS in England. Added to this, a further 1.6 million work in the social care sector, and the combined total represents around one-tenth of the working population (Imison, 2015). The levels of available staff and the environment in which they work remain an important concern for quality. Last year we highlighted the proportion of staff reporting that they were made to feel unwell by work stress, which shows no signs of decreasing this year (NHS England, 2015f).
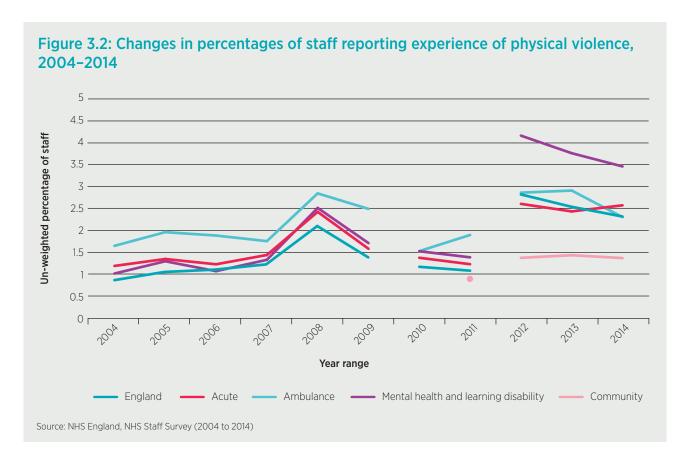
Staff engagement and wellbeing

The vast majority of care is mediated in some way through a staff member, and dissatisfaction is known to be associated with poorer outcomes for patients and service users (NHS England, 2014; Raleigh and others, 2009). Dissatisfaction can be indicated by increased levels of absence, bullying and complaints.

The percentage of staff reporting that they felt satisfied with the quality of work and patient care that they are able to deliver was broadly unchanged from 77 per cent in 2012 to 76 per cent in 2014, and the percentage reporting good communications with senior management rose from 28 per cent in 2012 to 34 per cent in 2014.

Nonetheless, there are still areas of concern. Last year we reported that in 2012 and 2013 the percentage of NHS staff reporting that they had been ill due to work-related stress was at its highest since the survey began at 38 per cent, and it remained at this level in 2014, with no signs of reducing. Also, ambulance trusts score consistently lower on the NHS Staff Survey than other types of NHS trust (NHS England, 2015f). For example, in 2014 only 73 per cent of staff working in ambulance trusts felt satisfied with the quality of work and patient care that they are able to deliver, compared with an NHS average of 76 per cent; and only 86 per cent agreed that their role makes a difference to patients, compared with 89 per cent.

In many ways, these poorer results are not surprising. Paramedic services are delivered in stressful situations, so we might expect reported illness due to work-related stress to be higher (49 per cent compared with an NHS average of 38 per cent in 2014). If it were possible to isolate responses from staff working in A&E departments, we probably would observe the same effect. Yet ambulance trusts also score poorly for aspects that should be under the control of management: for example, with only 59 per cent reporting that they would feel secure in raising concerns about unsafe clinical practice (NHS average 70 per cent), and just 17 per cent of staff reporting good communication with senior management (NHS average 34 per cent). This indicates significant dissatisfaction from staff working in ambulance trusts.

Negative work environments can result in conflict between staff. Around one quarter of NHS staff (22 per cent) reported having experienced harassment, bullying or abuse from their managers or other colleagues (NHS England, 2015f).

Figure 3.2: Changes in percentages of staff reporting experience of physical violence, 2004–2014

Source: NHS England, NHS Staff Survey (2004 to 2014)

