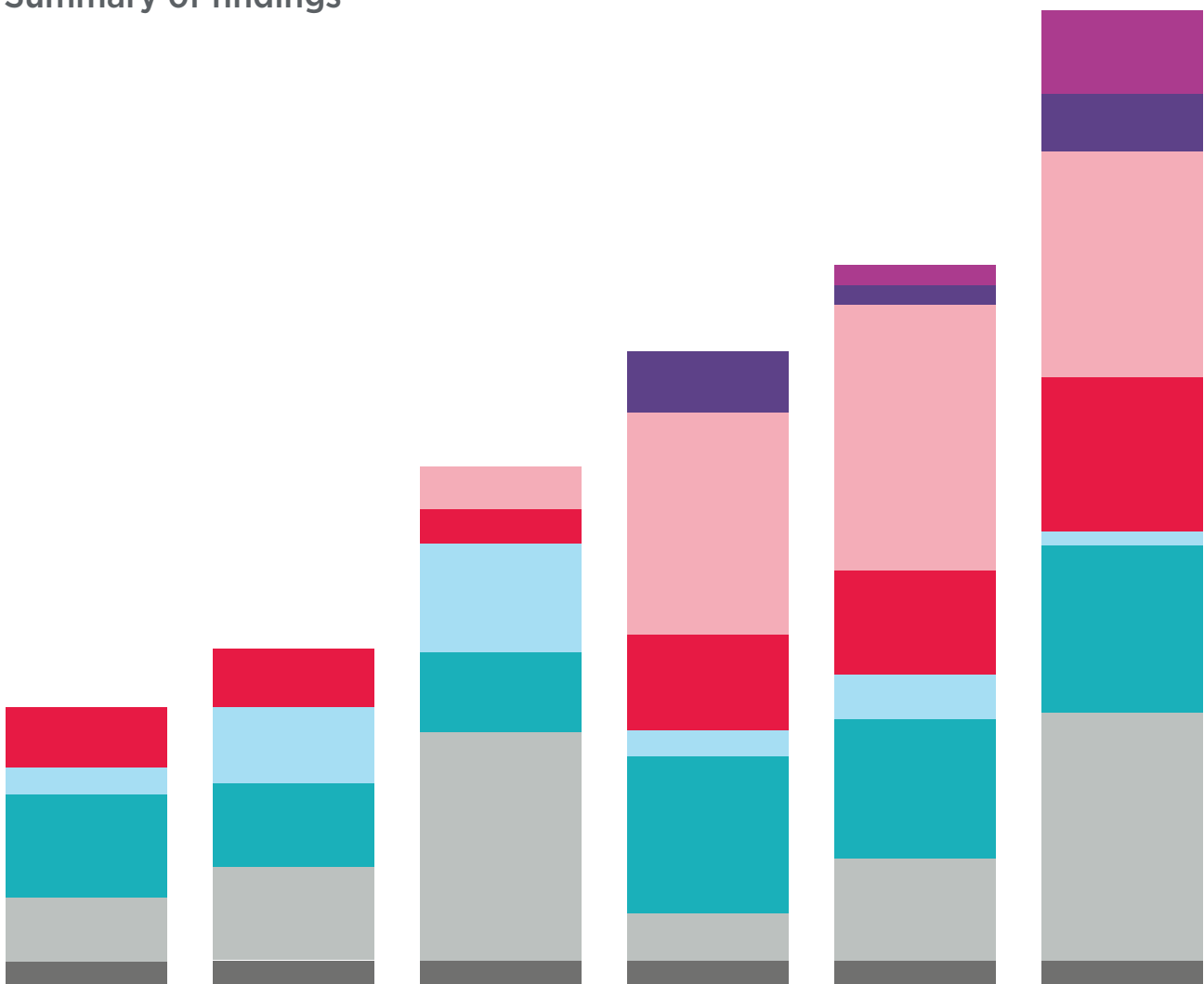


Is the quality of care in England getting better?

QualityWatch Annual Statement 2013:
Summary of findings



About QualityWatch

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

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

Introduction

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

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

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

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

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

The aims of the programme are to:

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

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

Our approach

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

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

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

Developing a range of indicators to assess quality

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

1. **Access:** Care services should be timely and provided within the appropriate setting with access to necessary skills and expertise.
2. **Safety:** Service users should not be harmed by the care they receive or exposed to unnecessary risk.
3. **Effectiveness:** Care services should be based, as far as possible, on relevant rigorous science and research, and/or nationally agreed best practice.
4. **Person-centred care and experience:** Care should be based on partnerships between professionals and service users (and, where appropriate, their families); and be delivered with compassion, empathy and responsiveness to the needs, values and preferences of the individual service user.
5. **Capacity:** Care systems should be sufficiently well resourced and with adequate distribution to enable delivery of appropriate services.
6. **Equity:** Care should be provided on the basis of need, regardless of personal characteristics such as age, gender or ethnicity; and in such a way as to reduce differences in health and well-being status and outcomes across sub-groups.

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

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

We initially identified over 1,500 possible indicators. In discussion with external experts we refined this to approximately 500 indicators, from which nearly 150 were prioritised to form the basis of our first wave of analysis. As mentioned above, this paper is a summary of a more detailed report that will be published later this autumn. The fuller report will present the analysis of a selection of our chosen indicators; analysis of a larger set can be found at www.qualitywatch.org.uk/indicators.

Main findings from the indicator analysis

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

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

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

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

In depth analyses on specific topics – ‘Focus On’ reports

Each year the QualityWatch programme will produce a number of in-depth analyses into specific topics that are critical to the quality of care, using a range of methods. Focus On reports provide snapshots and longitudinal analyses of aspects of quality in a particular area, or areas, of care. These analyses have contributed to our annual statement, as outlined in this paper, but each Focus On report will be published separately on the QualityWatch website at www.qualitywatch.org.uk/focus-on.

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

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

Recommendations

Improve measurement of quality

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

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

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

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

Improve urgent care

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

Monitor numbers of nurses

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

Conclusion

This paper is a summary of the first annual statement from the QualityWatch programme. It is not comprehensive but provides an overview of our initial research into the quality of publicly-funded health and social care services in England. Our analysis reveals three key messages:

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

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

Next steps

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

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

To keep up to date on our latest research and analysis, visit

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Nuffield Trust

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The Health Foundation

The Health Foundation is an independent charity working to improve the quality of healthcare in the UK. We want the UK to have a healthcare system of the highest possible quality – safe, effective, person-centred, timely, efficient and equitable. We conduct research and evaluation, put ideas into practice through a range of improvement programmes, support and develop leaders and share evidence to drive wider change.

QualityWatch

QualityWatch, a Nuffield Trust and Health Foundation research programme, is providing independent scrutiny into how the quality of health and social care is changing over time.

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