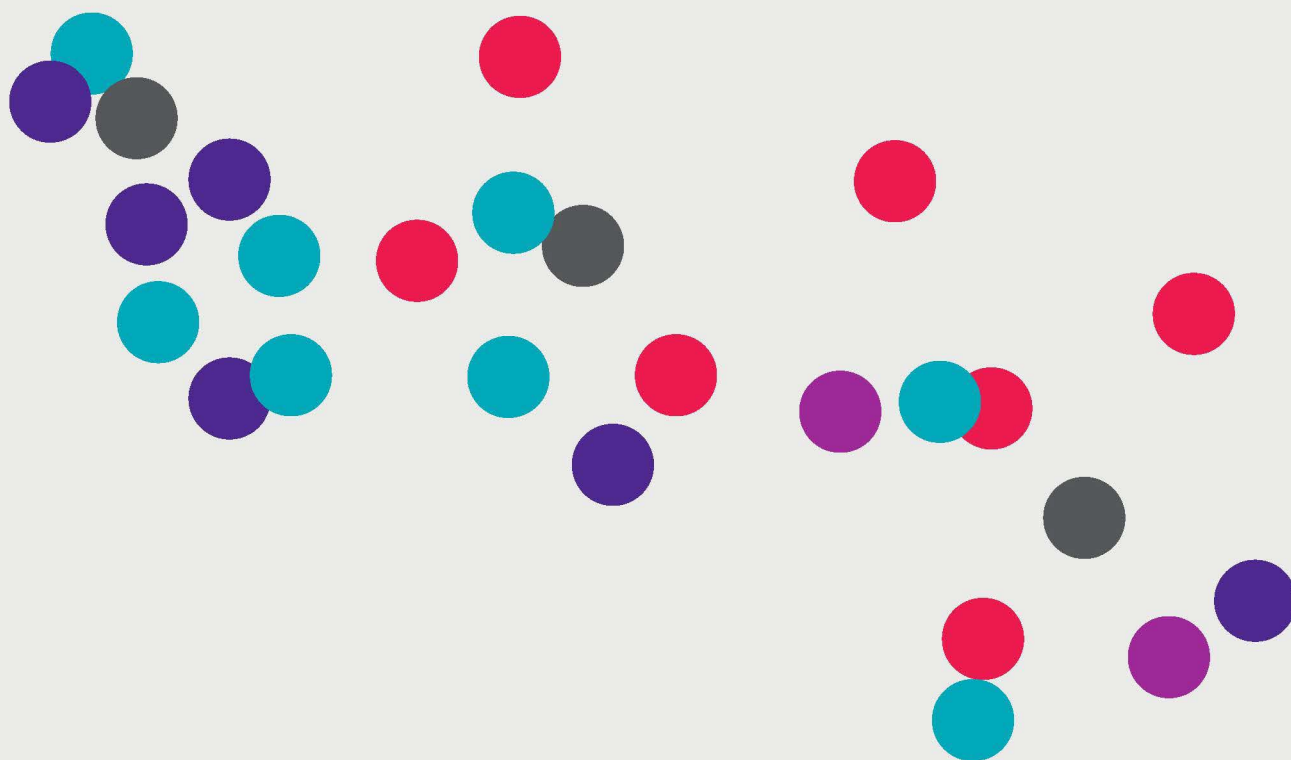


Quality at a cost

QualityWatch annual statement 2016



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About QualityWatch

QualityWatch is a major research programme providing independent scrutiny into how the quality of health and social care is changing. 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 also 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 fourth since the programme began in 2013 – presents an independent view of how patterns of quality have changed over time.

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Foreword

The profile of health and social care in England has never been higher. The NHS remains a top issue for the general public, with promises of additional funding for healthcare featuring prominently in the debate on the EU referendum. Daily headlines reveal the extreme pressures under which services are operating – from the Care Quality Commission raising the alarm that social care services are at ‘tipping point’, to the National Audit Office recently stating that ‘endemic’ problems with financial performance risk the sustainability of hospital services. And the omission of any extra support for health or social care in last month’s Autumn Statement was widely – and rightly – condemned as a missed opportunity.

But beneath all the headlines, how exactly is the considerable financial squeeze on public services affecting the quality of patient care? This is the central question for our QualityWatch programme and one which we revisit each year through our annual statement.

Our most striking finding is that, when pressures bite, the first thing to give is access to care. Waiting times for urgent and planned care have continued to slide throughout the duration of our QualityWatch programme to the point that most major targets are now being missed. While it should be remembered that English patients spend less time in A&E than their counterparts in many comparable countries, unacceptable delays for both emergency and planned care are nonetheless commonplace.

Just over a year ago, we said that the warning lights on care quality were glowing brighter, and predicted that patients would wait even longer for care in future; but pointed to quality being sustained and even improving in many important areas. On the surface, this year’s report seems to continue this story: care quality is being sustained in several areas – public health, patient satisfaction and stroke care to name a few. These achievements are impressive in themselves, and even more so when taken against a backdrop of a period of financial austerity more severe than in any other time in the history of the health service.

Once again we plot the decline in access to care in this year’s report – waiting times for planned treatment and ambulance response times continue on a downward trend. It seems that timely access to care is being forfeited in order to provide high-quality care once patients get into hospital. But for the first time, our analysis suggests that we may be reaching the point at which sacrificing access is no longer enough to manage the extreme pressures under which the NHS is operating.

First, lengthening waits for treatment increase risks for the patients affected. Waiting longer may mean preventable conditions are not addressed, while delays in treatment can mean minor ailments become bigger problems. The considerable pressures under which ambulance services are working and the lengthening waits for ambulances responding to life-threatening situations are deeply worrying.

Second, our report tracks a slowdown in the progress towards eradicating healthcare-associated infections (HCAIs). While impressive improvements have historically been made in this area, progress in reducing some common HCAIs appears to have stalled, while others are on the rise. While the Secretary of State’s

recent announcement on financial incentives for trusts to reduce *E. coli* infections is welcome, a big risk factor is bed occupancy, which remains at dangerously high levels. The risk to patient safety from HCAs in the future is concerning.

Finally, it may be that financial and other pressures will lead to 'delayed decline' in areas of quality so far unaffected. The deterioration in waiting times we see now did not begin until some years into the current decade of austerity, suggesting that financial pressures take some time to translate into quality lapses.

Preventing a quicker decline may well have been down to the hard work and goodwill of staff. But with workforce shortages, pay freezes continuing across the NHS and last month's Autumn Statement offering no relief from austerity in the NHS and social care for the remainder of the decade, we should be on high alert for any further decline in quality of care – whether patient experience, other waiting times or patient safety.

For now, considering the extent and depth of the financial squeeze, many services within the NHS are still bearing up well. But the success stories we see through our ongoing analysis have, in large part, been the result of careful and targeted investment. Sustaining this in the face of growing financial, demographic and workforce pressures will be a considerable challenge.

There is no doubt that more can – and must – be done to make the NHS as efficient and effective as possible. The ideas and innovative thinking to improve and transform services are in ample supply within the health service, but the NHS needs a chance to deliver them, through intelligent investment, support and time. Failure to do so could put an already stretched NHS at risk of serious lapses of care. Patients deserve better than that.

Dr Jennifer Dixon
Chief Executive
The Health Foundation

Nigel Edwards
Chief Executive
Nuffield Trust

Executive summary

This has been another significant year for the English health and social care systems. There are growing pressures on the NHS, with continued budget constraints, increasing population needs, growing workforce issues and risks, the ongoing development of new care delivery models and further shifts in accountability and regulatory frameworks, including the emerging sustainability and transformation plans.

As a result, health and social care services are expected to do more with less in a rapidly changing environment. This presents a major challenge to those involved in maintaining and improving the quality of care services.

QualityWatch, a joint research programme from the Nuffield Trust and the Health Foundation, provides authoritative and independent analysis to monitor how health and social care quality is changing in response to these pressures.

This annual statement presents a series of findings, drawn from the ongoing monitoring of more than 300 quality indicators and in-depth research, and provides a view on the state of care quality in England. We focus on six selected areas of particular interest in health and social care covering the settings of care provision and the elements that define quality. They highlight a range of trends in quality and shine a light on less well-known care quality 'stories'.

Public health and prevention

Analysis of trends in 20 public health outcome indicators between 2009 and 2015 suggests that the quality of public health and prevention services was maintained in most areas. However, there are some emerging areas of concern, such as rising sexually transmitted infection rates and alcohol-related hospital admissions. These could be early symptoms of future problems and warrant continued scrutiny.

Patients' experiences of primary care services

Primary care is under increasing pressure linked to workload and workforce shortages, with primary care doctors in the UK more likely to report that their job is 'very' or 'extremely' stressful compared with nine other similar countries (Osborn and others, 2015).

General practice, however, continues to have high levels of overall patient experience and satisfaction, but maintaining this remains a challenge. In recent years more patients are reporting difficulties with accessing services and having choice, including around how easy it is to get through on the phone to someone at GP surgeries or whether they are 'always' or 'almost always' able to see their preferred GP.

Ambulance response times and call handling

The amount of activity managed by ambulance services has increased substantially over recent years, despite a backdrop of concerns around workforce. Nonetheless the evidence indicates that between 2011/12 and 2015/16 the quality of care delivered through ambulance call handling has improved. There are more people getting through to the service on the phone promptly, twice as many calls are resolved with telephone advice, nearly half a million fewer calls resulting in ambulance journeys to A&E and a there was

a seven-percentage-point drop in the re-contact rate within 24 hours when emergency calls were closed with telephone advice.

However, ambulance response times to the most urgent calls continue to deteriorate and remain a concern. In September 2016, both Red 1 and Red 2 calls attended to within the eight-minute standard fell far short of the national target.

Hospital care

The continued growth in the size and needs of the population is reflected in the number of contacts patients have with hospitals (in A&E departments and inpatient, outpatient and day-case settings), which has increased year on year between 2002/03 and 2014/15, despite a reduction since 2007/08 in available overnight acute and general beds.

Other findings show that:

- There is a worrying increase in the number of patients on the waiting list for consultant-led treatment and a reversal in the improvements achieved in the amount of time patients had to wait.
- The number of diagnostic tests undertaken each month has doubled over the past ten years, but the proportion not delivered within six weeks has fallen dramatically over the same time period (from 55 per cent to 2 per cent), even if the national target of achieving 99 per cent of all diagnostic tests within six weeks is not currently being met.
- Between 2007/08 and 2015/16, there have been substantial decreases in the number and rates of healthcare-associated methicillin-resistant *Staphylococcus aureus* (MRSA) bloodstream infections and *Clostridium difficile* infections. While there are a small number of these infections each year still difficult to eradicate, these accomplishments are particularly noteworthy given current bed occupancy and NHS staffing levels, both of which have an influence on the occurrence of infections – although the tension between hitting access targets by treating more people and bed occupancy has the potential to undo all this good work.
- Recent trends also show an improvement in inpatient care being delivered in a personalised way with compassion, despite recent issues with NHS staff shortages. Although positive, there are still a number of patients who do not have a good experience in this respect and more still needs to be done.

Patients' views of mental health services

Mental ill health will affect many people from all backgrounds at some point in their lives, costs a substantial amount to the national economy and accounts for a nearly a quarter of all NHS activity. Yet spending on secondary mental health services is not in line with its impact nationally or with its activity ratio to non-mental health services.

Patient survey data indicate that parity of esteem between patient experience of mental health services and patient experience of other services has not been achieved and, while the majority of respondents to the community mental health survey viewed their care positively overall, responses were not as favourable as comparable measures of adult hospital inpatient care or primary care. Those with self-reported mental health conditions are also less positive about their care experience than patients who do not report a mental health condition.

Condition-specific care

Evidence from analysis of the care of patients with hip fractures indicates that the quality of care in this area has improved, despite increases in the incidence of hip fractures and the associated activity in hospitals. It is likely this is due to investments in the care pathway, the availability of national guidelines and data to support improvement.

Similarly, the quality of immediate care for patients who have had a stroke and their longer-term rehabilitation has also improved. This includes more patients with suspected stroke receiving a brain scan within an hour and an increase in the proportion of patients who had a psychological assessment on discharge. Care for this condition has also been supported by a long-term focus on stroke care.

Our verdict on care quality

Our analysis has shown that, in the face of considerable pressures, there are positive stories about care quality that run counter to recent prominent headlines suggesting that the NHS is in freefall.

However, while the achievements highlighted in the report are worthy of celebration, there is no room for complacency. The NHS and social care enter 2017 amid the tightest funding settlement for decades. Healthcare activity continues to rise, and the pressures on the health and social care systems show no signs of abating.

The next 12 months will prove a crucial test for the resilience of the health and social care system. Without continued investment in health and social care, we cannot confidently predict that improvements sustained thus far will continue to be made, or that the deterioration highlighted in this report will be reversed.

1

Health and social care quality and QualityWatch

The quality of care being provided is a central concern of all health and care systems. It is the foundation upon which positive individual healthcare outcomes and experiences can be achieved in a cost-effective way.

It has been yet another significant year for health and social care systems in England. Ongoing considerations include:

- **unprecedented increasing population needs** (Office for National Statistics, 2016a; 2016b)
- **growing workforce issues and risks** (Centre for Workforce Intelligence, 2014; National Audit Office, 2016; NHS Pay Review Body, 2016; Institute for Employment Studies, 2016; NHS Improvement, 2016; Baird and others, 2016)
- the **ongoing development of new care delivery models** (NHS England, 2016a)
- **further shifts in accountability and regulatory frameworks – including the emerging sustainability and transformation plans** (NHS England and others, 2015).

These considerations also need to be understood in the context of the continuing budgetary constraints affecting health and social care services:

- the **NHS is midway through a decade of the slowest funding growth in its history** (Roberts and others, 2012; Health Foundation, 2015; Nuffield Trust, the Health Foundation and The King's Fund, 2015; Commons Select Committee, 2016; Nuffield Trust, 2016)
- **central government funding to local government has been reduced** (Ismail and others, 2014; National Audit Office, 2014), resulting in decreased public spending on adult social care¹ and cuts to local government public health budgets.²

As a consequence of all of this, health and social care services are expected to do more with less in a rapidly changing environment. This presents a major challenge to those involved in maintaining and improving the quality of care services: many of the factors described above are closely linked to the delivery of good-quality care (Francis, 2013; Lafond and others, 2016), and there is a significant risk that the focus on managing system change and finances will come at the expense of quality.

