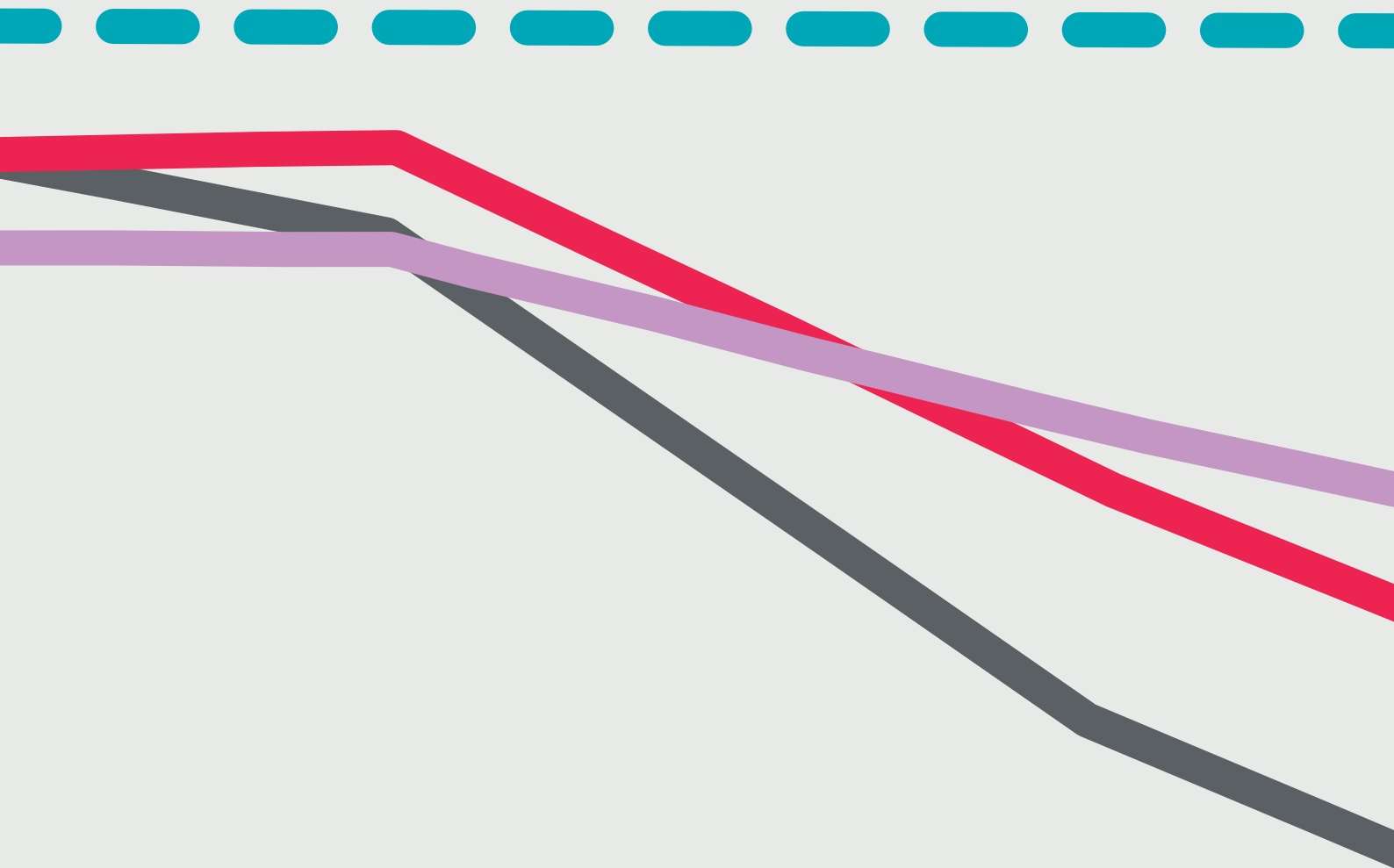


# Cause for concern

QualityWatch annual statement 2014



## 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](http://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 highlights trends in quality in five key areas of healthcare, and identifies some important areas of debate for the coming year.

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## Executive summary

The quality of health and social care services in England continues to be subject to intense scrutiny and debate. In this second annual statement from the QualityWatch programme, we draw on analysis of over 200 quality indicators and a series of in-depth reports to provide an overview of how patterns of quality in services are changing across a range of care settings.

The health and social care systems are currently facing challenges on a number of fronts:

- NHS funding is being constrained more than ever before, while there have been significant reductions in state-funded social care.
- The NHS is working through a series of major organisational changes.
- Past lapses in the quality of care, especially for some vulnerable groups, are setting a demanding agenda for change and improvement.

Despite the recent wave of negative headlines and concerns over significant lapses in quality, if we look over a longer timescale, in many ways the NHS has shown signs of continued improvements. Compared with 10 years ago, waiting times are much shorter; there have been improvements in important areas of safety (such as healthcare-associated infection); and there are more doctors and nurses. However, there are clear indications that we may be failing to hold onto these gains; the past year has seen an increasing number of signs that historic improvements in quality are not being sustained in some areas, or have even reversed. Stress signals identified last year are becoming even stronger and apparent in a wider range of services.

These signals give a clear cause for concern. This year's QualityWatch annual statement shows the following:

- Prompt access to services has declined in some settings over the last two years.
- In mental health services, the demand seems to be outstripping capacity for urgent care and for younger people.
- The wellbeing of frontline staff in both health and social care is critical to good-quality care, but there are indicators that suggest increasing problems in this area.
- Substantial inequalities in the provision and outcomes of care persist, and in many cases the information needed to analyse equity of care for marginalised groups is not available.
- While some areas continue to improve, for example child health and cancer outcomes, the NHS still lags behind the best in the world in these areas.

In the coming year, we anticipate even more debate about key aspects of quality. Some of the most important questions will concern the following:

- At what point do the lapses in performance and quality become intolerable to patients, politicians or those running health and care services?
- Which services, service users or patients should be targeted for support?

- How do we measure success in the quality of care and how do we address the most significant gaps in information in the relevant areas?

We would stress that there is no inexorable relationship between funding and the quality of care – in many situations, good-quality clinical care may often be the result of the most efficient use of resources. However, it is clear that there are areas where a shortage of funds has a more direct impact on the services that are offered, and limits the ability to pursue improvements or even threatens current levels of performance. But to reduce the quality debate to one simply about funding shortages risks excusing lapses of care.

While care in the vast majority of cases continues to be better than it was 10 years ago, there is evidence that the quality of several services has now started to decline. As financial pressures continue to mount and the system is working hard to accommodate rising demand, scrutiny of the quality of care delivered to patients and service users is more vital than ever before.

# 1

## Introduction

Currently there is a profound challenge to maintain the quality of services at a time when budgets for health and social care are more constrained than ever. A recent review of NHS finances concluded that the financial strength of NHS trusts is weak and declining, with 66 NHS trusts (out of a total of 249) now in deficit. The likely net overall deficit for 2013/14 is just over £100 million, compared with an overall surplus of £383 million in 2012/13 (Lafond and others, 2014). Local authority spending on adult social care has reduced by 12% in real terms since 2010 (ADASS, 2014).

But the need to focus on finances cannot excuse lapses in quality of the kind reported over the last few years, for example at Stafford Hospital, run by Mid Staffordshire NHS Foundation Trust, and at Winterbourne View, a private hospital near Bristol. The renewed emphasis placed on quality following the Francis report of the Mid Staffordshire NHS Foundation Trust public inquiry (Francis, 2013) and subsequent initiatives have created their own additional pressures on the NHS. This is also at a time when the NHS and local authorities are still adapting to new structures and organisations following the Health and Social Care Act 2012. Clearly, monitoring the quality of services delivered to the public is more important than ever.

The central question for the QualityWatch programme is very simple: *Is the quality of health and social care getting better or worse?* This is our second annual statement to shed light on that question. In this statement, we have selected a limited number of key themes to summarise what we have found over the past year.

The QualityWatch programme analyses 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 a more comprehensive assessment of quality. 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.

The aims of the programme are to:

- provide an authoritative and independent analysis of 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.

Measuring quality is not easy. We acknowledge that quality of care is a complex, multidimensional concept and can be viewed through many different lenses. The QualityWatch model considers six dimensions of quality and five care sectors, as shown in Table 1.