This has increased from 14 per cent in 2010, despite the focus on changing NHS culture since the publication of the Francis Report in 2013. While the proportion of staff who experience physical violence from their colleagues is low (2.3 per cent in 2014; see Figure 3.2), this still equates to nearly 25,000 people, and is higher than the national average of 1.1 per cent (Health and Safety Executive, 2014).
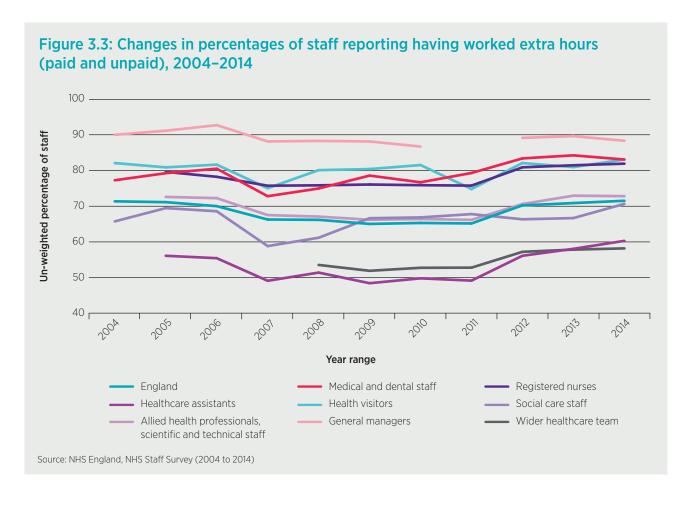
Levels of sickness absence are indeed higher in the NHS and social care than private sector and other public sector organisations (Office for National Statistics, 2015b). However, there are many possible explanations for this, including increased exposure to communicable disease. Also, the rate of sickness absence has not changed notably over time. In December 2010, 5 per cent of days were taken as sickness absence, while in December 2014 the figure was 4.8 per cent (HSCIC, 2015f). Absence rates over the last four years are consistently higher in staff working for the ambulance and mental health trusts.

When looking at absence rates across staff groups and pay banding, what is most striking is the relationship between skill level and sickness. The lower the pay band of the employee, the higher the rate of sickness absence – with those in Bands 1 and 2 having an average of 22 days off a year, compared with Band 9 employees taking an average of 4.3 days (Bhatia, 2015). This difference could be explained by the lower job control experienced by staff in Bands 1 and 2, which has been associated with higher rates of coronary heart disease (Bosma and others, 1997) and could be a reflection of the need for a more supportive team culture and management in the NHS.

We do note that the total number of written complaints about hospital and community health services has increased by 24 per cent from 97,500 in 2010/11 to 121,000 in 2014/15, which includes a notable increase in complaints relating to

administrative staff and delays and/or cancellation (HSCIC, 2015a). The increase in complaints is of concern, as it is widely recognised that formal written complaints are only the tip of an iceberg of dissatisfaction that service users may feel. However, despite this increase, the proportion of upheld complaints has remained around 50 per cent over the past five years.

More than two thirds of NHS staff (71 per cent) report working extra hours unpaid (NHS England, 2015f). Those most likely to work extra hours are general managers, health visitors, medical/dental staff and registered nurses (see Figure 3.3). The use of 12-hour nursing shifts is much higher in England (33 per cent) than most other countries in the European Union (15 per cent) (Griffiths and others, 2014), and long shifts can be predictive of low quality of care and work being left undone.

Figure 3.3: Changes in percentages of staff reporting having worked extra hours (paid and unpaid), 2004–2014

Source: NHS England, NHS Staff Survey (2004 to 2014)

Vacancy rates and turnover

Many health and social care organisations are reporting that they struggle to recruit and retain staff (Nuffield Trust, 2015a). Poor terms and conditions, coupled with demanding yet sensitive tasks, make social care a difficult area for retaining staff (Centre for Workforce Intelligence, 2013). In the acute sector, moves to mandate minimum safe staffing levels in certain areas following the Francis Inquiry (NICE, 2015), and policies intended to increase seven-day working in the NHS (Hunt, 2015b), have extenuated the issue.

The number of frontline staff leaving ambulance services across nine ambulance trusts in England increased by 95 per cent, from 626 in 2010/11 to 1,223 in 2014/15

(Barnes, 2015). It is not known whether these staff members moved to another ambulance trust, a different care sector or left the NHS entirely. In domiciliary care, around 31 per cent of staff leave their jobs each year (Skills for Care, 2014), and a recent report on care for people with dementia noted that turnover in the long-term care sector is known to undermine care standards (Knapp and others, 2014).

This situation has led to notable vacancy rates. Examples include 10 per cent of the total paramedic workforce estimated to be vacancies in 2014 (Migration Advisory Committee, 2015); one in 10 training places in general practice going unfilled (Dayan and others, 2014); and 8 per cent of organisations having between 100 and 250 full-time equivalent (FTE) nurse vacancies (Health Education England, 2014). These compare with a vacancy rate of 2.8 per cent across all health and social work activities in the UK, and 1.4 per cent for the rest of the public sector (Office for National Statistics, 2015b). Figures published on the NHS Choices website showed that all 135 acute trusts that report staffing data failed to hit their target for nurses working during the day in at least one hospital in April 2015, compared to 86 per cent in 2014 per cent last year (Lintern, 2015b).