QualityWatch provides authoritative and independent analysis in order to monitor the extent to which health and social care quality is changing in response to these pressures. The programme defines quality as care delivered in a safe, effective,

1 Local government is responsible for the supply of publicly funded social care services, either through commissioned or directly provided services.

2 Local government is responsible for some public health services and functions (Department of Health, 2016a). The remaining services and functions are the responsibility of the Secretary of State for Health and are commissioned through NHS England (NHS England, 2015c).

equitable and timely way, by the right people with the right skills and tools,³ and centred on the individual. It uses an extensive range of indicators to create narratives on how the quality of care has changed over time across different care sectors⁴ as well as carrying out a number of in-depth studies on specific topics. Each year, findings from across the whole programme are reviewed and compiled into an annual statement on the state of care quality in England.

This is the fourth QualityWatch annual statement. The findings presented here cover a broad range of settings in which people use the health and social care system, and deal with a range of different dimensions of quality (see Figure 2.1). The report shows that despite the demands and tensions being placed on the NHS and social care, quality is being maintained or improved in many areas – for example, in overall patient experience and satisfaction with GP practices, and in effective care for specific conditions. However, there are also several areas where quality is deteriorating. In some cases this has been apparent for a considerable time – most notably in regard to timely access to care, such as ambulance response times.

Since the pressures on health and social care services are unlikely to ease over the next few years, the risks to quality are set to continue to grow. It seems likely that some measures of quality will continue to deteriorate, with potential new declines in quality in areas that are, as yet, unaffected. Services that have no comprehensive overview of quality due to insufficient information are under particular risk, since it is harder to manage what is unknown.

3 Any mentions of ‘timely’ care refer to the ‘access’ element of quality. ‘The right people having the right skills and tools’ refers to the ‘capacity’ element of quality.

4 Care sectors are social care; primary and community care; secondary care; mental health; learning disability; and population and commissioning.

2

A view of quality

This section analyses the current state of care quality in England, informed by QualityWatch's continuous monitoring of more than 300 quality indicators and the in-depth research undertaken throughout the year.

The findings focus on six areas of particular interest in health and social care.⁵ These areas were selected through consultation with the national experts on the QualityWatch advisory board. Taken together, they aim to:

- cover a wide range of contexts in which people make use of the health and social care system
- provide a cross-sectional view that covers a broad range of the elements that define quality
- highlight a range of trends occurring in quality – from cases that are improving or maintaining to those that are deteriorating
- shine a light on some unexpected or less well-known care quality 'stories'.

Areas of focus were selected to provide balance across the above requirements. Information on areas not specifically covered within this report can be found on the [QualityWatch website](#) for further consideration.

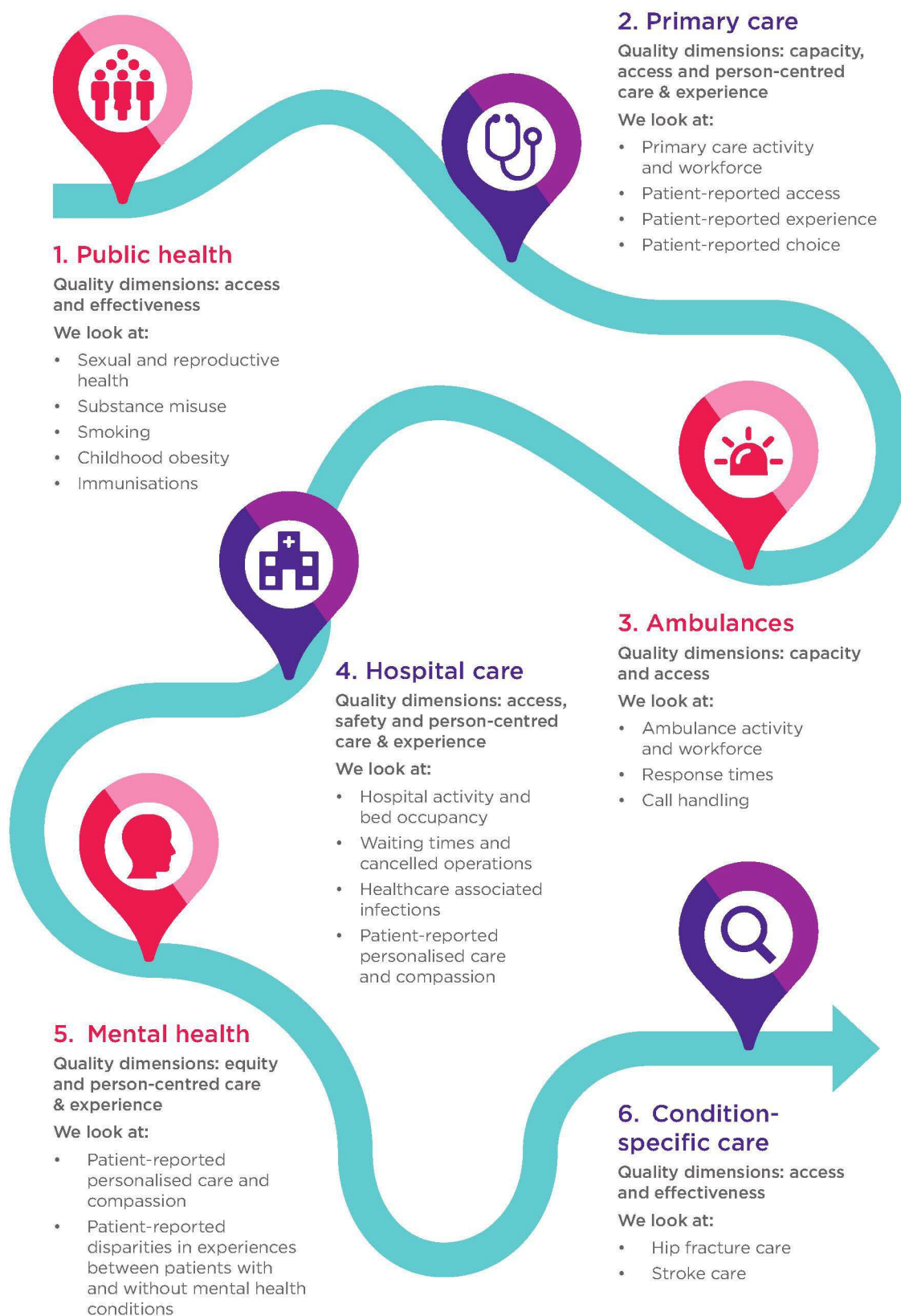
The topics covered here are as follows:

- public health
- patients' experiences of primary care services
- ambulance response times and call handling
- hospital care
- patients' views of mental health services
- condition-specific care.

Each area of focus is assessed in turn, following a simplified pathway of how users of health and social care might flow through the system (see Figure 2.1).

⁵ The findings within the report have used the most up-to-date data available at the time of analysis. Due to different sources of data having different publication schedules, and differences in the availability of historical data, the time periods that are reported on within the report vary according to the subject being discussed.

Figure 2.1: The areas of care covered in the QualityWatch annual statement



Note: Mental health care can be properly understood as an aspect of care that runs throughout the 'patient pathway'. It is presented in this report as the fifth topic along a simplified and linear pathway merely for presentational reasons.

2.1 Public health

Analysis of trends in 20 public health outcome indicators between 2009 and 2015 suggests that the quality of public health services was maintained in most areas. However, there are some emerging areas of concern, such as rising sexually transmitted infection rates and alcohol-related hospital admissions. These could be early symptoms of future problems and warrant continued scrutiny.

The aim of public health is to help people to stay healthy by minimising their risk and impact of illness and protecting them from threats to their health. The importance of public health to health and social care systems was highlighted in a 2002 report commissioned by the Government called *Securing our future health: taking a long-term view* (Wanless, 2002). The report warned that unless public health and prevention were taken seriously, the NHS would face the costs of a rising burden of avoidable illness.

One of the aims of the Health and Social Care Act 2012 (HM Government, 2012) was to strengthen public health by transferring a range of functions from the NHS to local government, and by bringing together disparate public health organisations into one organisation at a national level to form Public Health England (PHE).

An in-depth QualityWatch study (Davies and others, 2016) explored changes in quality across a range of public health services before, during and after this restructuring. It found evidence that, between 2009 and 2015, there were improvements in 10 indicators of public health outcomes (see Table 2.1), including the provision of long-acting reversible contraception (LARC) by general practitioners (GPs) and reduction of genital warts, drug treatment waiting times, smoking during pregnancy, and childhood obesity at age 4–5 years.

However, five of the 10 indicators that showed improvements overall also raised concerns: there was an indication that progress may have slowed in recent years in reducing smoking prevalence, teenage pregnancy and late diagnosis rates for HIV; in completion of substances misuse treatment; and in uptake of measles, mumps and rubella (MMR) immunisation.

More worrying was the observation that six indicators of public health outcomes had deteriorated: there had been a reduction in the number of people setting a quit date with NHS stop-smoking services; and increasing rates of four common sexually transmitted infections (STIs) and alcohol-related hospital admissions.

The authors concluded that there was little evidence of marked changes in the outcomes indicators overall and, where there were specific deteriorations, it was hard to ascertain the main drivers for those changes – for example, whether they were the result of system reforms, budget cuts or wider societal factors.

Beyond the Health and Social Care Act 2012, continued emphasis has been placed on the importance of public health and prevention by the *NHS Five Year Forward View*, which stated that “the future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health” (NHS England and others, 2014). Although the sustainability and transformation plans (STPs) being drawn up by local areas are generally focused on the delivery of healthcare, they are also

Table 2.1: Direction of trends in public health indicators from 2009 to 2015

Area of public health	Indicator	Direction of trend	
Sexual and reproductive health and HIV	Provision of long-acting reversible contraceptives by GPs	Improving	
	Genital warts	Improving	
	Late diagnosis for HIV	Improving but may have slowed	
	Teenage pregnancy	Improving but may have slowed	
	STI rates	Gonorrhoea	Deteriorating
		Syphilis	Deteriorating
		Genital herpes	Deteriorating
Chlamydia		Deteriorating	
Substance misuse	Substance misuse treatment waiting times	Improving	
	Completion of substance misuse treatment	Improving but may have slowed	
	Alcohol-related hospital admissions	Deteriorating	
	Number of people undergoing substance misuse treatment	Stable	
Smoking	Smoking in pregnancy	Improving	
	Adult smoking prevalence	Improving but may have slowed	
	Number of people setting a quit date with NHS stop-smoking service	Deteriorating	
	Proportion of successful quitters	Stable	
Childhood obesity	Obesity at age 4–5	Improving	
	Obesity at age 10–11	Stable	
Immunisations	MMR immunisation uptake at age 2	Improving but may have slowed	
	DTaP/IPV/Hib immunisation uptake at first and second birthday	Stable	

Source: Davies and others (2016)

required to set out how the most important and highest cost-preventable causes of ill health will be addressed, including diabetes and obesity in both adults and children (NHS England and others, 2015).

In addition to these broad-ranging initiatives, national policy strategies are being targeted at specific areas of public health. For example, the Government recently published a new strategy, *Childhood obesity: a plan for action* (HM Government, 2016). The strategy contains some positive measures aiming to tackle obesity in

childhood, although it has been widely criticised for being unambitious and falling short of what is needed to address the issue (British Medical Association, 2016; Faculty of Public Health, 2016; Royal College of General Practitioners, 2016). The introduction of standardised packaging for tobacco products, which came into force in May 2016, constitutes another targeted public health policy (Legislation.gov.uk, 2015).

However, policy objectives to strengthen public health provision in the NHS and local government will be difficult to deliver under the current financial settlement. In June 2015 it was announced that there would be in-year cuts to local government public health budgets by £200 million nationally, as part of a set of measures to reduce public debt (Department of Health, 2015). Then, at the end of November 2015, HM Treasury published its Comprehensive Spending Review setting out the Government's long-term economic plan (HM Treasury, 2015), which, when scrutinised, made it clear that there would be £3 billion worth of cuts across a range of healthcare areas, including public health (Commons Select Committee, 2016). Ultimately, there will be a 3.9 per cent per year cut to local government public health budgets over the next five years. This amounts to a real-terms reduction of at least £600 million in public health spending by 2020/21 (Nuffield Trust, the Health Foundation and The King's Fund, 2015).

Prioritising public health in times of austerity was identified by Davies and others (2016) as a key challenge. The senior public health professionals surveyed as part of that report highlighted the detrimental effects of increasing financial pressures on public health provision across local government and the NHS, including the exacerbation of inequalities. Professionals also expressed concerns regarding the uncertainty over financial planning for public health and the potential for tougher prioritisation decisions, alongside concerns about losing the skilled public health workforce (Davies and others, 2016).

These views have been echoed elsewhere, with concerns being raised over the capacity of public health teams to meet future demands and of local government to meet various challenges (Peckham and others, 2016; House of Commons Health Committee, 2016).

So, although the majority of public health outcome indicators show that the quality of public health services delivered was maintained up to 2015, there are warning signals for the future in some areas. Strengthening the case for prioritising public health, along with scrutiny of local commissioning decisions, may help to ensure the rhetoric of greater focus on prevention becomes a reality (Davies and others, 2016). Continued monitoring of public health outcomes is also warranted in order to ensure improvements are sustained and emerging challenges are identified and addressed.

2.2 Patients' experiences of primary care services

Primary care is under increasing pressure linked to workload and workforce shortages, with a greater proportion of patients reporting difficulties with accessing services over recent years. Although general practice continues to have high levels of overall patient experience and satisfaction, maintaining this remains a challenge. In particular, there are likely to be difficulties in balancing prompt access to care with patient choice and continuity of care, which also has the potential to affect other dimensions of quality, such as safety.