**Table 1: QualityWatch domains and care sectors**

Domains	Care sectors
Effectiveness	Mental health
Person-centred care and experience	Population and commissioning
Capacity	Primary and community care
Safety	Secondary care
Access	Social care
Equity	

Our understanding of whether things are getting better depends crucially on the information available at a national level to show broad changes. In this respect, there are significant gaps in data; and progress towards filling them over the last few years has been slow. Key areas are still beset by holes in information. For example, there is much interest in the use of community-based services to replace the need for expensive acute care; a goal hindered by there being few national datasets that routinely capture information about activity and quality in such settings. Also, there is very little regular, routine information about day-to-day activity in general practice available at a national level.

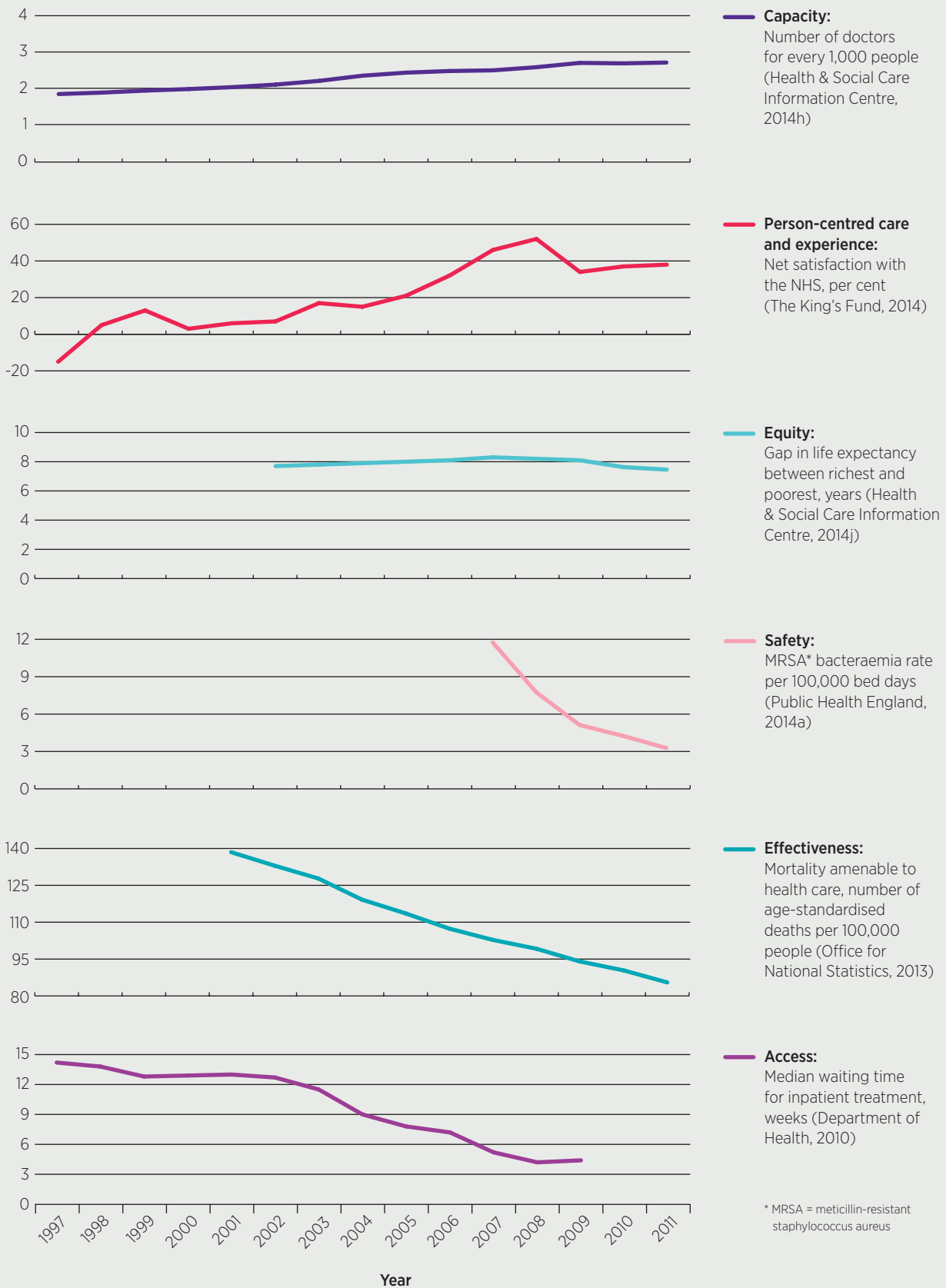
### Changes in quality – a historical perspective

Although much of the following analysis focuses on areas where we have concerns about recent stresses on the quality of health and social care, it is important to retain a broader historical perspective. In many ways, care services in England are better than they were around 20 years ago. For example, when compared with 1997, care services now have:

- shorter waiting times for acute treatment (see Figure 1.1) and a wider range of services accessible in community and primary care settings (Thorlby and Maybin, 2010)
- more awareness of safety (Darzi, 2008), with major successes in reducing harms, for example healthcare associated infection (see Figure 1.1)
- improvements in clinical effectiveness, evidenced by falling mortality rates from cancer, cardiovascular disease and suicide (Thorlby and Maybin, 2010)
- higher public satisfaction (see Figure 1.1) and an increased recognition of the importance of user views (Mockford and others, 2012)
- greater accountability nationally, for example via independent regulators, and to the public, for example via the NHS Constitution (Nuffield Trust, 2012)
- significant investment in new capital, including the opening of a succession of newly built hospitals, although funded largely through the Private Finance Initiative (PFI); in primary care, schemes such as the local improvement finance trust (LIFT) have led to investment in a range of facilities (Edwards, 2013)
- new technologies, which have been deployed in diagnosis and treatment (OECD, 2014)
- more doctors and nurses per head of population (HSCIC, 2014h)



Figure 1.1: Long-term trends in quality, 1997 to 2011



\* MRSA = methicillin-resistant staphylococcus aureus

- increased productivity, in terms of the amount of treatment delivered compared with the resources used to deliver it (Black, 2013; Bojke and others, 2013).

Over the time period shown, there is strong evidence to demonstrate long-term improvements in a number of areas. For example, Figure 1.1 shows a positive change over time for one illustrative measure from each of the six QualityWatch domains. The one exception to this is progress on health inequalities, which appears to have remained static.

## Patterns of quality in 2014

Describing the quality of services across all of health and social care is a complex task. A lot of information is contained in the indicators on the QualityWatch website (see [www.qualitywatch.org.uk/indicators](http://www.qualitywatch.org.uk/indicators)), although these do not claim to be comprehensive. Rather than describe them all here, in this report we focus on selected issues.

There are two important areas that we do not describe in detail. One area is the trends in users' experience of services, often measured through large national surveys. It is encouraging that these surveys have remained broadly consistent over the last few years (Figure 1.1); however, as we noted in last year's statement, such surveys have their limitations. They summarise an average experience across England, but that may hide poor experiences of care. For example, 3% of inpatients reported in 2013 that they were not treated with dignity and respect (Care Quality Commission, 2014). If that proportion is applied to all the 8.9 million individuals using inpatient care in England in that year, it represents more than a quarter of a million people.

Another issue we do not highlight this year is trends in safety. In recent years, a number of new safety metrics have been introduced (HSCIC, 2014g) and these generally indicate improvements – especially in acute care. However, we know much less about safety trends in primary care or community care, due to a lack of data. Research suggests that around 1–2% of primary care consultations contain an adverse event, which has significant implications considering that an estimated 90% of interactions with the NHS happen in primary care (Health Foundation, 2011). However, the research also suggests that the severity of most of these harms is low to moderate. Information on safety in social care is still limited but we do know, for example, that there are substantial numbers of medication errors in care homes (Barber and others, 2009). We also know that the rate of alerts about possible abuse of vulnerable adults that are fully investigated by local safeguarding teams has increased (from 180 alerts for every 100,000 people in 2010/11 to 205 in 2012/13) and the proportion of cases substantiated or partly substantiated has risen from 39% to 44% (HSCIC, 2014a). However, the proportion of service users reporting that they feel safe has been rising consistently, from 62% in 2010/11 to 66% in 2013/14 (HSCIC, 2014c).