Use of contract and agency staff

Many organisations are relying increasingly on contract and agency staff to fill the gaps, indicated by the 20 per cent growth in spending on temporary staff between 2011/12 and 2012/13 (Lafond and others, 2014). This trend continued into 2014/15, with spending on contract and agency staff increasing to £3.3 billion – around 7 per cent of all NHS staff costs (Nuffield Trust, 2015b). In the first three months of 2015/16, provider trusts spent £895 million on agency and contract staff (NHS trusts £380 million (Trust Development Authority, 2015); foundation trusts £515 million (Monitor, 2015)). The increased costs associated with temporary staff, and the suggested quality implications (Lintern, 2015a), mean that many services find themselves trapped in a vicious circle (Hunt, 2015a).

While boosting recruitment may seem a necessity, the current financial situation makes this extremely difficult. A recent letter from Monitor to NHS trusts urged them to fill only essential vacancies, because current financial plans are "unaffordable" (Bennett, 2015), and social care providers have warned that plans to increase pay in the sector could make care unaffordable for local authorities (Care England, 2015).

In summary, people working in health and social care services appear to be struggling with stress and there are high vacancy rates. Despite policy moves to reduce a reliance on contract and agency staff, current financial constraints have severely limited the options available to the NHS and social care services. While they are noble endeavours, other policies such as minimum staffing levels, seven-day working and a national living wage make it even harder for managers to address the situation.

High turnover and vacancies might be associated with staff feeling increasingly disengaged; responses to pay deal negotiation (following five years of pay restraint) and recent debates about seven-day working in the NHS appear to indicate that the workforce feels undervalued. However, the lack of change (or even improvement) in common measures of staff engagement (absence rates, reported satisfaction) suggest that this is not a simple picture. Other proxy measures for staff engagement (complaints and reports of bullying) have risen since 2010. Given the relationship between staff satisfaction and quality of care, it is likely that the current staffing situation – in both health and social care – is reducing quality.

Child health

The role of the NHS in maintaining and improving children's health has always been important. It is well established that events in early life affect health and wellbeing later in life, with associated increased care needs (Wanless, 2002). Prevention and intervention in the early years is believed to produce significant future cost savings, which means that investing in services that improve the health of children and young people has the potential to deliver long-term social and economic benefits to the nation (Davies, 2013).

Infant mortality has fallen consistently over time in the UK, and is comparable with other OECD countries (Kossarova and others, 2015). However, the UK rate is double that achieved by Sweden, which suggests that the UK can still do more to improve child health.

Health-related behaviours

There have been some recent reviews of child health outcomes. A review by the Children and Young People's Health Outcomes Forum (Lewis and others, 2015a, 2015b) found that England generally was performing well on preventive measures for children and young people. Examples of harm reduction from this and other reports include:

- the rate of under-16s killed or seriously injured in road traffic accidents fell from 28 per 1,000 in 2008 to under 20 per 1,000 in 2012 (Lewis and others, 2015a)

- fewer women are smoking during their pregnancy (15.1 per cent in 2006/07, compared to 11.4 per cent in 2014/15) (QualityWatch, 2015g), and alongside this there has been a much larger reduction in babies born at low weight than has been seen in most other OECD countries (QualityWatch, 2015h)

- the rate of teenage conception is falling (from 47 per 1,000 population in 1998 to 24 in 2013) (Office for National Statistics, 2015a)

- vaccination rates have significantly improved – the UK rate for diphtheria, tetanus and pertussis (DTP) vaccination was 92 per cent in 2008 and 96 per cent in 2013, while the measles vaccination rate increased from 86 per cent to 95 per cent over the same period. However, other OECD countries have achieved even higher rates (Kossarova and others, 2015).