Good-quality primary care is an essential aspect of a well-functioning health and social care system. It is typically the first contact of care, the principal point of continuity for the majority of patients in the healthcare system, and is associated with delivering better outcomes for patients (Starfield and others, 2005).

Despite the importance of this sector, there are currently no comprehensive up-to-date general practice activity data. This means it is difficult to reliably describe the amount and type of work undertaken by these care providers, the current pressures this sector is facing or how the situation has changed over time.

However, the Royal College of General Practitioners (2015a) states that primary care accounts for 9 out of 10 contacts that patients have with the NHS. An estimate from 2008 put the total number of primary care consultations in England at 300 million (Hippisley-Cox and Vinogradova, 2009), and other studies have pointed out the likelihood that general practice clinical workload will have increased since that estimate was first made (Baird and others, 2016; Hobbs and others, 2016).

There is evidence that growth in the number of GPs (QualityWatch, 2016a) has not kept pace with the likely increase in activity or population changes, and there is considerable variation in GP coverage between regions (Centre for Workforce Intelligence, 2014; Baird and others, 2016). National bodies highlight in the *General practice forward view* that many practices now face recruitment issues and are increasingly reliant on temporary staff (NHS England and others, 2016). That report contains actions for growing and developing the workforce, but also acknowledges that increasing the workforce is only one way to address increasing workloads and that driving efficiencies, modernising infrastructure and reforming support and service organisations could also contribute (NHS England and others, 2016).

Primary care doctors in the UK are also more likely to report that their job is 'very' or 'extremely' stressful compared with nine other similar countries (Osborn and others, 2015). This suggests that the current levels of stress experienced by GPs in the UK goes beyond the inherent stresses associated with primary care work and is likely to be related to the wider context of general practice in the UK.

The impact of general practice workload on quality was highlighted in a 2015 survey by the British Medical Association (BMA), where nine in 10 GPs reported that their workload negatively impacted on the quality of care given to patients (British Medical Association, 2015). The Royal College of General Practitioners (2015b) has warned that sustained workload pressures in general practices (influenced by both clinical and non-clinical drivers) were making it increasingly difficult for care to be provided safely due to fatigue.

As with activity, though, understanding quality in primary care is challenging given the limited national, publicly available information. What is available mainly relies on information from the annual reward and incentive programme the Quality and Outcomes Framework (QOF), patient surveys, and certain measures of hospital activity (such as admissions for conditions that can be effectively treated in primary care) as a proxy for the effectiveness of primary care.

Previous QualityWatch annual statements have used the GP patient survey to report in detail on access to primary care, showing that many of the access measures declined between 2011/12 and 2014/15 (QualityWatch, 2014; 2015). For example, the percentage of patients reporting that they found it easy to get through on the phone to someone at GP surgeries decreased from 78 per cent in 2011/12 to 71 per cent in 2014/15. Furthermore, the percentage of patients reporting that it took more than a week to see or speak to a GP or nurse rose by five percentage points from 2011/12 to 18 per cent in 2014/15. However, the most recent survey shows that these measures have not continued to deteriorate in 2015/16 (QualityWatch, 2016b).

Patients' own experiences of making an appointment are another barometer of quality in this area and are closely related to access measures. Like the patient-reported access measures, patient-reported experiences of making an appointment declined between 2011/12 and 2014/15, dropping nearly six percentage points to 73 per cent, but the latest survey reported no further deterioration in 2015/16 (QualityWatch, 2016b).

Likewise, patient choice is a measure that is linked to patient access. One way of assessing quality in patient choice is by measuring how many patients are able to see the GP of their choice, if they have an expressed preference on this issue – which, as reported in the latest patient survey, is nearly half of all patients (49 per cent) (Ipsos MORI, 2016). According to the July 2016 survey, only 35 per cent are 'always' or 'almost always' able to see their preferred GP, which is down 7 percentage points from June 2012 (Ipsos MORI, 2016).

Despite this, patients' overall experiences of their GP surgeries is positive, with more than 4 out of 5 patients saying their experiences were either 'very' or 'fairly good' in 2015/16 (QualityWatch, 2016c). This has decreased very little in the last five years, with 88 per cent in 2011/12 compared to 85 per cent in 2015/16 (see Figure 2.2).

Another question that can give an indication of whether patients feel positive about the services provided by their GP is whether they would recommend the surgery to someone new to the area. Responses to this question show the same high, positive levels as the patients' overall experience of the general practice surgery, although it has also fallen from 82 per cent in 2011/12 to 78 per cent in 2015/16 (QualityWatch, 2016c).

Overall, it appears that there are difficulties facing primary care due to increasing workloads and the development of the workforce to withstand these workloads, with patients increasingly experiencing difficulties in accessing services over recent years. Despite this, patient satisfaction with primary care, as measured in the GP patient survey, appears to have been maintained at quite high levels.

Figure 2.2: Percentage of patients who said that their overall experience of GP surgery was 'fairly good' or 'very good' between 2011/12 and 2015/16



Source: QualityWatch (2016c)

However, patient choice⁶, which is the closest existing measure for continuity of care in a primary care setting, appears to be becoming more difficult to satisfy. It could be argued that a reduction in continuity of care in this care setting has the potential to become a serious quality problem (Primary Care Workforce Commission, 2015). Population demographics are changing (Office for National Statistics, 2016a). As general practices see an increasingly large proportion of older patients and patients with increasingly complex needs, the continuity of care becomes ever more important for maintaining care that is delivered efficiently, effectively and safely. This is especially true given the important balance being struck with the need to provide rapid access, potentially leading to restrictions in the length of appointments: without continuity of care, extra time may be needed during appointments to get a patient's history and important aspects of care may be missed.

⁶ 'Patient choice' as measured by the proportion of patients responding to the GP patient survey who report that able to see a GP they'd prefer to.

2.3 Ambulance response times and call handling

Despite increased ambulance service activity and workforce issues, the quality of care delivered through ambulance call handling has improved. There is evidence that more people are getting through to the service on the phone promptly, more are being helped over the phone, fewer are being conveyed to A&E and more are given an appropriate response the first time. However, response times of ambulances to the most urgent calls continue to deteriorate and remain a concern.

The ambulance service cares for patients with unscheduled healthcare needs (such as emergency 999 calls and urgent hospital admissions requested by GPs) as well as scheduled needs (such as transporting people to attend outpatient appointments and day care facilities). NHS ambulance trusts play a major role in ensuring that patients receive the most suitable care as promptly as is appropriate for their needs and that fewer patients are taken to A&E departments unnecessarily. This is not only important at the time of the emergency; it can also reduce the amount of support patients need later on.

Ambulance activity and workforce

Ambulance services have experienced a substantial increase in activity over recent years. Between 2011/12 and 2015/16, ambulance calls increased by nearly 1.25 million (a 15 per cent increase) and the number of incidents in which a patient required onward transportation⁷ increased by nearly three-quarters of a million (an 18 per cent increase), to nearly 4.75 million (NHS England, 2016b). This equates to an average of just over 13,000 onward transportations per day in September 2016 (NHS England, 2016b). Similarly, between 2012/13 and 2015/16, the number of Red 1 and Red 2⁸ calls resulting in an emergency response arriving at the scene of the incident increased by over a million to a total of 3.36 million (a 47 per cent increase). In September 2016 this was a daily average of 6,766 calls (NHS England, 2016b).

This increase in ambulance activity has occurred against a backdrop of concerns relating to the ambulance service workforce. The total number of qualified ambulance staff in the NHS grew between 2004 and 2014, but not as much as other clinical staff groups (QualityWatch, 2016a). Furthermore, there are known problems with recruitment and retention of ambulance services staff (Department of Health, 2015), with localised problems of ever-increasing numbers of leavers (NHS Pay Review Body, 2016). Ultimately, there is a shortage of staff in this sector, which is reflected in the inclusion of this staff group on the Migration Advisory Committee's shortage occupation list (Home Office, 2016), with a national vacancy rate of 8 per cent (1,200) being cited in September 2015 (NHS Pay Review Body, 2016).

⁷ These were previously described as 'emergency journeys'. They include calls that have been passed from 111. As of April 2013, only incidents with a patient journey to type 1 or type 2 A&E are included, and one incident with two or more patients transported is counted as just one incident.

⁸ Category A (immediately life-threatening) calls are split into Red 1 and Red 2. Red 1 calls are the most time critical, and cover cardiac arrest patients who are not breathing and do not have a pulse, and other severe conditions such as airway obstruction. Red 2 calls are serious, but less immediately time critical, and cover conditions such as stroke and fits.

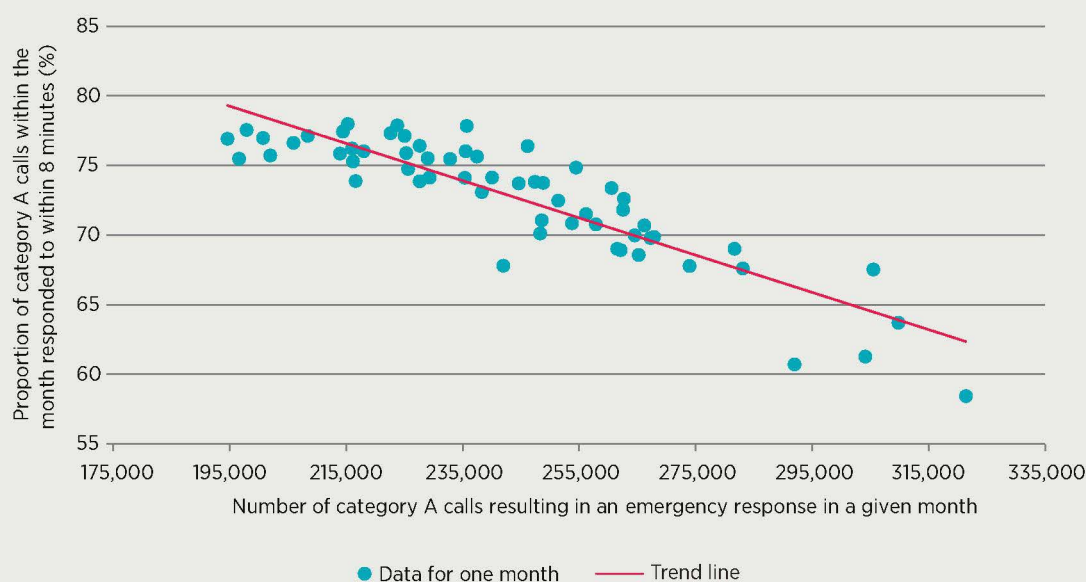
Ambulance response times

Previous QualityWatch annual statements have reported in detail on ambulance response times to life-threatening emergency calls, which showed steady declines in the proportion of calls for which an emergency response arrived within the national standard of eight minutes (Quality Watch, 2014; 2015). Nationally, the target of meeting this standard 75 per cent of the time was regularly missed throughout 2013/14 and 2014/15 (Quality Watch, 2014; 2015).

This decline has continued into 2015/16 and for the months to date in 2016/17⁹, with the national target for Red 1 calls only being achieved in April and May 2015 (QualityWatch, 2016d). In March 2016, Red 1 and 2 performance reached its lowest point since the targets were introduced in April 2011, with only 66.5 per cent of Red 1 and 58 per cent of Red 2 calls being attended within the eight-minute standard (QualityWatch, 2016d). Most recently, in September 2016, 68.3 per cent of Red 1 calls and 62 per cent of Red 2 calls were attended to within the eight-minute standard (QualityWatch, 2016d).

Looking closely at the interplay between calls to ambulance services and ambulance response times, there appears to be an inverse relationship between the total number of Red 1 and 2 calls and the percentage that can be responded to within the national standard of eight minutes (see Figure 2.3) (QualityWatch, 2016d).

Figure 2.3: Relationship between the number of 'red 1' and 'red 2' (category A) calls received nationally and the national percentage of calls responded to within 8 minutes per month



Source: QualityWatch (2016c)

However, the total number of calls received does not appear to be the sole reason for a breach of the target nationally in a given month. A breach is not always associated with higher call activity, and increased call activity doesn't always result in a breach, so there appear to be other factors that influence breaches of the target. For example, breaches may occur because of reduced capacity within

⁹ As of 19 April 2016 (South Western), 21 April 2016 (Yorkshire) and 8 June 2016 (West Midlands), trusts commenced the ARP clinical coding trial; therefore, only data up to but not including these dates have been supplied in the data set – data from April 2016 were not plotted in Figure 2.3.

the ambulance service to respond quickly enough when required. This may be influenced by a greater proportion of calls that are difficult to reach (for example when there is a longer distance to cover or if road conditions are difficult), by a greater proportion of cases that require more time to resolve, or instances where the ambulance service is unable to promptly transfer patients to an appropriate care setting such as an A&E department.

Evidence to support this latter proposition can be observed during the winter months. During these months, there are peaks in the number of ambulances queuing at emergency departments that coincide with breaches of the four-hour A&E waiting target (indicating that emergency departments have a reduced ability to admit new patients) (Fisher and Dorning, 2016). At the same time, there is a reduction in ambulance services' ability to respond to emergency calls within eight minutes (Fisher and Dorning, 2016).

More work is needed to look into how much impact each of these factors could have on ambulance response times. However, this remains a challenge in the absence of systematic national data on many of these factors, including the distances travelled by ambulance services or data on ambulance queuing outside of the winter period.

Ambulance call handling

Ambulance response times, however, are only one measure of ambulance service performance. In the remainder of this section we extend the analysis of the quality of this sector by investigating calls to the ambulance service, focusing on how well they are handled.

The 15 per cent increase in the total number of ambulance calls over the four years up to 2015/16 represents an increase of over 100,000 calls per month – for example, there were 633,538 calls in April 2011 compared with 745,032 calls in April 2016 (NHS England, 2016b). Despite this, over the same period the proportion of ambulance calls abandoned before being answered – a marker of slow telephone response times – has been maintained at a very low level, and only 1.2 per cent of all calls were abandoned in September 2016 (QualityWatch, 2016e).