In this annual statement we have chosen to focus on five areas that highlight concerns with the quality of care in 2014. These are as follows:

- Ease of access to services (assessed, for example, by looking at waiting times in Accident & Emergency (A&E), elective inpatient waits and the number of people receiving state-funded, community-based social care) appears to have declined in some settings over the last two years.

- There are serious concerns about mental health services, where the demand appears to be outstripping capacity for urgent care and for younger people.
- The wellbeing of frontline staff in both health and social care is critical to good-quality care – but indicators suggest increasing problems in this area.
- There are continuing substantial inequalities in the provision and outcomes of care. In many cases, the information needed to analyse equity of care for marginalised groups is not available.
- There are a number of measures of patient outcomes that show long-term improvements. However, the NHS still lags behind the best in the world in some areas – for example, with regard to infant mortality or cancer outcomes. This emphasises the value of taking a view on quality that is not just relative to the NHS' past performance.

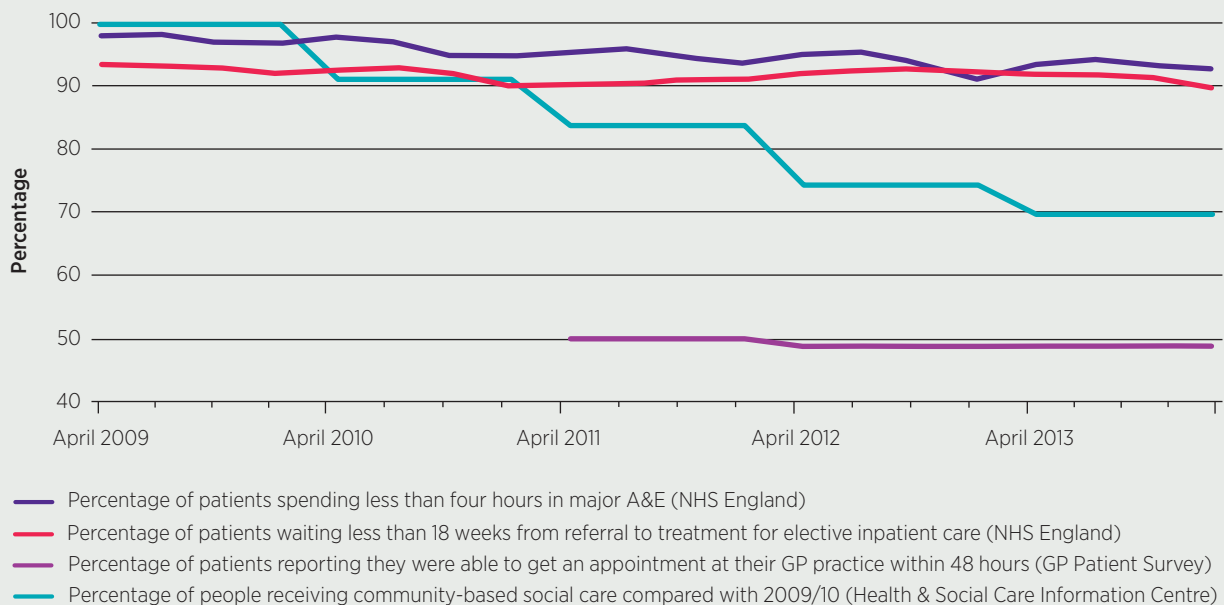
The rest of this annual statement presents evidence on these areas and discusses the implications.

## 2

## Access to services

The ability to access timely care, for a wide range of different services, is one of the most commonly used markers of quality and one that is especially sensitive to funding constraints. Our 2013 annual statement (QualityWatch, 2013) highlighted emerging concerns about access to care and the past year has seen a slew of reports and analyses focusing on this area. The spotlight has shone particularly strongly on waiting times for urgent care, yet there are worrying signs about the accessibility of planned hospital treatment and social care too. Four headline measures of access to services are shown in Figure 2.1.

**Figure 2.1: Trends in access to care in terms of target achievement for hospital care, patient-reported access in primary care and change against 2009/10 baseline for social care, from April 2009**



Source: NHS England, 2014a; 2014d; 2014e. HSCIC, 2014f

The most prominent measure of the quality of urgent care is the time that patients spend in A&E. Every year, 22 million people attend A&E and there is a national expectation that 95% of people will be seen and either admitted or discharged within four hours (Blunt, 2014). However, major A&E departments have been struggling to meet this target since 2012 and at the end of July 2014, the target had not been met at the national level for over a year. There are also other indications of problems in A&E, such as the increasing number of patients who wait more than four hours between the decision to admit and arriving on a ward ('trolley-waits'). This rose from 93,905 patients (2.6%) in 2010/11 to 167,941 patients (4.4%) in 2013/14 (NHS England, 2014a).

The recent pressure on A&E has been widely recognised in a range of reports (for example, College of Emergency Medicine, 2013; House of Commons Health Committee, 2013) and there is considerable debate on why A&E departments are struggling to meet the four-hour waiting time target. Our July 2014 report – *Focus On: A&E attendances* (Blunt, 2014) – examined some of the most common explanations for the pressure on A&E. We found that over the period studied (April 2010 to March 2013), increases in the number of older people using A&E may have accounted for a small part of the increase in waiting times (11%), but the unusually cold winter in 2012/13 accounted for a larger share of the decline in performance (19%).

Yet these factors together only explained a minority of the falling performance. There was some evidence that the lack of availability of inpatient beds also had a notable effect. Our analysis looked at the level of crowding within A&E departments, to see if existing A&E facilities are reaching capacity in terms of the number of patients that can be accommodated. When the physical space or staff numbers are near capacity, departments may reach a point where even small further increases in demand can result in a disproportionate increase in breaches of the four-hour waiting target. An overcrowded department may also have implications for safety (Carter and others, 2014). However, while an increasing number of patients were finding themselves waiting more than four hours, it is important to remember that these patients were still only a small percentage of patients using A&E, and the change experienced by the majority was less dramatic. For example, the average time spent in A&E increased by just 11 minutes between 2010/11 and 2012/13 (Blunt, 2014).

Other parts of the urgent care system are also showing signs of stress. In 2013/14, ambulance services only managed to respond to 74.8% of the 2.9 million most serious calls within eight minutes; less than their target of 75% (NHS England, 2014f). In primary care, there are also concerns that awareness of, and satisfaction with, out-of-hours services, as measured by the GP Patient Survey, has fallen year-on-year since 2011; now only 66% report that their overall experience of out-of-hours care was ‘good’, compared with 71% in 2011 (QualityWatch, 2014e).

There are also signs of longer waits for planned inpatient treatment where the expectation is that 90% of patients will be treated within 18 weeks of GP referral. In February 2014 across all relevant providers in England, the proportion of admitted referrals treated in less than 18 weeks fell below the target of 90%, and has also been missed in several subsequent months (NHS England, 2014e). In August 2014, the Secretary of State for Health announced that a ‘managed breach’ of the target would continue until 2015, to allow the NHS to address a minority of patients who had now been waiting considerably more than 18 weeks (Hunt, 2014). However, while waits of 18 weeks or longer are becoming more common, the increase in the average (median) waiting time was just four days, from 8.0 weeks in April 2010 to 8.6 weeks in April 2014 (NHS England, 2014d). This extra waiting might not have that much impact on individuals, but represents a very large number of delayed treatment days nationally.

The accessibility of GP care has been hotly debated over the last year (O’Brien, 2014). Evidence from the GP Patient Survey (NHS England, 2014e) reported a decline in the percentage reporting that ‘it is easy to get through to their practice by telephone’ (78% in 2011/12, compared with 73% in 2013/14). After contacting the surgery, around half of patients said that ‘they saw someone on the same or next working day’ (51% in 2011/12 and 49% in 2013/14), but a sizeable percentage

of patients also said that it 'took them more than a week to see someone' (13% in 2011/12 and 16% in 2013/14). The survey also asks when people wanted to see their GP, and found that just 6% wanted an appointment for the following week or later, although 14% did not have a specific day in mind.