There are positive signs for the prevention of harm in the general population of children and young people. The proportion of young people engaging in risky or harmful behaviours appears to be falling. In 2003, the percentage of children aged 11–15 which reported ever having had an alcoholic drink was 61 per cent. Since then the figures have fallen steadily to 39 per cent in 2013 (HSCIC, 2015b). In 2003, 9 per cent of children aged 11–15 were regular smokers. This fell to 3 per cent in 2013 (HSCIC, 2015b). While the degree to which this success can be attributed to the health system is unclear, it should help reduce future costs to the health service.
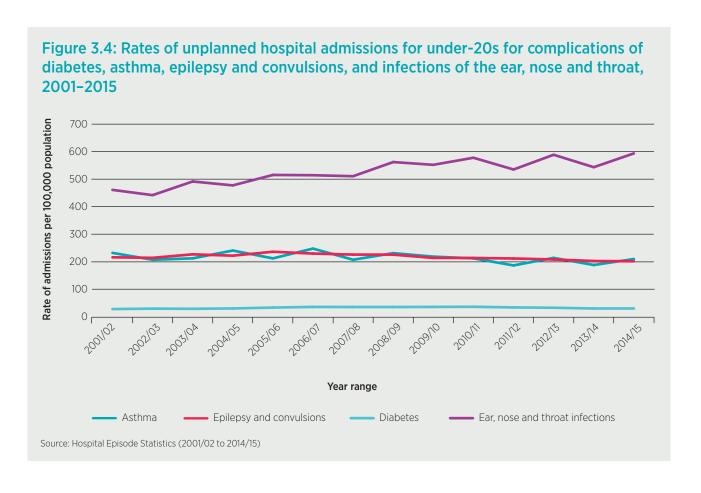
However, these gains may be offset by other trends. The National Child Measurement Programme monitors trends in obesity by measuring the weight and height of primary school pupils. Between 2006/07 and 2013/14 the programme found a consistent upward trend in the proportion of children aged 10–11 classed as obese, from 17.5 per cent to 19.1 per cent (HSCIC, 2015d). This can be explained in terms of both diet and exercise. Less than one fifth of children (17 per cent in 2013) eat the recommended five portions of fruit or vegetables

every day, and the number has been declining since a peak of 21 per cent in 2009. Similarly, the proportion of children who have at least an hour of moderate intensity activity a day fell from 24 per cent in 2008 to just 18 per cent in 2012, the latest year for which data are available (HSCIC, 2014a; Roberts, 2014). If these trends continue, they will make the future challenge of maintaining a high-quality health service in the face of a growing and ageing population even harder.

Long-term conditions

Fortunately, the majority of children will progress to adulthood having needed to use the NHS only occasionally. However, the many children in England living with a long-term condition will be much more exposed to care services. Harm from long-term conditions can also be limited if the conditions are well managed. A commonly used measure of this is the rate of unplanned admissions to hospital for conditions which can normally be managed in primary care, and this is represented in the NHS Outcomes Framework by the combined rate of admissions for diabetes, asthma, and epilepsy and convulsions in people under 19. While fluctuating, this rate has been falling. In 2003/04 it was 345.9 per 100,000 and in 2013/14 it was 313.4, a decrease of 9.4 per cent (HSCIC, 2015e).

Figure 3.4 shows the rates of unplanned admissions for the three conditions separately for the under-20s, as well as ear, nose and throat (ENT) infections, using definitions from a previous QualityWatch report (Blunt, 2013), and with the most recent year of data (2014/15). The trend suggested by the combined indicator appears to have continued, with most of the gains coming from a reduction in admissions from epilepsy and convulsions (228 per 100,000 in 2003/04 to 202 in 2014/15). Admissions for complications of diabetes have actually increased

Figure 3.4: Rates of unplanned hospital admissions for under-20s for complications of diabetes, asthma, epilepsy and convulsions, and infections of the ear, nose and throat, 2001–2015

Source: Hospital Episode Statistics (2001/02 to 2014/15)

very slightly (30 to 31 per 100,000). Annual fluctuations in the rates of unplanned admission for asthma can obscure the trend, but overall they appear to be falling, from a peak of 248 per 100,000 people under 20 in 2006/07 to 211 in 2014/15.

While this is a positive sign, it is worth asking whether more can be done. The National Review of Asthma Deaths (Royal College of Physicians, 2014) noted that poor recognition of the risks posed by the condition was an important avoidable factor in 79 per cent of the asthma-related deaths of children and young people receiving primary care. This led to the creation of the National Asthma Audit, which, over time, should provide much better information on the quality of asthma management in children and young people.