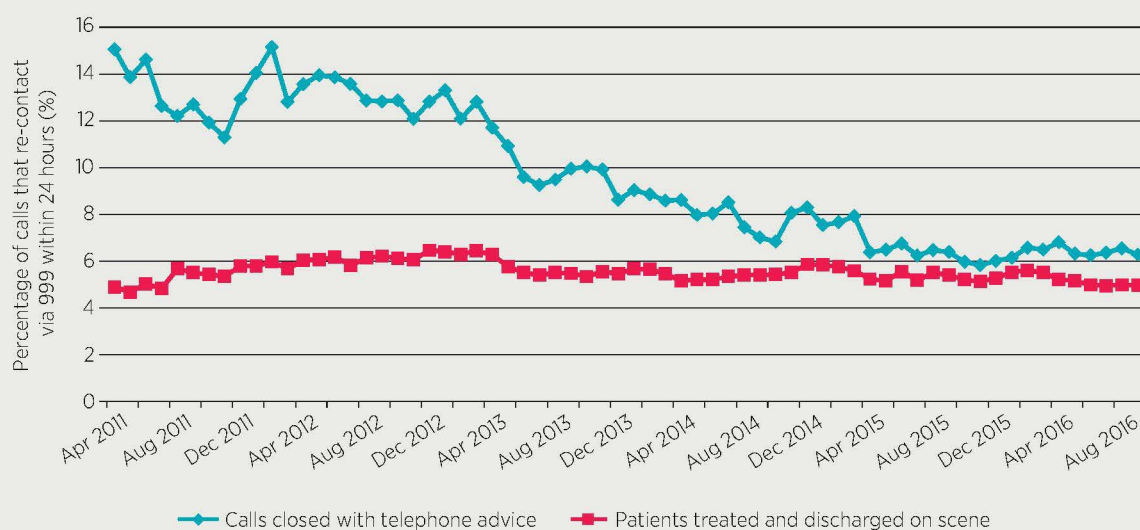
Increasingly, ambulance services are training staff to give advice on the phone, treat patients at the scene or take them to other facilities (such as a walk-in centre or primary care) to avoid unnecessary journeys to hospital (National Institute for Health Research, 2016). Reflecting this change in service provision, the proportion of emergency calls that were resolved over the telephone doubled between 2011/12 and 2015/16, with 10.2 per cent of all calls resolved by telephone advice in 2015/16 (QualityWatch, 2016e).

The number of incidents managed without the need for transport to an A&E department¹⁰ also increased by nearly half a million between 2011/12 and 2015/16 (QualityWatch, 2016e). This is not simply a reflection of increased ambulance activity since the proportion of incidents managed in this way also increased from 33.9 per cent to 37.9 per cent over the same period (QualityWatch, 2016e), so it could be assumed that the new training and service delivery is influencing this.

If the initial advice given over the telephone or treatment provided on the scene is appropriate, then fewer people should need to re-contact emergency services (except those whose situation may have escalated). The percentage of patients

¹⁰ This refers to patient journeys to a destination other than type 1 and type 2 A&E, plus the number of patients discharged after treatment at the scene or onward referral to an alternative care pathway.

Figure 2.4: Re-contact rates of 999 calls to ambulance services within 24 hours between April 2011 and September 2016



Source: QualityWatch (2016e)

whose emergency calls had been closed with telephone advice who then subsequently re-contacted 999 within 24 hours has fallen, from 13.2 per cent (44,185 calls) in 2011/12 to 6.3 per cent (42,637 calls) in 2015/16. In September 2016 the figure remained at 6.3 per cent (QualityWatch, 2016e) (see Figure 2.4), indicating that the quality of the telephone advice has improved.

The proportion of patients treated and discharged at the scene who then re-contacted emergency services within 24 hours did not change from 5.4 per cent between 2011/12 and 2015/16 (QualityWatch, 2016e). There has been no decline in this measure (see Figure 2.4), which indicates that the quality of the initial treatment provided at the scene has been maintained.

On the whole, despite large increases in ambulance activity and workforce issues, the services' handling of calls seems to be improving, with the data indicating that more people are getting through to the service promptly, more are being helped over the phone, fewer are being conveyed to A&E and more receive an appropriate response the first time. Ambulance response times to life-threatening emergency calls remain a concern, but the extent to which ambulance services can change the possible influencing factors remains unclear.

2.4 Hospital care

Changing hospital activity levels

The length of time patients are required to wait for consultant-led treatment to start after GP referral has fallen substantially since 2000, which corresponds with the introduction of national standards and their associated targets and increased use of independent sector providers. More recent trends show a worrying reversal in waiting times for patients, but this does not appear to have had any impact on patients' satisfaction with how long they are required to wait.

Improvements in consultant-led waiting times also correspond to expansion in specialist consultant staff, but this expansion took place during a time when waiting times also increased, making it hard to draw conclusions on the impact of the changes on this workforce.

The number of diagnostic tests undertaken each month has doubled between 2006 and 2016. Despite this substantial increase, the proportion of diagnostic tests not delivered within six weeks has fallen dramatically over the same time period, from 55 per cent to 2 per cent. However, nationally, the target of achieving 99 per cent of all diagnostic tests within six weeks is not currently being met.

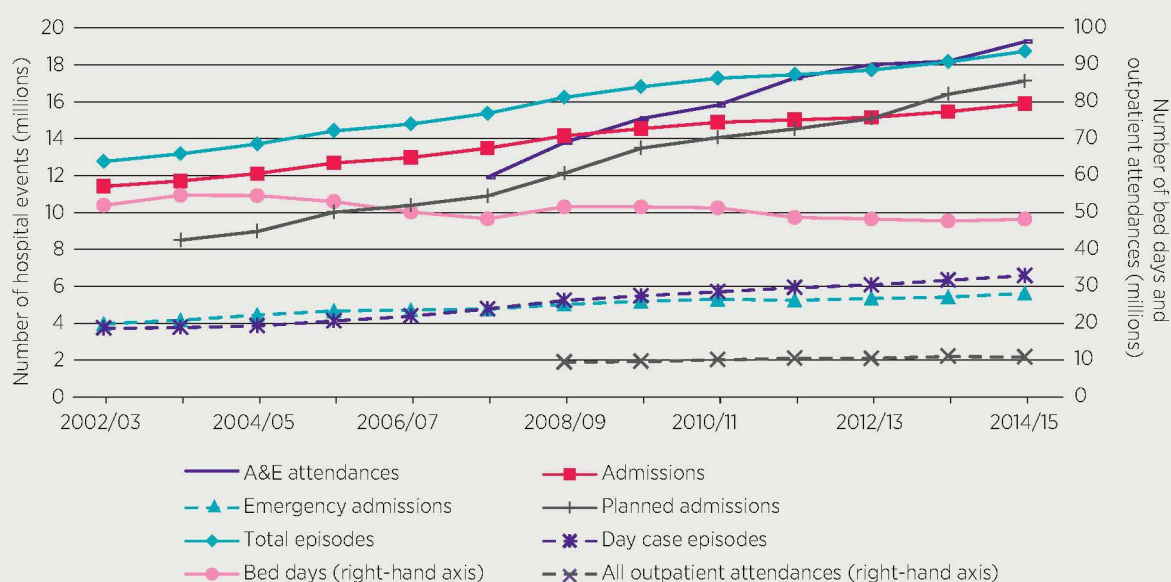
The amount of planned inpatient activity (as measured by planned admissions and day cases), and presumably the number of planned operations, increased by 15 per cent between 2008/09 and 2014/15 and by 77 per cent between 2002/03 and 2014/15. Unsurprisingly, the number of cancelled operations over this time period also increased, albeit at a slower rate than elective inpatient activity. As a ratio of elective admissions the rate of cancelled operations is very low and is being maintained between 0.72 and 1.8 per cent.

The continued growth in the size and needs of the population is reflected in the changing number of contacts patients are having with hospitals (i.e. activity in A&E departments and in inpatient, outpatient and day-case settings), which have increased year on year over the 13 financial years investigated (see Figure 2.5 and Table 2.2). This is discussed in more detail below.

A&E attendances increased by 7.35 million between 2007/08 and 2014/15 (NHS Digital, 2016a). The latest monthly figures show that there were 1.95 million attendances at A&E in September 2016, which is 5 per cent more than in the same month the previous year (NHS England, 2016c). Attendances over the latest 12 months are also higher than levels in the preceding 12-month period – an increase of 4.6 per cent (NHS England, 2016c).

The total number of admissions to hospital increased by nearly 4.5 million between 2002/03 and 2014/15. Between 2008/09 and 2014/15, planned admissions increased at a greater rate than emergency admissions (a 15 per cent increase compared to a 12 per cent increase). However, the growth in planned admissions has slowed in recent years and the number actually fell between 2013/14 and 2014/15 (NHS Digital, 2015a). In September 2016 there were 476,000 emergency admissions – 2.6 per cent more than in September of the previous year (NHS England, 2016d). There was also a 3.7 per cent increase in emergency admissions when comparing the total numbers of emergency admissions between

Figure 2.5: Trends in English hospital activity between 2002/03 and 2014/15



Source: NHS Digital (2016a; 2015a; 2015b). Robust national-level data for all the hospital activity measures featured are not publicly available as far back as 2002/03. Data for planned admissions have only been published since 2008/09, A&E attendance since 2007/08 and outpatient attendances since 2003/04. A&E attendances cover all types of A&E departments. Data represent information from Hospital Episode Statistics (HES) returns and not weekly situation reports (Sitreps), and exclude planned follow-ups.

Table 2.2: Changes in English hospital activity between 2002/03 and 2014/15

Activity type	Total change (millions) - 2014/15 compared with earliest baseline [†]	2014/15 percentage change compared with earliest baseline [†]	2014/15 percentage change compared with 2013/14
Total episodes	5.98	47%	3%
Admissions	4.48	39%	3%
Emergency admissions	1.66	42%	4%
Planned admissions [†]	0.28	15%	-2%
Day-case episodes	2.86	77%	4%
Bed days [*]	-3.74	-7%	1%
All outpatient attendances [†]	43.17	102%	4%
A&E attendances [†]	7.35	56%	6%

Source: NHS Digital (2016a, 2015a; 2015b).

Negative values represent a decrease.

* A bed day is a day during which a person is confined to a bed and in which the patient stays overnight in a hospital.

† 'Earliest baseline' is the first data point in the time series for the relevant activity type. Robust, national-level data for all the hospital activity measures featured are not publicly available as far back as 2002/03. Data for planned admissions have only been published since 2008/09, A&E attendance since 2007/08 and outpatient attendances since 2003/04. For all others, robust, national-level data time series were available from 2002/03.

October 2015 and September 2016 to October 2014 and September 2015 (NHS England, 2016d). Between quarter 1, 2015/16 and quarter 1, 2016/17, the number of elective admissions¹¹ increased by 44,046 to 1.4 million (NHS England, 2016e).

Outpatient attendances increased by over 43 million between 2003/04 and 2014/15 to just over 85.6 million (NHS Digital, 2015b), and between quarter 1 2015/16 and quarter 1 2016/17 total attendances increased by 758,353 to 15.2 million (NHS England, 2016e).

Overall, between 2002/03 and 2014/15, the total number of hospital episodes¹² increased by nearly six million (NHS Digital, 2015a). The number of bed days¹³, however, decreased by 7 per cent over the same time period (NHS Digital, 2015a). This is related to a decrease in the average (mean) length of stay, which has dropped by nearly three days (NHS Digital, 2015a).

These increases in activity are not solely due to changes in overall population levels. Mid-year population estimates show that between 2002 and 2015 there was a 10 per cent increase in the English population, which is less than the growth rate observed for hospital activity (Office for National Statistics, 2016b). This is supported by a study that assessed acute hospital care activity trends between 2006/07 and 2012/13 (Smith and others, 2014). The study found that, in addition to population growth, the increasing proportion of older people in the population was also a factor in the increasing number of admissions, but activity actually increased 60 per cent more than would be expected given the increase in age and size of the population during this period.

The following sections explore what has been happening to diagnostic and referral-to-treatment waiting times and cancellation of operations, using these indicators as proxies to see how, nationally, hospitals have responded to this increasing activity and whether access is being maintained.

Treatment waiting times

In 2004, the NHS Improvement Plan set out that, by 2008, no one would have to wait longer than 18 weeks from GP referral to the start of consultant-led treatment (Department of Health, 2004a) – also known as the referral-to-treatment (RTT) 18-week waiting time standard. Initially, targets were introduced stating that a minimum of 90 per cent of admitted patients (adjusted for pauses in the waiting time, where a patient had declined reasonable offers of admission and chosen to wait longer) and at least 95 per cent of non-admitted patients had to be treated within 18 weeks of referral.

Both of these targets were achieved nationally from November 2008 and were largely maintained until January 2014 for admitted patients and June 2015 for non-admitted patients (QualityWatch, 2016f). In line with the introduction of the targets, there was a drastic reduction in the number of patients on the waiting list

11 An admission is categorised as elective when the decision to admit can be separated in time from the actual admission. A planned admission is a subset of elective admissions. For planned admissions, a date is given approximately at the time that the decision to admit was made, usually as part of a planned sequence of clinical care (NHS Digital, 2016d). The different data sources use the different definitions of non-emergency admissions, resulting in discrepancies between annual and quarterly data.

12 An episode of care is defined as the set of services provided to treat a clinical condition or procedure within a given time period.

13 A bed day is a day during which a person is confined to a bed and in which the patient stays overnight in a hospital.

for consultant-led treatment, from 4.19 million in August 2007 to 2.35 million by December 2008 (QualityWatch, 2016f). However, the number of people waiting for treatment has since started to increase again, and reached 3.7 million by September 2016 (QualityWatch, 2016f).

In 2012/13 an additional target was introduced for patients that were still waiting for treatment to begin (also known as ‘incomplete pathways’), whereby at least 92 per cent of the patients waiting to start treatment should have waited less than 18 weeks. Nationally, the target was met for the first time in January 2012, and continued to be achieved for several years after the introduction of the target, until November 2015 (QualityWatch, 2016f).