Our March 2014 report – *Focus On: Social care for older people* (Ismail and others, 2014) – looked at the change in numbers of older people in receipt of state-funded social care. We found that the numbers of service users in residential care and nursing home care saw relatively small overall reductions from 2009/10 to 2012/13. However, the number of older people receiving community-based services declined by 26% between 2009/10 and 2012/13 (245,855 older adults). Community-based services include:

- meals (a reduction of 54,795 individuals, 59%)
- day care (36,480 individuals, 35%)
- equipment and adaptations (109,460 individuals, 28%)
- home care (68,010 individuals, 15%).

Recent figures for 2013/14 suggest this trend has continued, with almost 300,000 fewer older adults receiving publicly-funded community-based services; a 30% reduction compared with 2009/10 (Holder, 2014). This disproportionate decline in the number of people accessing community-based social care has been linked to the tightening of local eligibility thresholds (Fernández and others, 2013).

While it appears that there is continued support for those people who need residential or nursing home care, spending on this sector has reduced (from £3.6 billion in 2009/10 to £3.1 billion in 2012/13; Ismail and others, 2014), meaning that providers have to absorb reduced fees. The fact that local authorities are focusing on severe need was highlighted in a report of the House of Commons Committee of Public Accounts (2014), which also noted that local authorities have reduced their spending on preventive care and support to adults.

In summary, it is becoming harder to access care in many settings, with some people facing extreme waits or, in the case of social care, having to fund the services they need themselves. Many of these problems in access are linked to pressure on state funding, and it is notable that additional monies have been made available in some cases to address them. For example, last year the Department of Health announced £500 million to help A&E cope with winter pressures in 2013/14 and 2014/15 (Department of Health, 2013), and in June 2014 the Secretary of State for Health announced £250 million to help ease pressure on the elective waiting list (Hunt, 2014). Meanwhile, the Prime Minister's Challenge Fund made £50 million available to improve access in general practice (NHS England, 2013). While these extra resources are no doubt welcome, the important question is how long these payments can sustain improvement in the system and what will happen when they run out.

# 3

## Mental health

It has been estimated that mental health problems in England impose an economic and social cost of over £105 billion a year (Centre for Mental Health, 2010). Yet there is a widely held belief that mental illness does not receive the attention it deserves and that 'parity of esteem' is needed between physical and mental health problems. Of particular concern is the care of people with serious mental illness, for whom mortality rates (for those aged under 75) are over three times higher than those for the rest of the population (HSCIC, 2014f). Even the minister responsible suggests that services are 'stuck in the dark ages' and 'not fit for purpose' (Buchanan, 2014).

One key worry is declining accessibility of some services. The last few years have seen a 17% reduction in the number of inpatient beds for people needing care for mental health problems: from 26,448 in 2008/09 to 21,949 in 2012/13 (NHS England, 2014b). Consequently, the number of full-time equivalent (FTE) inpatient psychiatric nurses also fell over a similar period (from 26,070 in April 2010 to 22,747 in April 2014; a fall of 13%). Some of this reduction can be explained by initiatives to place an increasing number of patients under the care of community teams; however, the number of psychiatric nurses in community settings also fell slightly, by 1% (from 15,866 in April 2010 to 15,696 in April 2014). The number of FTE mental health doctors was effectively unchanged over the same period: from 8,931 to 8,910 (HSCIC, 2014h) – despite the overall number of doctors and nurses in the NHS increasing slightly (QualityWatch, 2014d).

There is evidence of an increase in demand for crisis care in mental health (NHS Confederation, 2014). This can be delivered either by crisis resolution and home treatment services in the community or by liaison psychiatry teams in hospitals. While liaison psychiatry services have been proven to be effective (Parsonage and others, 2012), the make-up and availability of these services vary around the country – some services might only have one member of staff or even just access to an off-site crisis team (Foley, 2013). These services are particularly important in A&E, where 18% of breaches of the four-hour waiting time target occur for mental health service users, despite this group accounting for only 11% of A&E attendances (HSCIC, 2013a).

Some patients will have crises that require immediate admission to inpatient care. The number of emergency inpatient admissions in mental health specialties increased by 2% between 2011/12 and 2012/13 (from 74,913 to 76,293), bucking an established trend for reducing numbers of unplanned mental health admissions (HSCIC, 2013b). A notable minority of these admissions will require detention. The number of people detained under the Mental Health Act by clinicians on admission to hospital has increased by 17%: from 25,754 in 2008/09 to 30,253 in 2012/13. However, the number of people admitted through other routes to detention has not increased. In 2008/09, 2,138 people were detained by a court of law or prison authorities and 14,701 were detained while already in hospital. In 2012/13, these numbers were 1,788 and 14,249 respectively (HSCIC, 2013c).

Clearly, people arriving in inpatient care because they have been detained under the Mental Health Act represent a notable and increasing fraction of NHS emergency inpatient admissions under mental health specialties. This fact, combined with the reduction in inpatient beds available for people with mental health problems, has caused some to wonder whether Mental Health Act powers are increasingly being used to ensure access to a bed (HSCIC, 2013c).

There is also some evidence from routine hospital data of longer waiting times for people with mental health problems. Analysis of Hospital Episode Statistics (HES) reveals that there were 392,654 first outpatient consultations under mental health specialties in England in 2012/13 – a 16% increase from 2009/10. However, whereas 95% of patients with physical ailments had a first outpatient consultation within 18 weeks of being referred by their GP, only 74% of mental health patients were seen in this time in 2012/13 (see Figure 3.1). While this proportion had previously been improving for mental health services, it has fallen steadily since 2010/11. The median waiting time for the first outpatient assessment by a physical health specialist was 27 days in 2012/13 (unchanged from 2010/11), while for a mental health specialist it was 35 days in 2010/11 and 48 days in 2012/13. However, there are known data quality problems with mental health waiting times data, and we do not have reliable national information on waiting times for more specialist treatment (such as eating disorder services or psychological therapies for people with severe mental illness) once people are within the system.

**Figure 3.1: Percentage of first outpatient consultations received within 18 weeks of referral, 2008/09 to 2012/13**



Source: HSCIC, 2014d

One area that has received attention recently is mental health services for younger people. It is particularly challenging to measure changes in quality in this area, but there are a few sources of information that provide some limited insight. The number of admissions to adult mental health wards in England for patients



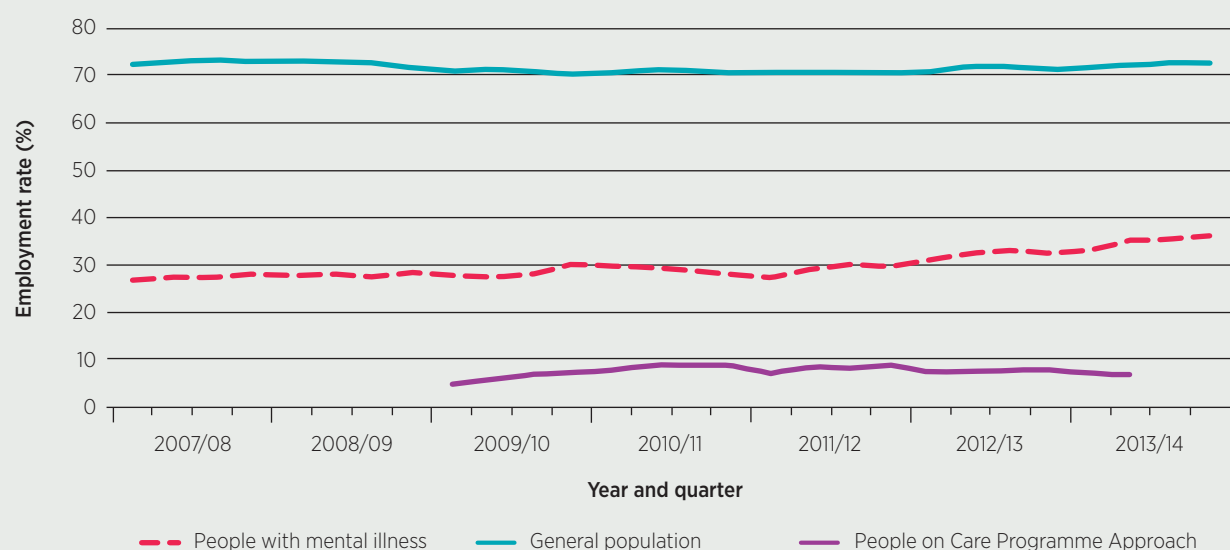
under the age of 18 fell between 2011/12 and 2012/13, from 440 to 236. However, provisional figures from the first eight months of 2013/14 show that 303 patients under the age of 18 had been admitted by the end of November 2013 (HSCIC, 2014e). Early Intervention in Psychosis (EIP) services help young people aged 14 to 35 to recover from a first episode of psychosis, and support more than 10,000 young people each year. These services are proven to be effective in reducing the risk of suicide and increasing employment rates. A survey of 96 of the 125 EIP services in England found the majority (53%) reporting that the quality of their service had decreased in the past year (Rethink Mental Illness, 2014).