Success in controlling unplanned hospital admissions for chronic conditions is put into perspective by comparison to the rates of admission for ENT infections (Figure 3.4). These conditions which usually can be managed in primary care, but have not been the focus of policy attention in same way as long-term conditions. Rates of admission have risen from 492 per 100,000 in 2003/04 to 594 per 100,000 in 2014/15, and a similar trend is observed in the NHS Outcomes Framework indicator of emergency admissions for lower respiratory tract infections. This suggests that the management of acute illness in children and young people requires the same level of attention as chronic conditions received in the 2000s, if admission rates are to be brought under control.

Workforce for children and young people

Many of these issues relate to care outside of hospital. While the number of FTE medical staff employed purely in child-focused specialties rose from 7,200 in 2004 to 9,600 in 2014 – in line with an increase in the general medical workforce (HSCIC, 2015b) – the number of paediatric doctors working exclusively in the community fell by 5 per cent, from 1,215 in 2011 to 1,149 in 2013 (QualityWatch, 2015f; Royal College of Paediatrics and Child Health, 2013).

Some other community posts have increased, such as health visitors (8,175 FTEs in March 2010 to 11,495 in March 2015), but others have not, such as school nurses (1,146 FTEs to 1,168) (HSCIC, 2015h). Yet even posts that have increased may now be under threat, as the Department of Health has said it will be "open" to local authorities to make financial savings from health visitor budgets when a total of £200 million public health cuts are delivered to councils early next year, as long as they meet their statutory duties (Merrifield, 2015).

The majority of interactions that the NHS has with children and young people will be through primary care. However, aside from vaccination rates, we know relatively little about the quality of the care that they receive. The Quality and Outcomes Framework measures typically do not cover children, and although frameworks of child health indicators do exist (Kavanagh and others, 2009), very few of the measures are consistently reported at national level.

Child and adolescent mental health services

A recent review of crisis services for people with mental illness (Care Quality Commission, 2014a) found that some services operate policies which actively exclude young people, leaving police custody suites their only option for a place of safety. In general there is a lack of quality information around mental health services – an issue which was highlighted in last year's QualityWatch annual statement (QualityWatch, 2014). This issue is particularly acute with regards to CAMHS.

A report by the House of Commons Health Committee (2014) found serious and deeply ingrained problems with the whole system of children and adolescent mental health services, from prevention and early intervention through to inpatient services, and described the lack of information as "operating in a fog" (House of Commons Health Committee, 2014, p. 3). Waiting times for outpatient CAMHS have increased, and young people and their parents have described "battles" to get access to CAMHS. The Committee found "major problems" (House of Commons Health Committee, 2014, p. 5) with access to inpatient services, with children's and young people's safety being compromised while they wait for a bed to become available.

Another issue that the Committee noted was a lack of funding for early intervention services. This is a clear example of the challenges that care services are currently facing to maintain preventive programmes within their financial constraints. Yet these programmes can prevent a range of short-term and lifetime costs, not only in healthcare but also in education, criminal justice and quality of life for children and their carers (Davies, 2013).
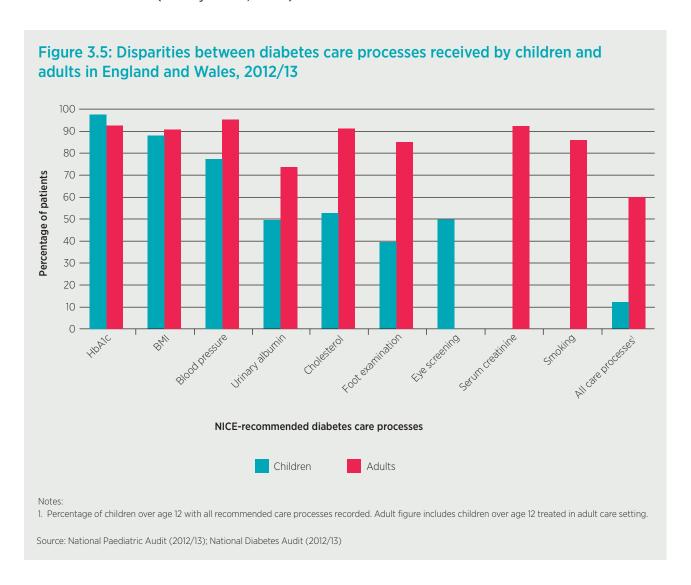
It seems that parity and integration between physical health and mental health services for children and young people is a continuing issue. When parents of children receiving inpatient treatment were surveyed about whether the ward that their child had stayed on had the appropriate equipment and adaptations that their child needed, only 68 per cent of those with children with a mental health condition or learning disability said that it did, compared with 81 per cent of parents and carers whose children did not have these needs (Care Quality Commission, 2015b). Similarly, only 48 per cent of those with children with a mental health condition or learning disability felt that staff definitely knew how to care for their child's individual or additional needs, whereas this figure rose to 72 per cent for parents whose children did not have these additional needs.