In June 2015 the Government abolished the admitted and non-admitted targets, although performance data are still collected.¹⁴ The incomplete patient pathway target was made the sole measure for officially monitoring performance of treatment waiting times (NHS England, 2015b).

Unsurprisingly, since the abolition of the targets there has been a decline in the proportion of admitted and non-admitted patients receiving care within 18 weeks. This reduced by 9 percentage points for admitted (unadjusted) patients (it was 77 per cent in September 2016) and by 5 percentage points for non-admitted patients (it was 90 per cent in September 2016) (QualityWatch, 2016f).

The focus on maintaining the incomplete patient pathway target does not appear to have prevented this target from being breached nationally. After nearly two years of achieving the target, the threshold of 92 per cent was narrowly missed for the first time in December 2015 (91.8 per cent). It has subsequently only been met in two months (January and February 2016) up to September 2016 (QualityWatch, 2016f). Beyond performance against the RTT 18-week standard, the median waiting time for patients still waiting for treatment has increased by just over a week, from 5.5 weeks in April 2012 (when the incomplete pathway standard was introduced) to 6.6 weeks in April 2016, which equates to an average of an additional two days waiting per year on to the median waiting time (QualityWatch, 2016f).

Since these measures consider how long a patient waits for consultant-led treatment, it might be assumed that performance would be influenced by having the right numbers of consultants available to support the treatment of patients. Between September 2009 and March 2016, there was a 25 per cent increase in consultants, with the highest absolute increases occurring in general medicine (33 per cent, 2,493 doctors) and surgical groups (28 per cent, 1,889 doctors) (NHS Digital, 2016b). While this increase correlates to a period of improvement in the RTT waiting times, it also covers a period deterioration has occurred, so it is hard to draw any conclusions on this.

Despite the recent increases in waiting times, there does not appear to have been an associated negative shift in patients’ views on treatment waiting times. In 2011, when patients were asked in the adult inpatient survey how they felt about the length of time they were on the waiting list before their admission to hospital, 73 per cent of respondents felt ‘they were admitted as soon as they thought was necessary’, and 75 per cent thought the same in 2015 (Care Quality Commission, 2016). In 2015, less than one in 10 patients felt ‘they should have been admitted a lot sooner’ than they were, while 16 per cent said that they should have been admitted a ‘bit sooner’ (Care Quality Commission, 2016).

¹⁴ Only unadjusted data for admitted pathways remains part of the data collection, since there is no longer a need to adjust it for patients’ actions on their waiting time as this is no longer an official measure of performance.

This is reflected in information from patient complaints. In quarter 1 2016/17, the proportion of written complaints to the NHS on the subject of waiting times compared with all complaints in all subject areas is very low, at approximately 2 per cent (1,170 complaints) (NHS Digital, 2016c). This level of complaints is also very low in comparison to the total number of patients currently on the waiting list. Furthermore, there has been very little change in the number of complaints about waiting times between quarter 1 2015/16 and quarter 1 2016/17 (NHS Digital, 2016c), despite the number of people on the waiting list increasing by 600,000 over the same time period (QualityWatch, 2016f).

Diagnostic test waiting times

The Department of Health, recognising the importance of prompt diagnostic testing to enable shorter treatment waiting times, created a diagnostic waiting times collection, which has been published since January 2006, as a first step in monitoring the RTT 18-week standard waiting time (NHS England, 2016f). The data covers 15 key diagnostic tests or procedures in three areas: imaging (such as magnetic resonance imaging (MRI)), physiological measurements (such as audiology assessments) and endoscopy (such as colonoscopy) (NHS England, 2016g).

One of the main measurements from the data collection was the proportion of patients waiting six weeks or longer for a diagnostic test, following a referral from a GP. Achievement of this measurement was first viewed as a 'milestone' from March 2008 in efforts to achieve the standard set for RTT waits of 18 weeks by December 2008 (NHS England, 2016g). In 2012/13 it became a national standard in its own right, whereby less than 1 per cent of patients should wait six weeks or longer for a diagnostic test (Department of Health, 2011). This now forms part of the NHS Constitution and NHS England's *Everyone counts: planning for patients 2013/14* (NHS Commissioning Board, 2013).

Following the introduction of the diagnostic waiting time 'milestone', the total number of diagnostic tests being waited for by patients decreased dramatically from January 2006, where it was 809,927, to a low of 403,955 in December 2008 (NHS England, 2016h). However, since then, the number has been steadily increasing: in January 2016 it reached 818,599, surpassing the levels of a decade before in January 2006 (NHS England, 2016h). In September 2016 the number of diagnostic tests patients were waiting for was 882,312 (NHS England, 2016h).

However, these figures need to be understood in the context of the rapidly increasing number of diagnostic tests undertaken each month. There were nearly 816,000 tests in January 2006. Within a decade, in January 2016, the number was over 1.7 million (NHS England, 2016h). The proportion of diagnostic tests not delivered within six weeks has actually fallen dramatically over the same time period, from 55 per cent to 2 per cent (QualityWatch, 2016g).

After the introduction of the diagnostic waiting time standard in April 2012, the proportion of diagnostic tests not delivered within six weeks¹⁵ initially hovered around the target of 1 per cent, shifting from short periods in which it was achieved to sporadic breaches in one or two months, before being achieved again. This occurred for just under two years, until November 2013 (QualityWatch, 2016g).

¹⁵ The proportion of diagnostic tests not delivered within six weeks, across all 15 key diagnostic tests, is used as a proxy for meeting the national standard that less than 1 per cent of patients should wait six weeks or longer for a diagnostic test. The proportion of patients can be calculated for each diagnostic test separately but because a patient may be waiting for more than one diagnostic test, then across all diagnostic tests it is the proportion of diagnostic tests not delivered within six weeks.

Since that time (including September 2016 data), the target has not been reached for nearly three years (34 months), although percentages remain very low, ranging between 1.2 and 2.4 per cent, and at 1.5 per cent in September 2016, with no increase or decrease in trend over that time (QualityWatch, 2016g).

In 2006, the median waiting time fluctuated around five weeks for diagnostic tests, but fell to around two weeks in January 2008 (QualityWatch, 2016g). The lowest median wait, of around 1.5 weeks, occurred in January 2009 and has been increasing – to a maximum 2.5 weeks in December 2015. Peaks do occur in December every year, as a result of people not being able to schedule or attend appointments over the Christmas holidays. Most recently, the median waiting time was 1.8 weeks in September 2016 (QualityWatch, 2016g).

Cancelled operations

The number of elective operations that were cancelled for non-medical reasons¹⁶ increased between quarter 1 1994/95 and quarter 4 2015/16 (QualityWatch, 2016h). There is a seasonal variation in the trend, with a peak in each financial year mainly in quarter 4 (January to March). A particular spike occurred between quarter 4 1999/2000 and quarter 4 2001/2002, after which it returned to the previous trend levels, then continued to increase in line with the longer-term trend (QualityWatch, 2016h).

In quarter 4 2015/16, some 23,180 elective operations were cancelled, which was 8,714 more than in quarter 4 1994/95, representing a 60 per cent increase over 20 years (QualityWatch, 2016h). This was the highest number of cancellations since quarter 4 2000/01, when 24,976 elective operations were cancelled (QualityWatch, 2016h).

Despite this notable increase in the number of cancelled operations over this time period, the rate of cancelled elective operations, as a percentage of elective admissions, has remained very low (1.2 per cent in quarter 4 2015/16) and relatively unchanged over time (QualityWatch, 2016h). This suggests that despite the increasing number of planned admissions (as described above), the NHS has coped with the increased activity in this area. The fact that there was an 11 per cent increase in full-time equivalent hospital and community health service doctors in surgery from 20,090 in September 2009 to 22,278 in March 2016 – over a similar period – is likely to have helped the service to do so (NHS Digital, 2016b).

¹⁶ Cancellations for non-medical reasons are defined as last-minute cancellations by the hospital for non-clinical reasons during the time period. 'Last minute' means on the day the patient was due to arrive, after the patient has arrived in hospital, or on the day of the operation or surgery.

Healthcare-associated infections

There have been substantial decreases in the number and rate of healthcare-associated methicillin-resistant *Staphylococcus aureus* (MRSA) bloodstream infections and *Clostridium difficile* infections (CDI). This is likely to be a consequence of long-term, continuing national policy interventions and multi-faceted local action in hospital, including preventative treatment of patients before or upon admission (in the case of MRSA), the spread of good infection control practice in surgical and other procedures, and actions on hand hygiene and hospital cleanliness – all of which is reflected through improvements in patient perspectives on how clean wards or rooms were during their inpatient stay.

There are, however, a small number of these infections each year that appear to be difficult to eradicate, despite a recent stretching of expectations regarding what should be achieved.

These accomplishments are particularly noteworthy in the light of current bed occupancy and NHS staffing levels, both of which have an influence on the occurrence of infections – although the tension between achieving access targets by treating more people and bed occupancy has the potential to undo this good work.

It should be noted that other healthcare-associated infections (HCAIs) have not had the same level of focused national intervention for as long as MRSA infection and CDI have. This could create a risk to patient safety in the future, especially as current trends show recent increases in the incidence of these other infections.

Quality is defined across several different dimensions in the QualityWatch programme (see the chapter on ‘Health and social care quality and QualityWatch’). One of the most critical of these is the need to deliver care safely, since this dimension entails the avoidance of any harm that would not have occurred without the care itself being provided. The classification of ‘never events’ – occurrences that are deemed so serious and wholly avoidable that they should never happen while a person is receiving healthcare – serve to underline the importance of safe care in quality (NHS England, 2015a).

Several indicators of whether care is delivered safely in a hospital setting exist, including the number of falls, pressure ulcers, blood clots and medication errors (QualityWatch, 2016i). However, the remainder of this section will focus on HCAIs – *Clostridium difficile* infection (CDI) and methicillin-resistant *Staphylococcus aureus* (MRSA) infection, which are unpleasant and potentially severe or fatal.

History of infection control

Prior to the 2000s, very little national policy focus was given to HCAIs until two reports by the National Audit Office focusing on hospital-acquired infections in 2000 and 2004 (National Audit Office, 2000; 2004). These reports brought to national attention the harm caused by HCAIs to patients, their financial burden and the barrier they placed to the safe delivery of healthcare. From 2000 onward, dedicated financial support has been provided, targeted guidance has been issued and initiatives have been implemented with the aims of making hospitals cleaner, improving infection control and tackling HCAIs in hospital and other care settings.

For example, between 2000 and 2004, an extra £68 million was invested nationally in improving the cleanliness, tidiness and appearance of hospitals. In 2000, independent assessment of hospital cleanliness was introduced and, in 2001, the first national cleaning standards for the NHS were issued (Department of Health, 2004b).

The influence of these actions may be reflected in patients' perceptions of the cleanliness of hospital settings. In 2006, only 54 per cent of respondents from the adult inpatient survey said that their hospital ward or room was 'very clean' (QualityWatch, 2016j). In 2015, the proportion of respondents had increased to 71 per cent, demonstrating a real improvement over nearly a decade (QualityWatch, 2016j), which suggests that having a targeted strategy has had a long-term impact on cleanliness.

Multiple initiatives were introduced at a hospital level for MRSA infection, including increased hand hygiene, isolation of MRSA-positive patients, suppression/ decolonisation therapy and screening for asymptomatic carriers (Fuller and others, 2013). For CDI, there has been a reduction in antimicrobial prescribing for people over 65 (in the hospital and community) – a practice that increases the risk of developing CDI (NICE, 2015).

Changing MRSA infection rates

In order to begin to understand the scale of infection rates, MRSA bloodstream infection surveillance became mandatory in England in April 2001 (Public Health England, 2016). Surveillance was enhanced in October 2005 to include data on individual patients affected by the infection and the care they received, rather than being aggregated, and reporting frequency was increased (Public Health England, 2016). It was also announced in 2004 that hospitals would be expected to halve MRSA infections by 2008. And more recently, in 2013, NHS England introduced a zero-tolerance approach to MRSA, meaning that each organisation is expected to achieve zero MRSA bloodstream infections – as well as the expectation that all cases will involve a post-infection review to identify why an infection occurred and how future cases of infection can be avoided (NHS Commissioning Board, 2013/14).

The numbers of MRSA infections overall and those contracted in hospitals have decreased dramatically. There was an 82 per cent reduction in all reported cases between 2007/08 and 2015/16 (4,451 cases to 819), and an 82 per cent reduction in trust-apportioned¹⁷ cases between 2008/09 and 2015/16 (1,606 cases to 297) (QualityWatch, 2016k). Similarly, the number of death certificates mentioning MRSA infections in England and Wales decreased from 1,230 in 2008 to 292 in 2012 (Office for National Statistics, 2013a).

In 2014, guidance was issued to restrict screening to patients at high risk of developing MRSA infection (Department of Health, 2014). A national audit of screening practice in 2011 had shown that the prevalence of MRSA and risk of developing infection had fallen to a level where the universal screening strategy was not a cost-effective approach, especially as there was not 100 per cent compliance with that method (Fuller and others, 2013).

In 2015/16, 819 cases of MRSA bloodstream infection were reported across all acute NHS trusts in England (Public Health England, 2016). This equates to a very low risk of contracting MRSA through the delivery of hospital care, at a rate of 1.5

¹⁷ That is, cases that are presumed to have been acquired while the patient was admitted during their hospital stay.

cases per 100,000 population per year (Public Health England, 2016). Yet, while this is a major success, the figures still mean that achieving zero cases – in line with the 2013/14 policy – has not been accomplished.

The first annual increase since 2007/08 has occurred in 2015/16 – albeit from a low base – in the rate of trust-apportioned MRSA cases (Public Health England, 2016). This will need to be monitored to determine whether this represents the beginning of a genuine sustained increase (and to determine the cause), or just random variation in the data.