An NHS England survey of high-acuity child and adolescent mental health services (CAMHS) asked providers to identify the number of inpatient admissions where young people were deemed to have been harmed by the distance and disconnection from local services, family and friends (out-of-area admissions). Out of 10 NHS England specialised commissioning areas, seven reported an increase in the proportion of these admissions between 2012 and 2013, with areas reporting between 8% and 37% of their admissions being out of area in 2013 (NHS England, 2014c). These increases reflect a trend for increasing numbers of out-of-area placements, which is also observed in adult services. For example, there is evidence that an increasing number of patients are being admitted to hospitals far from home because of a lack of inpatient capacity in their local area – this applied to 1,145 patients in 2011/12 but 1,785 in 2012/13 (Lintern, 2014). However, under-reporting from the independent sector and data quality issues (such as the lack of patient postcode information, which is missing in 1% of NHS records but 11% of independent sector records) make robust analysis of the problem difficult (HSCIC, 2014e).

In terms of care in community settings, the Improving Access to Psychological Therapies (IAPT) programme delivers evidence-based psychological therapies for people with depression and anxiety disorders. The numbers of people on the programme have been increasing steadily and the programme represents a form of provision for the NHS that did not previously exist. However, it is estimated that only 11.6% of those eligible were accessing IAPT at the end of 2013/14 (HSCIC, 2014b). While 435,406 of the 709,117 people (61%) entering IAPT treatment waited fewer than 29 days (HSCIC, 2014b), a recent survey of 2,000 people who had tried to access talking therapies within the last two years (whose conditions may or may not be included in the IAPT programme) found that half had waited more than three months for an assessment, with one in 10 waiting more than a year for assessment (Mind, 2014).

Our May 2014 report – *Focus On: Antidepressant prescribing* (Spence and others, 2014) – used national datasets to analyse how changes in prescribing patterns were linked to key factors, including patient characteristics, economic indicators and GP prescribing behaviour. We found that the amount of antidepressants dispensed in the community each year had increased by 38% between 2008 and 2012, from 29 to 40 million items. Unemployment was significantly associated with this trend: a 1% rise in unemployment typically meant that one and a half more tablets were given out per person on a GP list, each year. We also found that some GP practices prescribed far more antidepressant medication than others, even where their patients were similar – suggesting over-use or under-use in many parts of England. GPs who prescribed more antibiotics also tended to prescribe more antidepressants, suggesting that patterns of prescribing by doctors vary widely, without clear clinical justification.

**Figure 3.2: Employment rate of mental health service users compared to the general population, 2007/08 to 2013/14 (%)**



Source: HSCIC, 2013e; 2014i

We know that there is a strong and enduring relationship between a person's economic circumstances and their health and social status. For this reason, the rate of employment for people with mental illness can be used as an outcome measure for mental health services. While the employment rate is significantly lower than that of the general population, it has narrowed notably over the last four years (HSCIC, 2014i; see Figure 3.2). However, the proportion of people with more severe or complex mental health issues (indicated by being on a Care Programme Approach, CPA) who are employed has been falling: it fell from 9% in 2011 to around 7% in 2012/13 (HSCIC, 2013e).

In summary, inpatient services for mental healthcare are becoming harder to access for both adults and children, and staff levels in these services have reduced. Patients are increasingly having to be admitted out of area, which is expensive and can be harmful. However, community services such as IAPT are improving access to therapies for people with less severe conditions (albeit from a low base) and the rate of employment for people with mental illness is increasing faster than the rate for the general population. It is a concern that information about the quality of services offered is limited, which impedes our understanding of the services and planning for improvement. Lastly, this chapter has focused on national trends but there are substantial variations between areas, which merit further investigation.

While there is no inexorable relationship between funding and the quality of care, it is interesting to note that spending on mental health services has been growing more slowly than spending on acute hospital care. Primary care trusts increased spending on mental health services by 1% in real terms, compared with a 2.4% increase in spending on hospitals between 2011/12 and 2012/13, and provisional accounts data from foundation trusts suggest that this disparity widened in 2013/14 (Lafond and others, 2014). Furthermore, there is evidence that funding for services proven to be effective, such as EIP, is being reduced (Rethink Mental Illness, 2014).

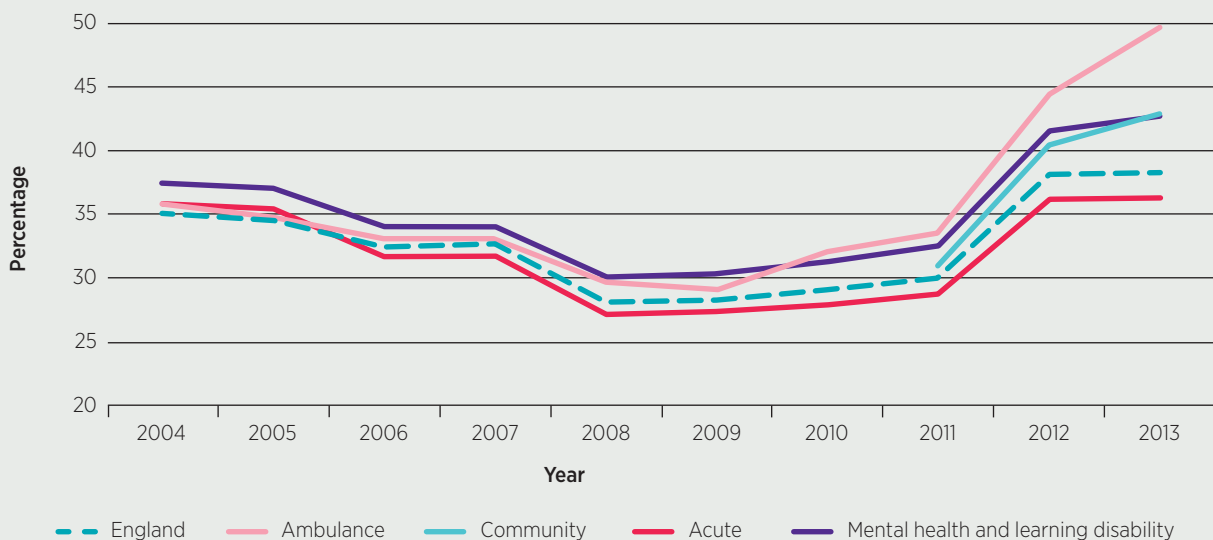
## 4

## The workforce

Although the technology of modern healthcare has the power to surprise and amaze us, it is still true that health and care services mainly rely on professionals providing face-to-face contact with patients. For this reason, the wellbeing of the workforce is critically important – especially during times of organisational change and financial pressure. It has been shown that work-related stress among staff has a negative impact on patient experience and outcomes (Raleigh and others, 2009) and the publication of the Francis Inquiry report (Francis, 2013) drew particular attention to the element of compassion in care delivered by frontline staff.

The NHS Staff Survey (NHS England, 2014g) includes some routine measures that indicate rising levels of work-related stress in the NHS. In 2004 and 2005, nationally around 35% of NHS staff reported that they had been ill due to work-related stress (see Figure 4.1). Over the following years, this figure fell by approximately seven percentage points to a low point of 28% in 2008/09. The number of staff reporting stress began to increase slowly, but there was a sharp increase of eight percentage points in reports of illness between 2011 and 2012, and it remained at this level in 2013. The average value across all NHS organisations was 38% in 2013, the highest level since the survey began. The scores for many individual trusts are even higher.