The Royal College of Paediatrics and Child Health workforce census found that there had been a reduction in the proportion of services having regular educational meetings with CAMHS, and that all forms of joint working regarding CAMHS had decreased (Royal College of Paediatrics and Child Health, 2013). The House of Commons Health Select Committee (2014) also noted that many local authorities were not taking the opportunity to integrate with CAMHS and, in a time of financial constraint, they did not see CAMHS early intervention services as "core business" (2014, p. 3).

Disparities with care for adults

While it is good practice that children and young people receive care separately from adults, it is not always the case that the services are equivalent. For example, the National Institute for Health and Care Excellence (NICE) recommends that children aged 12 and older who have diabetes receive seven specific care processes. Adherence to this is measured by the National Paediatric Diabetes Audit (Royal College of Paediatrics and Child Health, 2015), which has found that the percentage of children cared for in paediatric diabetes units (PDUs) (total of 25,221 children under the age of 25) having the relevant measures checked, eyes screened and feet examined has been increasing over time in England and Wales. However, in 2012/13 only 12 per cent of children received all seven processes (see Figure 3.5). The equivalent audit for adults (HSCIC, 2014b) found that 60 per cent of adults received all their recommended care processes. The adult diabetes audit

also includes children treated in adult care settings, with almost as many children as there are children treated in PDUs (22,753 children aged 0-19). Analysis in the adult audit by age groups showed that children with type 1 diabetes were less likely to receive all the recommended care processes (ages 0-9 and 10-19 with 28.6 per cent and 13.9 per cent respectively) than the older age groups (e.g. ages 70-79 with 60.8 per cent). The discrepancy between the completeness of the care received by adults and children with diabetes should be examined further (QualityWatch, 2015c).

Figure 3.5: Disparities between diabetes care processes received by children and adults in England and Wales, 2012/13

Notes:
1. Percentage of children over age 12 with all recommended care processes recorded. Adult figure includes children over age 12 treated in adult care setting.

Source: National Paediatric Audit (2012/13); National Diabetes Audit (2012/13)

The Care Quality Commission's children and young people's inpatient survey found that 43 per cent of 12-15 year-olds felt that they were not fully involved in decisions about their care (Care Quality Commission, 2015b). The equivalent figure from the adult inpatient survey was very similar at 44 per cent (Care Quality Commission, 2015c).

Young people with complex physical health needs are likely to need continued support as adults. A study on arrangements for the transition between child and adult services (Care Quality Commission, 2014b) found that young people and their families often struggled with a lack of information, support or services

available to meet their complex needs. A review of 103 case notes found that 80 per cent did not have a transition plan in place. Clearly, the transition to adult services is not always as smooth as it should be.

In summary, services for children and young people are holding the rate of unplanned hospital admissions for long-term conditions steady, and broader societal trends (in which health services play a part) appear to be reducing some of the potential harms to which young people are exposed.

However, three issues remain:

1. The need to provide a similar quality of service to children and young people as for adults.

2. The need for appropriate support for children and young people with mental illness.

3. The need to limit the trend for increasing obesity in childhood.

The essence of these three challenges is one of prevention: care services stand to save a large amount of money in the future by investing a relatively small amount now. However, with constrained funding and pressing immediate problems, it is not easy to take a long-term view – especially in services that help to support the NHS where funding is being cut. Care must be taken that the *Five Year Forward View*'s commitment to prevention becomes a reality.

4
Discussion

In considering whether the quality of care for patients, service users and the public is getting better or worse, this report draws the following conclusions:

- Despite clear signals that performance in many areas is deteriorating, **care services are improving in many markers of quality**. In this report we have seen sustained improvements in the prevention of harm to children, and reductions in unplanned admissions for children and young people with chronic conditions. In addition, there have been continued improvements in both the measuring and delivery of safety in acute settings (Vincent and Amalberti, 2015).