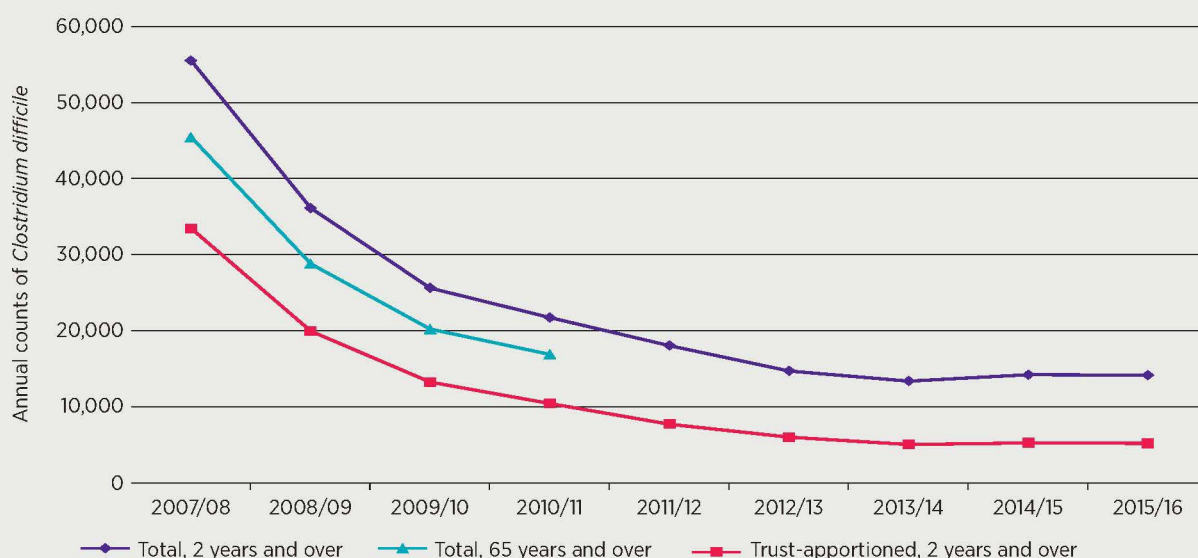
Changing *C. difficile* infection rates

A similar level of policy interventions has also been targeted at CDI, although there are slight differences and they follow different timelines to those for MRSA infection. Mandatory surveillance of CDI in hospitals began in 2004 for patients aged 65 years and over. This was extended in 2007 to people aged two and over, with subsequent enhancements as with MRSA (Public Health England, 2016). Additionally, in October 2007 a target was set for a 30 per cent reduction in the number of cases of CDI reported in 2010/11 against a 2007/08 baseline (National Audit Office, 2009). But beyond this there are no national standards set in relation to CDI, although in 2013/14 NHS England reported that they would support an approach based on significant reductions in incidence (NHS Commissioning Board, 2013/14).

The number of people contracting *C. difficile* in hospitals has decreased dramatically. There was an 85 per cent reduction between 2007/08 and 2015/16 of trust-apportioned cases in people aged two and over (33,434 to 5,164) (QualityWatch, 2016k; see Figure 2.6). Furthermore, mortality rates for deaths involving *C. difficile* fell year on year between 2007 and 2012 in England and Wales, where it was implicated in 15.3 deaths per million population in 2012 (Office for National Statistics, 2013b).

However, while the risk in 2015/16 of contracting *C. difficile* while receiving hospital care was again very low (a rate of 26.0 per 100,000 population or 14,139 cases in NHS trusts in England), this is greater than the risk of contracting MRSA (Public Health England, 2016; NHS Commissioning Board, 2013/14).

Figure 2.6: Trends in trust-apportioned cases of *Clostridium difficile* infections, 2007/08 to 2015/16



Source: QualityWatch (2016k)

The future of healthcare-associated infections

There is no disputing that substantial progress has been made in improving hospital cleanliness and reducing the incidence of MRSA infection and CDI. This is especially the case in recent years: levels of infections have been maintained despite increasingly high bed occupancy rates (NHS England, 2016i) and shortages in NHS staff (National Audit Office, 2016), both of which, evidence suggests, have a direct influence on the incidence of some HCAs (Kaier and others, 2012). Maintaining low MRSA infection and CDI rates in light of the changes to the rate of bed occupancy in particular is noteworthy, since between 2007/08 and 2015/16 the number of acute and general beds decreased by nearly 19,000 (a drop of 15.5 per cent)¹⁸ (NHS England, 2016i).

However, there may be difficulties in maintaining this progress given the balance to be struck between bed occupancy rates and the requirement to achieve access targets by treating more people. This balancing act is not new. In 2004 the Department of Health warned that there was “no doubt that treating more patients brings challenges [to the average daily bed occupancy of general and acute beds]” and that there were concerns that “the success in reducing waiting lists and a rise in bed occupancy rates have led to a higher rate of MRSA” (Department of Health, 2004b).

Risks to patient safety from bacterial infection are also not restricted to MRSA and *C. difficile*. Focusing solely on MRSA and *C. difficile* by mainly targeting HCAI guidance and implementing initiatives for these infections runs the risk of missing potentially preventable issues with other infections. As far back as 2009, the National Audit Office was highlighting that there had not been the same impact on other avoidable infections, where there was a lack of robust and comparable surveillance information (National Audit Office, 2009). In fact, recent data from Public Health England show that the number and rate of methicillin-susceptible *Staphylococcus aureus* and *Escherichia coli* bloodstream infections in NHS acute trusts in England are currently on the increase (Public Health England, 2016) and pose greater risk to patient safety in the future. For example, in 2015/16 there were 38,132 reported cases of *E. coli* bacteraemia compared to 32,309 in 2012/13. This is a rate of 70.1 per 100,000 population in 2015/16 up from 60.4 per 100,000 population in 2012/13 (Public Health England, 2016), and this is now the most common bloodstream infection in England and Wales. Noting this issue, the Secretary of State for Health recently announced plans to prevent hospital infections, including allocating more money to hospitals that reduce infection rates and publishing *E. coli* rates by local area (Department of Health 2016b).

Personalised inpatient care and compassion

Recent data show that the majority of patients feel involved in decisions about their care during their inpatient stay, and felt that they were treated with dignity and respect. This has improved over recent years, despite issues with NHS staff shortages. Although these are mainly positive findings, there are still a number of patients who do not have a positive experience in this respect and more needs to be done to address this issue.

As well as looking at access to hospital services and outcomes for patients receiving care, having an understanding of what people think about their care and treatment in hospital is important for understanding the quality of services. The

¹⁸ Measured as the average daily number of available overnight beds.

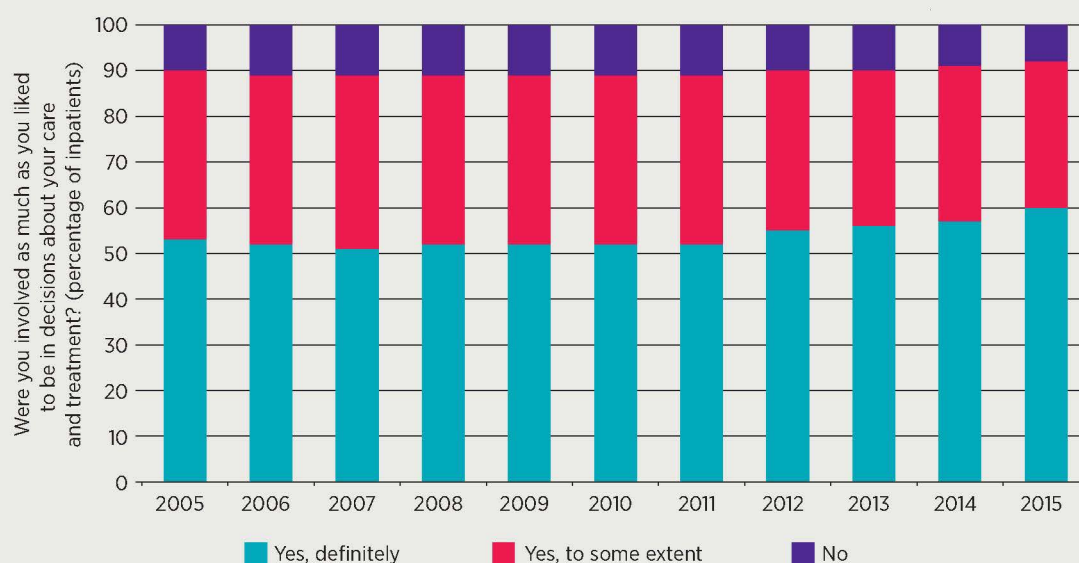
NHS inpatient survey tries to capture this information. QualityWatch has observed, through its ongoing monitoring, that these patient-reported experience measures generally remain static over time with very little change in responses year on year.

However, contrary to these long-term trends, there have been some interesting signs of change over recent years in the thoughts of patients regarding:

- whether they feel they were involved in decisions about their care
- whether they feel they were treated with dignity and respect in hospital.

The majority of respondents to the NHS inpatient survey felt that they were involved in decisions about their care. The percentage of patients responding 'yes definitely' when asked increased from 53 per cent in 2005 to 60 per cent in 2015 (QualityWatch, 2016l) (see Figure 2.7). Conversely, the percentage of respondents who do not feel involved in decisions has changed very little – it was 10 per cent in 2005 and 9 per cent in 2015.

Figure 2.7: Trends in patient-reported experiences of being involved in decisions about their care and treatment, 2005 to 2015



Source: QualityWatch (2016)

The majority of patients also stated that they were always treated with dignity and respect in hospital. This positive response also increased from 80 per cent in 2011 to 84 per cent in 2015 (QualityWatch, 2016m). Yet, conversely, there has been very little change in the percentage of respondents not feeling they were treated with dignity and respect: this moved from 3 per cent in 2011 to 2 per cent in 2015.

These measures indicate that people feel that inpatient care is delivered compassionately and in a personalised way. It should also be noted that these recent improvements have occurred against a backdrop of shortages in NHS staff (National Audit Office, 2016). Such shortages raise the risk of not having enough staff to carry out the basics of clinical care, let alone to focus on patients in this way, so these findings could be interpreted as even greater achievements.

However, more still needs to be done to decrease the number of people who are not treated in the way they were expecting. Writing for QualityWatch recently, the interim chair of Healthwatch England echoed this sentiment, arguing that genuine patient engagement was achievable through an understanding of what would have made things better for those who did not have a good experience (Mordue, 2016).

2.5 Patients' views of mental health services

The majority of respondents to the community mental health survey (CMHS) viewed their care positively overall and said they had 'definitely' been treated with dignity and respect in 2015. However, responses were not as favourable as comparable measures of adult hospital inpatient care or primary care.

In addition, the adult inpatient survey provides evidence of disparities in perceptions of hospital care, between patients with mental health conditions and those without. The survey indicates that respondents with self-reported mental health conditions have less positive experiences.

Combined, these data indicate that parity of esteem between patient experience of mental health services and patient experience of other services has not been achieved – nor has it been achieved between patients with and patients without mental health conditions in a single service.

Most policy initiatives are not designed specifically to address the lack of parity of esteem in experiences of people with mental ill health. However, they will hopefully support the reduction of these gaps by improving people's experiences of mental health services and improving the physical health of patients with mental ill health.

To further support this, more needs to be done to remove disparities in the amount of information on mental health services and services that patients with mental health ill health receive compared with other NHS services.

Mental ill health will affect many people from all backgrounds at some point in their lives, whether personally, or in their families, communities or workplaces. One in four adults experiences at least one diagnosable mental health problem in any given year; at any one time, one in six adults has a mental health problem; and one in 100 has a serious mental illness (SMI) (HM Government, 2011; NHS England Mental Health Taskforce, 2016a). The scale of mental ill health can also be observed in its cost to the economy, which is estimated at £105 billion a year and is roughly the same as the cost of the entire NHS (NHS England Mental Health Taskforce, 2016a).

The provision of mental health services spans many care settings and accounts for 23 per cent of NHS activity (NHS England Mental Health Taskforce, 2016a). In 2014/15, nearly two million adults were in contact with specialist mental health and learning disability services. Estimates indicate that 90 per cent of adults with more severe mental health problems are supported by community services (NHS England Mental Health Taskforce, 2016a). Yet spending on secondary mental health services is not in line with its activity ratio to non-mental health services (NHS England Mental Health Taskforce, 2016a).

In addition to the differences between the financial settlements given to mental health and non-mental health services, it is widely recognised that parity of esteem has yet to be achieved in terms of access to mental health services or in care outcomes. For example, waiting times for outpatient appointments are longer for mental health specialities compared to physical health specialties (QualityWatch, 2015). There are also disparities between patients with and without mental ill health in their emergency care use and in terms of how efficiently they are treated, with patients that have mental ill health being negatively affected (Dorning and others, 2015). Ultimately, premature mortality in people with a

serious mental illness is significantly greater (351.8 per cent higher in 2013/14) than the general population¹⁹, and the gap has widened since 2008/09 (NHS Digital, 2016e).

Because of findings such as these, there has been a lot of focus on parity of esteem between physical and mental health in recent years and there have been several policy initiatives to support its achievement. For example, in 2010, the public health strategy 'Healthy lives, healthy people' was the first of its type to give equal weight to both physical and mental health (HM Government, 2010). In 2011, *No health without mental health* was published with the key objective that more people with mental ill health should have good physical health (HM Government, 2011). NHS England has also established a 'Parity of esteem' programme²⁰ that set up initial priorities for urgent focus during 2013/14 in relation to this issue.

Owing to the purpose of these strategies and initiatives, they focused mainly on the physical care of patients with mental ill health, as well as on improving the overall mental health of the population through good mental health and improving recovery from mental ill health. They did not cover in detail the experiences of people with mental ill health, although *No health without mental health* did begin to raise this by setting the objective that more people should have a positive experience of care and support wherever it takes place (HM Government, 2011).

More recently, the *Five year forward view for mental health for the NHS in England* (NHS England Mental Health Taskforce, 2016a) and its implementation plan, *Implementing the five year forward view for mental health* (NHS England Mental Health Taskforce, 2016b), took the strategy for experiences of those with mental ill health further. Although they did not explicitly talk about achieving parity of esteem in relation to patient experience for people with mental ill health irrespective of the care they receive, they did put patient experience at the heart of the transformation of mental health care.