**Figure 4.1: Percentage of NHS staff reporting that they had been ill due to work-related stress, 2004 to 2013**



Source: NHS England, 2014g

This trend is corroborated by results of the Labour Force Survey (LFS), which asks a sample of all working adults in the UK whether they have suffered from any illness, disability or other physical or mental problem that was caused or made worse by their job. In 2011/12, 1.4% of respondents reported that they had (Health and Safety Executive, 2013). Although this survey uses a different methodology than the NHS Staff Survey uses, it found that LFS respondents performing health and social work activities reported much higher rates of work-related stress (2.2%) than the average across all industries. It is also notable that the health and social care measure has been rising since 2008/09, whereas the all-industries measure has been static.

There are no simple explanations for what lies behind these survey results. Our analysis shows that the type of NHS trust that people work in is clearly important. Ambulance trusts have the highest levels of work-related stress, with just a fraction less than half of all respondents to the NHS Staff Survey reporting being made to feel unwell by work-related stress. Across the wider NHS, it seems that workload and staff shortages may contribute to the problem: the 2014 NHS Staff Survey reported that 44% of respondents said that they were unable to manage conflicting demands on their time and 47% reported that there were not enough staff to enable them to do their job properly (NHS England, 2014g). These levels have not increased over time in the same way as staff stress, although the proportion reporting lack of staff has risen from 43% in 2010. The trend is also not reflected in increased staff sickness absence, which has been broadly steady (QualityWatch, 2014c). However, we note the proportion of staff respondents reporting that they felt pressured to work while unwell rose from 22% in 2010 to 25% in 2013, which could be having the effect of suppressing the levels of staff sickness absence reported.

The past year has seen an increase in nurse staffing numbers, particularly in the acute sector in response to the challenges set out in the Francis report (Francis, 2013). Much of this increase has been achieved through greater reliance on contract and agency staff, which have higher costs per employee relative to permanent staff. This increase in staff who are not permanent employees also raises concerns about quality and continuity of care (Commission for Health Improvement, 2004). One way to measure the use of bank and agency staff is by how much hospitals spend on employing them each year. In 2012/13 prices, bank and agency staff cost NHS hospitals £2.9 billion in 2011/12 and £3.5 billion in 2012/13, an increase of 20% (Lafond and others, 2014).

While NHS staff are experiencing a pay restraint imposed by the government's public sector pay policy, pay for staff working in social care is being cut. There are reports that local authorities' cost savings have been achieved by paying lower fees to providers, which has led to lower pay for the care workforce, low skill levels within the workforce and inevitably poorer levels of service to users. Out of 1.5 million people working in social care, the National Audit Office (2014) estimates that between 160,000 and 220,000 workers earn less than the minimum wage, and an estimated three in 10 care workers are on zero-hour contracts. This has serious potential implications for quality, especially in a sector where information on quality of care is extremely limited and a substantial proportion of care is delivered to vulnerable people in their homes without direct oversight. One of the few indicators available that could be used to measure work stress for social care workers is sickness absence. The mean number of sick days taken by social care

staff (directly and indirectly) employed by adult social services departments in England increased slightly over the three years 2011 to 2013: from 9.7 days a year to 10.3 days a year (HSCIC, 2014k).

In summary, the wellbeing of the workforce is essential to delivering high-quality care. Measured stress in NHS staff has been rising, and there is evidence of an association between staff satisfaction and patient experience. We simply do not have the information to assess whether reduced pay for social care staff is reducing quality of services, but this would seem to be a reasonable assumption. In all care sectors we see a double action of funding constraints, where morale is impacted because of freezes or cuts to pay, and lack of resources impinging on professionals' ability to do their job and the conditions under which they work.

# 5

## Inequalities of care

A fundamental aspect of the quality of NHS-funded services in the UK is that 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.

The problem of health inequalities has long been identified in a series of national and local reviews – the most recent being led by Marmot (2010), which found that people living in the poorest neighbourhoods will, on average, die seven years earlier than people living in the richest neighbourhoods. Yet the most recent data available, for 2010 to 2012, show some promising signs that the established trend for increasing health inequalities may have abated, and in the case of males even reduced slightly (Public Health England, 2014b). The causes of this extend well beyond the direct role of healthcare provision, but health and care services can play an important part. Similar indications can be seen in a measure which more closely links to the role that health and care services can play. The degree of variation in a measure of avoidable mortality (that is, mortality for people under the age of 75 from causes considered to be amenable to healthcare) has shown signs of decreasing more quickly in more deprived areas over the last decade (Barr and others, 2014; QualityWatch, 2014b).

However, in areas over which the NHS has more direct control, there has not been a similar improvement in equity of access to care. There is some evidence that those with the greatest need are often the least likely to access medical care. The relationship between treatment rate (adjusted for age and sex) and deprivation for selected surgical procedures exhibits distinct deprivation gradients in access to treatment. For example, lower surgery rates for elective hip replacement can be observed in the most deprived areas of England, particularly in the bottom two deciles (134 and 135 operations for every 100,000 people respectively), with higher rates of treatment in the more affluent parts of the country (between 165 and 172 operations for every 100,000 people for the five most affluent deciles) (QualityWatch, 2014a). This is despite evidence that there is a higher prevalence of joint problems in more deprived areas; for example, there are higher rates of GP consultations for osteoarthritis (the most common reason for requiring a hip replacement) in more deprived areas (Chaturvedi and Ben-Shlomo, 1995). Potentially, the lower rates of procedures in the more deprived areas could be indicative of some unmet need (and an example of the ‘inverse care law’ – the availability of good medical care tends to vary inversely with the need for it in the population served; Hart, 1971). While rates of elective hip replacement increased in all deprivation categories between 2003 and 2013, the differences in rates between the most deprived and least deprived areas were consistent over the data period, with the two most deprived deciles having much lower treatment rates than the more affluent areas. Similar patterns were found in the treatment of inguinal hernia repair (QualityWatch, 2014a).

Other procedures showed the opposite relationship with deprivation over the 10-year period, with lower treatment rates observed in the higher socioeconomic groups; for example, elective knee replacements (153 operations for every 100,000 people in the most deprived decile and 131 in the least) and cataract surgery (771 for every 100,000 people in the most deprived decile and 547 in the least). This could be associated with a greater uptake of privately funded treatment in less deprived areas. In both cases, the differences in treatment rate between the deprivation deciles were consistent over the 10 years.

The analysis of inequality in terms of difference between rich and poor areas is important but is not the only way to monitor inequalities between social groups. However, there are remarkably little data that allow us to track service use and health differences for example by ethnicity or levels of disability. Although there is a notable tradition for monitoring both ethnicity and disability in the NHS, data on these are not being linked with some key metrics of healthcare. Monitoring these aspects is particularly important as the resources required to provide care to these (sometimes challenging) groups can often be sacrificed to bolster mainstream services, or services for which there are measurable quality indicators.

This concern extends similarly to other marginalised groups, such as homeless people. Homeless people tend to have high levels of urgent care use – they attend A&E six times more than average, they are admitted to hospital four times as often, and because their illnesses are often more severe, they stay in hospital twice as long (Hewett and Halligan, 2010). Recent analysis of the homeless population indicated that they had higher than average-level health problems and that over 15% with physical health problems were not receiving support, while 7% had been refused access to a GP or dentist within the past 12 months (Homeless Link, 2014).

In summary, population-level health inequalities based on deprivation still exist, but some progress appears to be being made. Measures that are more specific to healthcare, such as access to specific treatments, show little change in their distribution by deprivation. Health inequalities for specific groups also exist but are less well measured.



# 6

## Setting expectations

When we consider trends in quality, our expectations are typically based either on a predefined target or relative to past performance. However, in some cases we have access to broadly comparable measures from other countries; these can be used to provide valuable additional context with which to better understand the current position on quality. This chapter highlights just two examples of how this can be done, and the extra perspective we gain by doing it.

### **The UK lags behind other countries on measures of child health**

Several recent reports have highlighted a series of gaps in service provision for children (RCP, 2014; RCPCH, 2012a; RCPCH, 2012b), and especially the increasing evidence showing that the UK is not doing as well when compared with other countries (Davies, 2012; Kennedy, 2010; Lewis and Lenehan, 2014; UNICEF 2013). The lack of appropriate child health data and indicators both in the UK and at the European level, especially on the provision of healthcare services to children, makes it challenging to identify areas where improvements are most needed (Wolfe and McKee, 2013).