- However, it is also clear that **there are several areas in which there are signs of falling levels of quality**. Some, particularly access to care, have deteriorated compared to the levels that were being achieved in the late 2000s. Despite past attempts to rationalise access measures (Keogh, 2015) and move to outcomes-based indicators (Nagendran and others, 2012), access remains a high-profile topic. We have highlighted that in some cases, reduced access can have significant impacts on outcomes, which means that there is a case for prioritising these over other measures. Even more concerning is that access to some services now appears to be on a consistent downward trend, which the policy interventions tried so far have done little to mitigate. The question is not whether we should accept today's levels of access as the 'new normal', but how much further access might decline by 2020. There is no reason to expect that services will in future hold to the level of performance that they deliver today.

- Mental health and ambulance services appear consistently throughout the themes we highlight in 2015. **There is less information about quality in mental health services, but what we can see is often not good** – especially around access to services. While the area received a substantial amount of policy attention in 2015, it is too early to see whether that will translate into improvement. The ambulance service is clearly under significant strain, with falling performance on its eight-minute targets, high turnover and worse relations with management than the rest of the NHS. Yet the ability to rely on a prompt emergency response when needed is critical in terms of public expectations of the health service.

- Whatever the progress in health technology, most care is delivered through direct contact with NHS or social care staff, and staffing is essential to good-quality care. However, **there is a substantial risk that the current staffing situation in both health and social care may be reducing the quality of care received by patients**. There are worrying indications of stress, high vacancy rates and increases in instances of bullying, which should be of major concern to managers and policy-makers.

- At least two of the themes we have highlighted this year involve preventive care. That is, services which either prevent crises, or minimise the harm caused if they do occur. **Rising rates of childhood obesity and access to mental health crisis care are prime examples where quality and effectiveness can be improved**. Both NHS and social care services have a track record in investing in longer-term preventive work, and we can see the benefits in many areas such as screening and immunisation, or more recently in positive trends in the management of chronic conditions (Blunt, 2013). Yet it is often hard to allocate scarce resources to services that deliver a future benefit in a tight financial environment, with immediate need very apparent and under the focus of significant media and political attention. (The QualityWatch programme will examine preventive care in a future *Focus On* report.)

The need for better data

The links between good quality information and better services are well established (Tsai and others, 2015). By international standards, information about NHS services is quite good – but when looking at an area such as quality, it is staggering how little we know about what is delivered by some services. As we have noted before, in an era where policies are all about promoting alternatives to hospital-based care, it is of concern that community-based services are the ones where we have the least basic information about the types, volume and quality of care delivered (Dorning and Bardsley, 2014). Even when services such as general practice keep electronic records, policy-makers and managers are not yet able to use them at a national level to improve care and increase efficiency. This position makes it even harder for the NHS to evolve, and means it is running a significant risk.

As new models of care develop, access to better, more granular data will become essential. The old aggregate returns (themselves a very inefficient form of data collection) will simply not reflect the diverse way in which modern services are delivered. Systems that can extract quality and management information direct from service user records – while maintaining confidentiality for individuals – are the only way that care services will be able to understand the quality of the care that they are providing. This review includes many examples of services being criticised for simply having no idea whether the care they provided was acceptable or not.

This year may come to be seen as a turning point for the NHS. The new models of care were announced by NHS England, alongside a burgeoning devolution agenda. We have seen that devolution of health to the four nations of the UK has resulted in less comparable information with which to gauge quality (Bevan and Mays, 2014). This must not be allowed to happen as health is devolved to English regions. This is particularly important as financial constraint comes even more to the fore, with the need to make £22 billion in efficiency savings by 2020/21 (on top of the £30 billion already achieved by the 'Nicholson challenge' – the majority of which came from pay restraint; Roberts and others, 2012). This means that the debate of quality versus cost is more to the fore than it has been for some time. Financial performance is relatively easy to measure, so it is vital that care services have access to comprehensive quality information to match. If they do not, the lessons of the Francis Report may be forgotten .

Where next?

The first decade of the century saw major investment in health services and some historic gains in performance, particularly in reducing waiting times. However, our third annual assessment of the quality of care in England reveals that improving – or at least maintaining – quality is proving more challenging than in recent times. While there have been some key improvements, there are also clear signals that performance is deteriorating in many areas.

As the NHS faces up to its unprecedented financial challenge, a key question is how much further performance may deteriorate, particularly in terms of access to services. As our analysis has indicated, there is no reason to expect that services will in future hold to the level of performance that they deliver today.

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