One way of understanding whether parity of esteem exists in what people with and without mental health think about services, and the challenges that health and social care services face in addressing this, is to:

- compare what patients report on their views of mental health care and compare them to responses from patients where views of a different care setting are sought, or
- compare what patients with mental ill health report on their experiences of care compared to the views of the same care from those without mental ill health.

Employing these two types of comparisons, the remainder of this section investigates the experiences of patients with mental ill health further using the community mental health survey (CMHS), the adult inpatient survey and a survey of primary care patients.

In 2015, the majority (72 per cent) of respondents to the CMHS²¹ rated their overall care as at least 6 out of 10 (on a 0–10 scale, where 0 is very poor and 10 is very good). This has changed very little since the 2014 or 2013 surveys (QualityWatch, 2016n). Nearly one in five patients reviewed their care as 10 out of 10 in each of the three years.

¹⁹ Reporting on deaths between 1/4/2013 to 31/3/2014; in contact with Mental Health Minimum Data Set: 1/4/2011 to 31/3/2014.

²⁰ See www.england.nhs.uk/mentalhealth/parity

²¹ Please note that the CMHS is not weighted for age or sex.

On the whole, these views are a positive reflection, sustained over a few years, of community mental health services. Nonetheless, when comparing them with what all patients responding to the adult inpatient survey say about their care while in hospital, or with primary care patients' experiences of general practice, the achievements seem more limited.

For example, in 2015 a larger proportion of respondents to the inpatient survey (79 per cent) rated their overall care as at least 6 out of 10 on the same scale compared with respondents to the CMHS (72 per cent) (QualityWatch, 2016o; 2016n). The difference is most notable, though, in the proportion of patients that rate their care as 10 out of 10 – some 18 per cent of respondents to the CMHS do so compared with 27 per cent of patients to the inpatient survey in 2015. Furthermore, as explored in the section on 'Patients' experiences of primary care services' overall, patients' experiences of GP surgeries are good. When given the option of describing their experience as 'very good', 'fairly good', 'neither good nor poor', 'fairly poor' or 'very poor', more than two out of five patients (43 per cent) rated their care as 'very good' as reported on in July 2015 (NHS England, 2016j).

Similarly, when comparing patients' views on privacy and dignity, in 2015 the majority (73 per cent) of respondents to the CMHS also felt they had 'definitely' been treated with dignity and respect, again with little change from the 75 per cent who said the same in 2014 (QualityWatch, 2016p). In contrast, as previously explored in the section on 'Personalised in-patient care and compassion' in the same year, 84 per cent of respondents to the adult inpatient survey said that they had 'always' been treated with dignity and respect (QualityWatch, 2016m).

In addition to comparing the results between different care settings, it has also become possible more recently through the adult inpatient survey to look at differences between the perceptions of patients with and those without a mental health condition when receiving care in the same setting.

In 2015, inpatients with a self-reported mental health condition did not rate their care as positively as those without. When asked about their overall experience, 79 per cent of respondents with a mental health condition rated their overall care as at least 6 out of 10 (on a 0–10 scale, where 0 is very poor and 10 is very good), whereas 91 per cent of respondents who did not have a mental health condition reported the same (Care Quality Commission, 2016). Moreover, 19 per cent of patients with a mental health condition rated their care as 10 out of 10, compared with 27 per cent of patients without a mental health condition (Care Quality Commission, 2016).

In addition to this overall rating, inpatients who reported having a mental health condition had a poorer hospital experience than those without across a range of indicators. They did not feel involved in decisions about care or treatment (43 per cent said they were definitely involved, versus 60 per cent of patients with no self-reported mental health condition) or in the decision to discharge (25 per cent reported not being involved, compared with 14 per cent of people with no self-reported mental health condition) (Care Quality Commission, 2016). Furthermore, a smaller proportion of people with a mental health condition received an answer they could understand from the doctor when they asked an important question (52 per cent, compared with 71 per cent of people without a self-reported mental health condition) (Care Quality Commission, 2016).

All of this points toward a lack of parity of esteem in the experiences of patients with and without mental ill health, just as with the observations on patient access

and outcomes. Many of the policy initiatives and financial investments that come with the recent mental health strategies are mainly designed to address access and outcomes – such as creating new inpatient beds for children and young people, the introduction of standards in waiting times²² (Department of Health and NHS England, 2014) and focusing on the physical health in patients with mental ill health (NHS England Mental Health Taskforce, 2016a). However, hopefully improvements in those areas will help support reducing the gap between the experiences of patients with and without mental ill health.

Finally, data on people's experiences of using a service, comparing those that do have mental ill health with those that do not, is only currently available for the most recent year. The only nationally available, detailed measures of people's experiences when they have a mental health condition have, for a long time, been through the results of the survey of community mental health services. This has presented real difficulties, since the survey only measures one aspect of mental health care and does not cover other care services that are not designed to be specifically for mental health patients, such as in primary care. This is despite the fact that nine out of 10 adults with mental health problems are supported in primary care (NHS England Mental Health Taskforce, 2016a). And while the extension of the adult inpatient survey, which now separates out the responses of those with and without mental ill health, is welcome, there remains a general paucity of information regarding mental health services compared with other services. This shortfall was recognised in the *Five year forward view for mental health for the NHS in England* (NHS England Mental Health Taskforce, 2016a), which called for a data and transparency revolution to ensure greater consistency in the availability and quality of NHS-funded services across the country, with specific recommendations for certain bodies to enable this to happen.

22 Waiting times for Improving Access to Psychological Therapies and treatment of a first episode of psychosis using mental health services.

2.6 Condition-specific care

Evidence from analysis of both process and outcome measures for the care of patients with hip fractures indicates that the quality of care in this area has improved, despite increases in the incidence of hip fractures and the associated activity in hospitals. It is likely that this has been made possible through investments in this care pathway, the availability of national guidelines and data to support improvement.

Similarly, the quality of immediate care for patients who have had a stroke and their longer-term rehabilitation has also improved. Care for this condition has also been supported by a long-term focus on stroke care.

So far, this report has provided an insight into the state of quality in selected areas within different broad care sector categories. The remainder of the analysis looks at the state of quality and any recent changes in this for specific conditions, using the data collected as part of the national audit programme and supported by other data sources. Looking at quality in this way means that quality defined as effectiveness can be explored in a bit more detail.

Services that deal with hip fractures and stroke are analysed because there have been interesting developments in the quality of care in these areas (including care provided through rehabilitation after the immediate management of the event). Moreover, these areas will become increasingly important since they disproportionately affect those in older age groups (Neuburger and Wakeman, 2016; Stroke Association, 2016) as the number and proportion of older people in the population increases (Office for National Statistics, 2016a).

Care for patients after a hip fracture

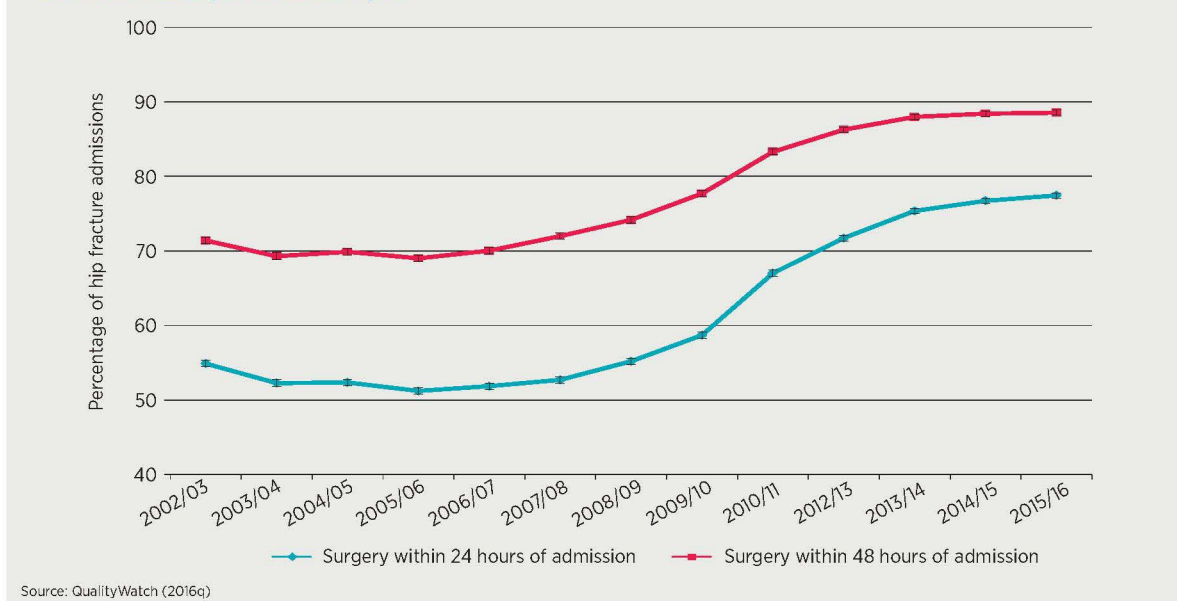
The total number of admissions for hip fractures per year increased from 48,915 admissions in 2002/03 to 57,668 admissions in 2014/15 – a 17.9 per cent increase (QualityWatch, 2016q). The National Institute for Health and Care Excellence (NICE) has published guidance on hip fracture management (NICE, 2011) and 12 quality standards (NICE, 2012). The quality of hip fracture care can be determined by assessing performance against these standards.

One of the standards relates to timing, with early and appropriate surgery for hip fractures being the most effective form of pain relief, potentially quickening the rehabilitation and reducing complications. The proportions of people undergoing surgery within 24 and 48 hours following admission for hip fracture have followed similar trends to one another, declining initially between 2002/03 and 2005/06 but rising steadily after that, until around 2012/13, when the rate of improvement slowed. Performance from this point remains steady up to 2014/15 (QualityWatch, 2016q) (see Figure 2.8). Surgery within 24 hours of admission took place for 77.4 per cent of patients with hip fractures in 2014/15, and within 48 hours for 88.5 per cent of patients.

A clinical audit of hip fracture care has also shown that performance against the other standards of care (such as assessments on admission, carrying out appropriate clinical interventions for certain patient groups and post-clinical care assessments) has also improved over time (Royal College of Physicians, 2015).

Analysis of patient outcomes for hip fracture care show that, between 2002/03 and 2014/15, a total of 61,883 patients died within 30 days of being admitted to

Figure 2.8: Trends in the timeliness of operations for patients admitted with hip fractures between 2002/03 and 2014/15



hospital following hip fracture – an overall crude mortality rate of 9 per cent at 30 days (QualityWatch, 2016q). The total number of deaths peaked in 2005/06 (5,327 deaths) and has decreased, with falls seen in almost all years, down to a minimum in 2014/15 (4,123 deaths). Similarly, sex- and age-standardised 30-day mortality rates have decreased markedly over time. In 2002/03 there were 101.9 deaths per 1,000 admissions, while in 2014/15 there were 71.5 deaths per 1,000 admissions – an overall decrease of 29.8 per cent in the standardised rate (QualityWatch, 2016q).

Between April 2002 and March 2015, there were a total of 60,385 readmissions within 28 days of discharge from hospital following hip fracture. The crude readmission rate over this period was 8.8 per cent (QualityWatch, 2016q). In contrast with mortality after hip fracture, the number and rate of age- and sex-standardised readmissions increased between 2002/03 and 2014/15 (QualityWatch, 2016q). There were 72.4 readmissions per 1,000 admissions in 2002/03, which rose to 102.4 readmissions per 1,000 admissions in 2014/15, which gives an overall increase of 41.2 per cent. However, it is not clear what the reasons for this are – it could be linked to inappropriate inpatient care²³, poor aftercare in out-of-hospital settings, or a result of the overall success of improving mortality rates, since the pool of individuals who are at risk of readmission is greater with better mortality rates (Laudicella and others, 2013).

Combined, these results suggest that despite the observed increase in hip fracture activity in hospitals, aspects of the quality of hip fracture care have been improving. This is likely to be related to year-on-year investment in hip fracture care, with marked improvements in the availability of specialist nurses and senior orthogeriatricians across the country (Royal College of Physicians, 2014), as well as policy approaches such as introducing national guidelines and carrying out national audits to drive up quality.

²³ Evidence does suggest that shorter length of stay is not likely to be a factor (Smith and others, 2013; Clarke and others, 2012).

Care for patients after a stroke

Between 2005/06 and 2015/16, the number of patients in England recorded on primary care practice registers as having had a stroke²⁴ increased by 20 per cent (from over 830,000 to nearly 1 million), despite there only being an 8 per cent increase in overall register size over the same time period (NHS Digital, 2006; 2016f). NICE (2008) defines a number of quality standards for stroke care that provide descriptors for patients and healthcare professionals of what defines high-quality care. The stroke audits collect data against these standards in order to understand the quality of the assessment and management of stroke and patient rehabilitation after stroke.

For example, patients who have had a stroke who meet certain criteria should ideally have a brain scan immediately on arrival to hospital to determine whether the stroke has been caused by a blocked artery (ischaemic stroke) or burst blood vessel (haemorrhagic stroke); which part of the brain has been affected; and how severe the stroke is, in order that appropriate treatment can be provided as quickly as possible. As part of the Accelerating Stroke Improvement (ASI) programme, which was launched in 2010 by the Department of Health, an associated standard for this process was introduced whereby at least 50 per cent of patients should have a brain scan within one hour (Society of Radiographers, 2015). This standard has been consistently missed, but the proportion of patients having their scan within an hour increased from 41.9 per cent in 2013/14 to 47.5 per cent in 2015/16 (QualityWatch, 2016q).

In addition, patients who have had an acute stroke should also have their swallowing assessed, as this is commonly affected, and there is a risk of aspiration, i.e. food and drink getting into the lungs, potentially causing further harm such as the development of chest infections or pneumonia. In 2013/14, 64 per cent of patients had their swallowing assessments within four hours of admission to hospital, and this increased to 72 per cent in 2015/16 (QualityWatch, 2016r).