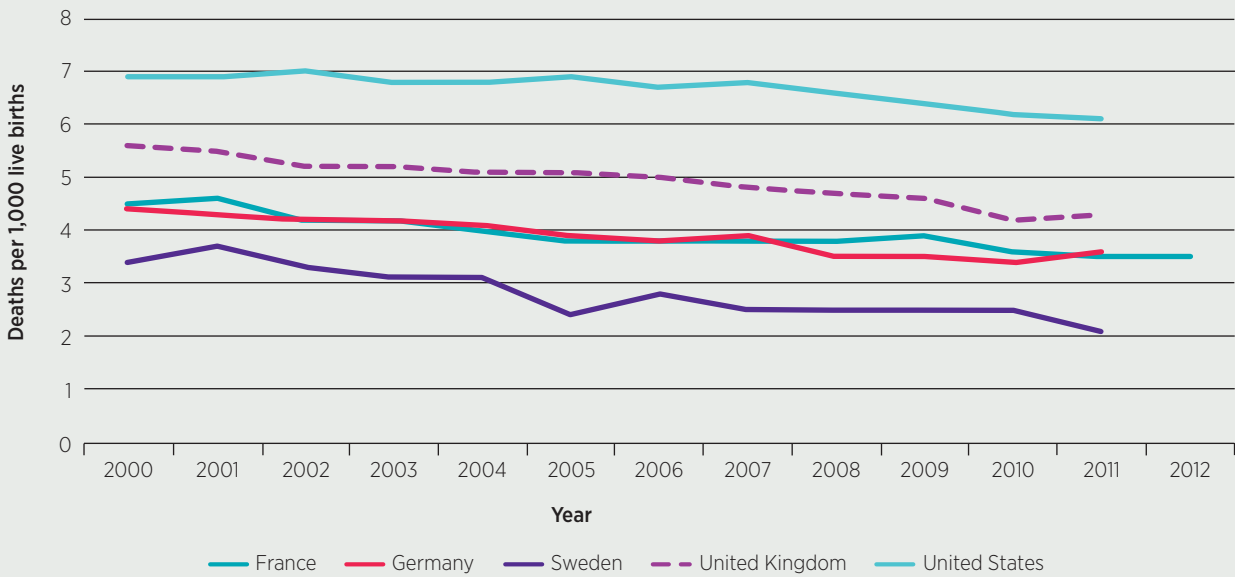
Only a few internationally comparable indicators are available to measure the quality of care provided to children. One is the infant mortality rate, which is defined as the number of babies and children who die before they turn age one for every 1,000 live births. While variations will be caused by social inequalities, they will to some extent reflect the quality of the healthcare system. In the UK, the infant mortality rate has been declining since the 1980s and is now at 4.3 deaths for every 1,000 live births (OECD, 2013). While this is a major achievement, the UK still has one of the highest rates compared with other similarly developed countries. In 2011, Sweden had half of the infant mortality rate of the UK and a similar reducing trend (see Figure 6.1). If the UK had a rate equal to that of Sweden, it would equate to nearly 1,950 children being saved (Wolfe and McKee, 2013). A recent study found that 20% of child deaths in England and Wales had 'modifiable factors' (Sidebotham and others, 2014), suggesting that there is still scope to reduce the rate of infant mortality in the UK.

Vaccination against diphtheria, tetanus and pertussis (DTP), and against measles is considered to provide safe and effective protection against these illnesses, and the proportion of children vaccinated and protected from these illnesses can be considered an indicator of the quality of care (OECD, 2013). Since 2008, the UK has improved significantly on the rate of DTP vaccination; the rate increased from 92% in 2008 to 97% in 2012. Despite a dip in the mid-2000s, the vaccination rate in the UK for measles has since increased; in 2012 it had increased to 93%. However, this is still below the recommended World Health Organization target of 95% coverage (HSCIC, 2013d).

Therefore, while these national coverage rates are increasing, rates vary across countries and regions and it is essential to increase coverage further. In 2013, there was a measles outbreak in Wales, which was linked to the early 2000s

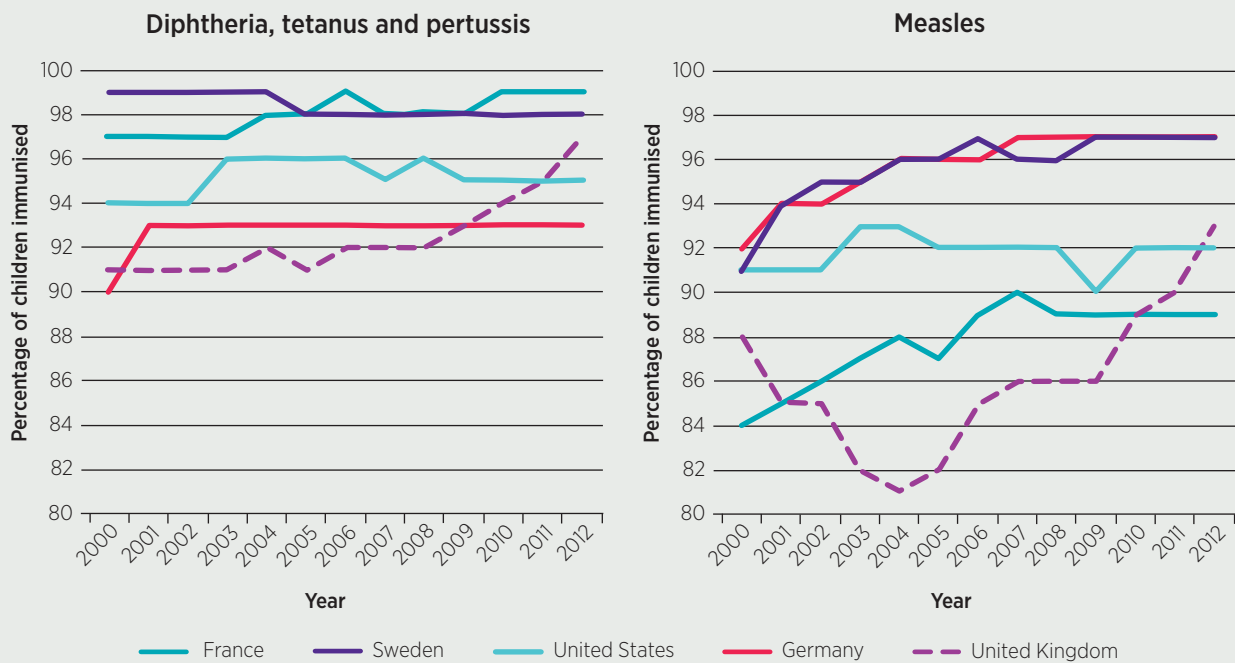


**Figure 6.1: Infant mortality – number of deaths for every 1,000 live births – in selected industrialised countries, 2000 to 2012**



Source: OECD, 2013

**Figure 6.2: Percentage of children immunised for diphtheria, tetanus and pertussis, and measles, by the age of two, 2000 to 2012**



Source: OECD, 2013

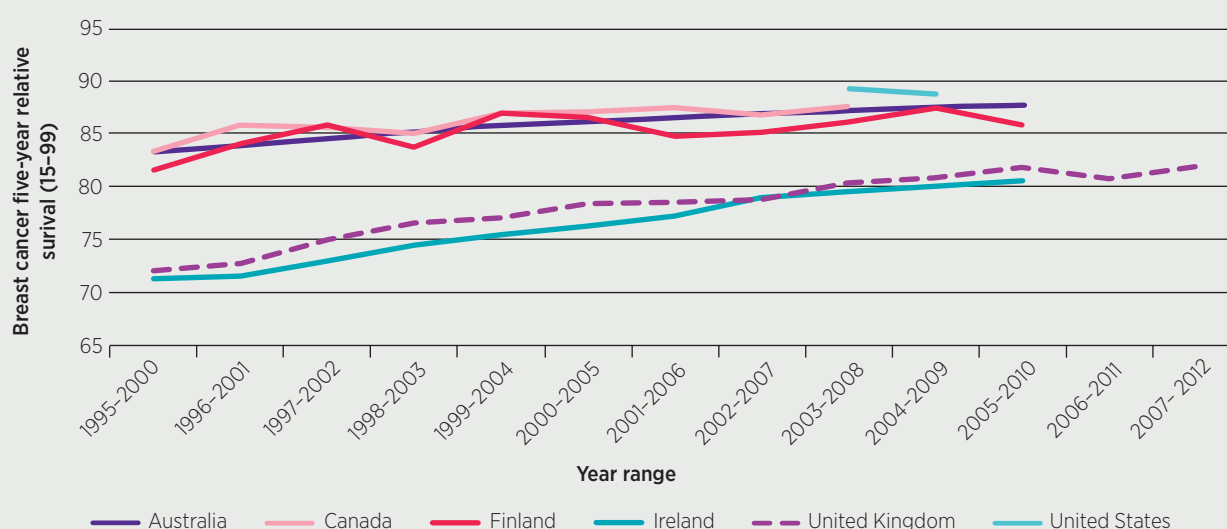
when vaccination rates were below 80% for cohorts of children (OECD, 2013). In order for the vaccines to have a protective effect on the entire community (herd immunity), apart from protecting the individual, coverage needs to remain high throughout the country. For example, DTP coverage in England in 2012/13 has been reported at 94.7% (seven out of 10 strategic health authorities exceeded 95%), and measles, mumps and rubella (MMR) coverage at 92.3% (no strategic health authorities achieved 95% coverage) (HSCIC, 2013d). According to the same report, vaccination coverage in England is slightly below the other UK countries for all routine childhood vaccinations (HSCIC, 2013d).

### Strong performance on cancer screening is not yet matched by performance on cancer outcomes

Cancer survival, together with cancer screening, coverage and mortality, are often used to assess the quality of cancer care. Survival rates are a broad indicator of the effectiveness of the healthcare system, capturing both early detection and the effectiveness of treatment (OECD, 2013).

The five-year relative survival rate<sup>1</sup> for breast cancer has been steadily improving in the UK over time, reaching 82% in 2007–2012 (see Figure 6.3). However, when compared with several other countries of the Organisation for Economic Co-operation and Development (OECD), the UK continues to lag behind in terms of survival, with the United States achieving the highest five-year relative survival levels (just under 90%). This is despite the UK's breast cancer screening rate – that is, the proportion of eligible and invited people who are actually screened – having been consistently high when compared with other countries (73% in 2011, compared with the OECD average of 62%).

**Figure 6.3: Five-year breast cancer survival rates in women, aged 15 to 99, 1995 to 2012 (%)**



Source: OECD, 2013

1. Relative survival is the ratio of the observed survival by cancer patients over a specified period of time after diagnosis, to the expected survival in a comparable group from the general population.

A similar pattern is observed in breast cancer mortality, which captures both the quality of the entire healthcare system (for example, prevention, early detection and treatment) and also incidence rates. This has been declining in the UK since the early 2000s, from 37.7 to 30.4 deaths for every 100,000 women. But while the UK continues to have one of the highest mortality rates, it appears to be improving more rapidly than other countries and may soon overtake them (Appleby, 2011). This annual statement has used breast cancer as an illustrative example, but trends are similar for cervical cancer and colorectal cancer where equivalent measures exist.

In summary, these examples from the areas of child health and cancer treatment emphasise the importance of taking a broad view of quality measurement and looking beyond the NHS for comparative groups. The UK has made significant progress over the last decade. Yet this progress is tempered by the evidence from other countries that the NHS can still do better.

# 7

## Discussion

Our first QualityWatch annual statement – *Is the Quality of Care in England Getting Better?* – highlighted that, on the whole, gains in quality made through the 2000s were being maintained (QualityWatch, 2013). However, there were some emerging areas of concern such as levels of nurse staffing in hospitals and pressure on urgent care. The report also sounded an important caveat that an assessment based purely on existing indicators or data at a national level will be limited in its portrayal, as significant variation exists throughout England. Furthermore, there are still many aspects of care, and care services, for which routinely available information on quality is inadequate or non-existent. Those caveats apply just as much to this second annual statement.

In this year's report we detect a change. Although many aspects of healthcare have continued to improve, signs of strain in the system have become increasingly apparent through the year. In many services, progress is slowing down or even reversing. For some time now, staff in the NHS have been preparing to manage services through an extended period of austerity. Key to such an objective has been a focus on protecting recent progress in quality by increasing efficiency. However, the harsh realities of this challenge are now becoming evident in the reduced accessibility of services, raising concerns particularly about the quality of care for people with mental health issues and increasing stress levels of staff. These are serious challenges to maintaining quality within health and social care services.

We have also demonstrated the importance of the NHS looking at comparisons beyond its own past performance to understand the quality of the care it delivers. Including an international perspective is vital, as while measured progress in the UK may be impressive, performance in comparable countries might be even better – for example in child mortality.

It is important to remember that the problems appear to be manifesting in some parts of the care system (such as mental health) more than others. There are also some reasons to be optimistic – or at least less pessimistic – for the coming years. The Francis report has widespread implications for how the NHS, in particular the acute sector, addresses some aspects of quality (Francis, 2013). There is some evidence that the profile given to quality at board level, particularly relative to debates about finances, has increased (Thorlby and others, 2014). This interest can be seen for example in the intention to increase nurse staffing and debates about minimum levels of ward staffing, but it is too early to expect to see measureable changes in quality as a result. Whether this focus on quality can be maintained as the financial challenge continues to increase will be a crucial test for the NHS in the coming years.

We also highlight the continued need for better information with which to understand patterns of quality (such as for measuring the equity of access to care by certain population groups) and for more imaginative use of that information

(such as conducting international comparisons). A more comprehensive measurement of quality would require better information about the views of service users, on both their perceptions of how effective their treatment was and their experiences of using the service. This involves both making the most of available data and finding new ways to gain insight into the quality of services through new information.

The role of QualityWatch is to describe changes in the patterns of the quality of care through a period of austerity. It is for policy-makers, commissioners and providers of care to decide how to respond to any decline in quality. Yet we are aware that there are many conflicting pressures on them as they do this, and there are no simple catch-all solutions to the challenges that care services are facing. Where services are struggling it may not be clear how a service can improve without additional funding. Yet, as various commentators have noted (for example Øvretveit, 2009), not all quality improvements have to cost significant amounts of money. We must also be mindful of the dramatic increases in work stress reported by care staff – any improvements based on increasing workload or holding down pay may be unsuccessful and possibly counter-productive. Further efforts to achieve the unachievable may do more to damage the service than protect it.

In the coming year we anticipate even more debate about key aspects of quality. Some of the most important questions will be as follows:

- **At what point do lapses in performance and quality become intolerable to patients, politicians or those running health and care services?**

We have seen evidence that many performance measures are slipping, yet there is room for debate about how significant this actually is to the public and service users. First, we must remember that these indicators represent just a single slice of the quality of care that a service provides. Second, the lack of absolute thresholds as to what should be an acceptable level of quality in many areas means that in many cases there may be room for debate about whether certain previous levels of performance might be a luxury which we can no longer afford. It may also be that reducing performance in the very short term allows a service to be reconfigured so that it can improve performance in coming years, or that reducing access to one service is a justifiable sacrifice to keep another service open. In each case these will be challenging political decisions, not all of which will be solely about funding. However, when declines in performance are reasoned away like this there is a risk that deterioration in standards may be tolerated without proper consideration.

- **Which services, service users or patients should be targeted for support?**

This annual statement has used a range of performance measures and studies to highlight aspects of health and social care where the quality of care appears to be a concern. Those responsible for funding or providing such services may consider the implications in their own localities. The same techniques can be used to monitor whether they improve after interventions (such as after the redesign of a service). They can also suggest whether changes to services are being made at the expense of quality. For these reasons it is particularly important that any changes have room for local evaluation, audit and assessment. Just as important are mechanisms for the sharing of lessons on success and failure, so that schemes in other areas can be implemented and adapted.

- **How do we measure success in quality and how do we address the most significant gaps in our information?**

We have seen evidence that much of the vital information we need to monitor and understand service quality is missing. The current policy concern to develop community-based alternatives to hospital care faces the challenge that information about services in community settings is very underdeveloped. For example, the NHS is currently unable to monitor accurately certain basic measures of activity such as the number of GP consultations each year.

While care in the vast majority of cases continues to be better than it was 10 years ago, there is evidence that the quality of several services is now starting to decline. As financial pressures continue to mount and managers reconfigure services to accommodate rising demand, continuing to scrutinise the quality of care delivered is more vital than ever before.

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