High-quality stroke care immediately after the event leading to the planning of longer term rehabilitation also requires stroke patients being assessed and managed by the right staff within the right timeframe²⁵, with documented goals agreed within five days. Analysis of the audit demonstrates that this has improved, from occurring for 44.1 per cent of patients with stroke in 2013/14 to 56.4 per cent in 2015/16 (QualityWatch, 2016r).

Longer-term care and rehabilitation after the occurrence of stroke is just as important as caring for a patient immediately after stroke. High-quality ongoing rehabilitation after a stroke also requires input to a patient's care from a number of key individuals. However, there is no one measure for looking at this accurately, although three areas combined can be used as a proxy: speech and language therapy, physiotherapy and occupational therapy. In 2015/16, 41.6 patients had speech and language therapy, 73.5 per cent of patients had physiotherapy and 79.6 per cent of patients had occupational therapy (QualityWatch, 2016r). Performance on all three measures increased over time, with the biggest

24 Stroke and transient ischaemic attack (TIA). TIA, often described as a 'mini stroke', is caused by a temporary disruption in the blood supply to part of the brain. It causes symptoms similar to a stroke but does not last as long – sometimes only a few minutes or hours – and fully resolves within 24 hours.

25 Good quality is defined here as the assessment and management by a stroke nurse and at least one member of the specialist rehabilitation team within 24 hours of admission to hospital, and by all relevant members of the specialist rehabilitation team within 72 hours.

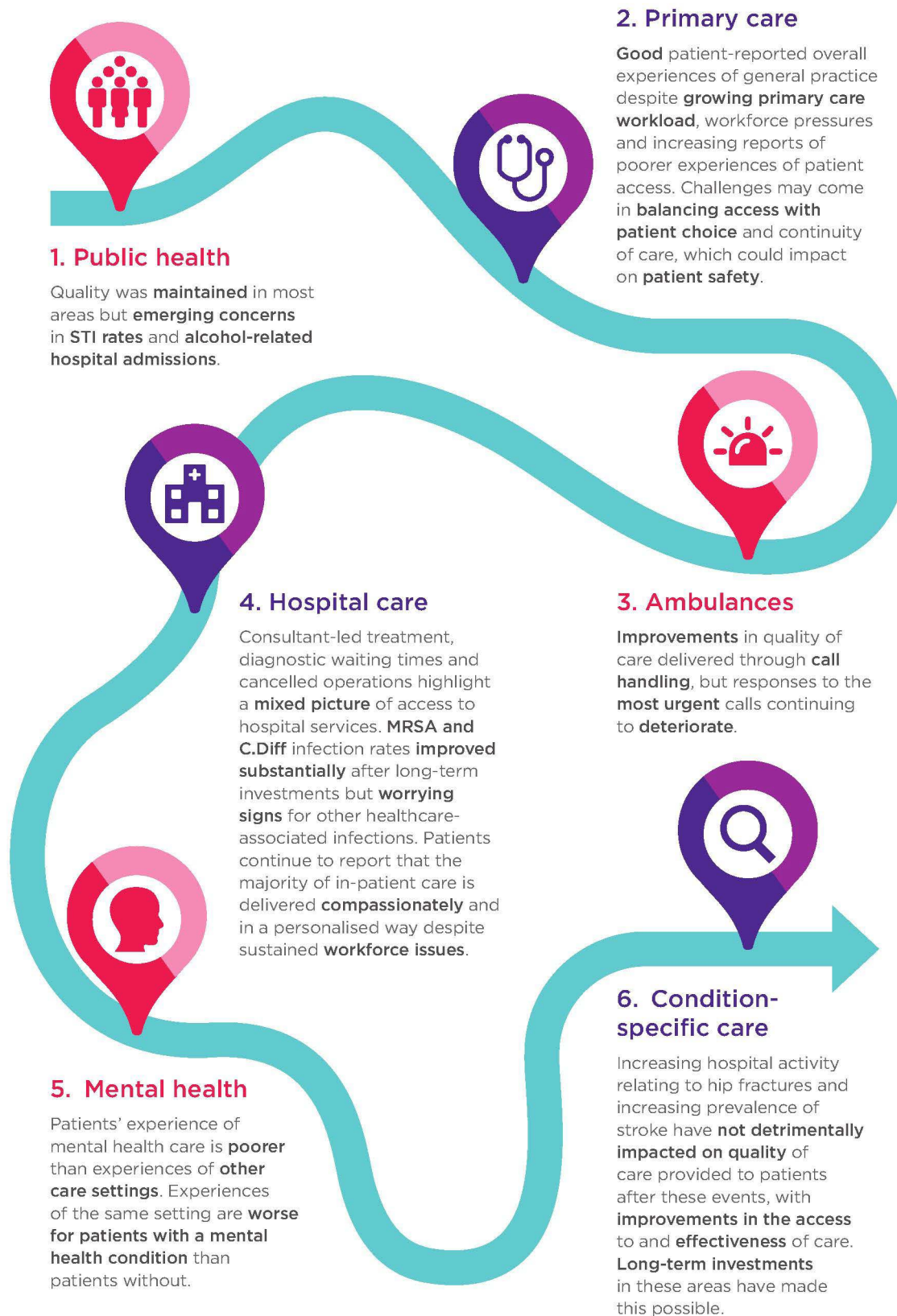
improvement seen in occupational therapy, which increased by 23.8 percentage points between 2013/14 and 2015/16.

After a stroke, many patients suffer a temporary loss in bladder control, which can be distressing and leave patients feeling a loss of dignity. Therefore, assessing the cause and providing ongoing support and treatment for loss of bladder control is essential to high-quality stroke rehabilitation. The proportion of eligible patients who have a continence plan within three weeks of admission has increased over time and reached 89.3 per cent in 2015/16 (QualityWatch, 2016r).

Similarly, patients recovering from stroke can experience a range of different emotions, such as depression and anxiety. In order to support patients in coping with these feelings, psychological assessment should be provided to determine what the appropriate care should be. Analysis of the audit data shows that the majority of patients had a mood and cognition screening on discharge and that this increased 10 percentage points from 79 per cent in 2013/14 to 89 per cent in 2015/16 (QualityWatch, 2016r).

Overall, this information provides evidence that the quality of care for patients who have had a stroke has improved. In a similar way to care of hip fractures, there has been a long-term focus on improving stroke care, including the National Stroke Strategy (which sets a direction for the development of services in England between 2007 and 2017), the availability of national clinical guidelines and the availability of information to assess performance and drive improvement.

Figure 2.9: Findings in this year's QualityWatch annual statement



Note: Mental health care can be properly understood as an aspect of care that runs throughout the 'patient pathway'. It is presented in this report as the fifth topic along a simplified and linear pathway merely for presentational reasons.

3

Discussion

Last year, our annual statement on care quality concluded that waiting times for hospital and other care services were under severe strain and unlikely to improve in the future. In that previous report, we argued that, despite many examples of excellent care, the warning lights were glowing more brightly, with lengthening waiting times, worsening staff morale and concerns over mental health care.

Just over a year on, these warnings appear prescient. This 2016 annual statement is published amid intense national debate over the NHS and social care. Virtually every day, headlines point out the problems being faced in relation to growing pressures on A&E and ambulance services; the low levels of staff morale within services (including the effects of the long-running junior doctors dispute); the pressures on social care services, which are widely agreed to be at 'tipping point'; or the dire financial health of both the NHS and social care, which is also regularly highlighted in parliament.

But while those headlines might suggest that care quality is in freefall, the analysis presented here and through the wider QualityWatch programme reveals a much more complex picture. Below, we summarise the findings that have emerged from the programme and set out some lessons for the future.

3.1 What we have learned

Important aspects of quality are being maintained

Although there are concerns in some areas, it is also true that care quality has been improved or maintained in a number of settings. Notable examples include:

- Improvements in certain areas of **public health and prevention**, such as the provision of long-acting reversible contraception (LARC) by general practitioners (GPs) and reduction of genital warts, drug treatment waiting times and smoking during pregnancy
- Improvements in **ambulance service call handling**, including:
 - twice as many calls resolved with telephone advice in 2015/16 than in 2011/12
 - nearly half a million fewer calls resulting in ambulance journeys to A&E in 2015/16 compared with 2011/12
 - a seven-percentage-point drop in the proportion of patients whose emergency calls were closed with telephone advice who then subsequently re-contacted 999 within 24 hours between 2011/12 and 2015/16
- Sustained high rates of **diagnostic tests** occurring within six weeks following a referral from a GP, with rates barely changing in recent years, and the latest data from September 2016 showing that 98.5 per cent of all diagnostic tests are occurring within six weeks

- Reductions in rates of **MRSA infection and CDI**, including:
 - an 82 per cent reduction in trust-apportioned cases of MRSA infections between 2008/09 and 2015/16 (1,606 cases down to 297)
 - an 85 per cent reduction of trust-apportioned CDI cases in those aged two years and over between 2007/08 and 2015/16 (33,442 down to 5,164)
- Improved high rates of adult inpatients reporting that during their stay in hospital they feel **involved with decisions** about their care and feel they are treated with dignity and respect:
 - 60 per cent of respondents to the adult NHS inpatient survey reported that they were definitely involved in decisions about their care in 2015, up from 53 per cent in 2005
 - 84 per cent reported that they were always treated with dignity and respect in hospital in 2015, up from 80 per cent in 2011
- Adherence to **recommended processes and treatments** in some areas, such as more patients with suspected stroke receiving a brain scan within an hour.

This is not to say that there are no problems in care quality, but these achievements are impressive, since they have occurred against a backdrop of increasing pressure on services caused by a growing population and changing population demographics, increasing care activity, growing workforce issues and risks, worsening staff morale, and financial challenges. For example, the ambulance service has improved the way it manages calls, despite staffing problems affecting the service and ambulance calls increasing by 1.25 million over four years.

Targeted investment in care quality works

Many of the improvements observed in this report are likely to stem from long-term investments and policies designed specifically to drive up quality in those particular areas.

For example, the improvements in rates of healthcare-associated infections (HCAIs) MRSA and *C. diff* have reduced significantly over a seven-year period between 2007/08 and 2014/15. This has been achieved, in large part, by a combination of financial investment; action on hospital cleanliness through policy and process changes; hospital-level initiatives including hand hygiene and patient screening; and the introduction of standardised national data collections with associated achievement targets. By contrast, there has not been the same level of investment in tackling other forms of HCAIs like *E.coli* and MSSA, and rates of these infections are increasing.

Improvements in care quality have slowed or stalled in key areas

There are many examples where the improvements observed in the quality of care have slowed in recent years, stalling in some cases, or examples where negative findings of quality have persistently remained. Specific indicators that have been analysed in this report that show these trends include the following:

- The numbers of trust-apportioned MRSA infections slowed down to around 300-400 per year between 2012/13 and 2015/16
- The proportion of people undergoing surgery within 24 hours following admissions for hip fracture has changed very little between 2012/13 and 2014/15

- The percentage of adult inpatients that said they do not feel involved in decisions about their care has changed very little in more than a decade since 2005 and reflects about one in 10 patients.

Growing waiting times remain a serious concern

While the effectiveness and safety of healthcare is broadly being maintained, it seems that this is increasingly coming at the cost of providing timely access to care right across the health and care sector.

Waiting times for consultant-led treatment, ambulance response times and waiting times for A&E are all areas of concern, with performance against some of these rising to levels not seen since earlier this decade. For example, achievement against the national standard that immediately life-threatening emergency calls should be attended by an ambulance within eight minutes fell to its lowest point in five years in March 2016, with just 58 per cent of calls reached within that time. The target for this standard is that three quarters (75 per cent) should be reached within that time. Waiting times for patients requiring consultant-led treatment have grown by over a week since 2012.

These trends are concerning because lack of timely access to appropriate care may mean preventable conditions go undetected, while delays in treatment may mean minor ailments become bigger problems.

People with mental ill health report poorer-quality healthcare experiences

While patients' experience of adult inpatient care in general remains good, people with mental ill health consistently rate their overall experience of healthcare in this setting as much lower than those without mental ill health. Often they do not feel as involved in decisions about their care or treatment, are less likely to be involved in decisions about their discharge from hospital and did not get answers they could understand. Similar disparities apply when comparing patients' experiences of mental health care services with services that are not solely designed for treating mental ill health.

The paucity of data inhibits our understanding of care quality

Large parts of care quality remain a mystery, because of gaps in robust, timely and relevant information. These data gaps may result in a focus on managing only those areas that can be measured, leaving those that are not measured at risk from failure to tackle poor performance and deprioritisation. For example, we have not reported on quality within social or community care because of a continued lack of timely data.

Even where data are available, there is a risk that viewing indicators in isolation may mask quality variations within a service. For example, data on ambulance call handling indicate an improvement between 2011/12 and 2015/16, but ambulance response times have deteriorated markedly over the same time. Also, patients' reporting on their overall experiences in primary care is good, but their views in response to certain questions on access to primary care declined between 2011/12 and 2014/15.

3.2 Lessons for the future

The analysis contained in this report, along with our wider monitoring of care quality indicators, is by its nature backward-looking – data can only tell us about what has happened in the past. But our expertise as organisations involved in interpreting and understanding healthcare policy and in analysing data through the whole QualityWatch programme mean we can offer some perspectives on the future of care quality in England.

Further improvement is not guaranteed

We have shown that certain key areas where care quality has historically improved have started to slow or stagnate. These trends raise important questions about the drivers for this reduction in improvement, and ultimately the extent to which quality can be expected to continue to improve in future. It is possible in some areas that the level of quality may have reached a natural ‘ceiling’ of performance, beyond which further gains cannot be made.

In other areas, this may be the start of a reversal in trend and deterioration in quality. While the sustained low rates of MRSA infection and CDI in the context of rising bed occupancy has been a remarkable achievement, the progress in reducing these infections has begun to slow and has not been matched by reductions in other HCAs. As hospitals face pressures to improve achievement against access targets, we have concerns that some HCAs could start to become more widespread as hospitals running at already high occupancy levels have to accommodate yet more patients.

The current funding squeeze could see further delayed decline

Some of the indicators relating to patients’ access to physical health services that are now deteriorating did not see a marked change in the first years after the policy of austerity began in 2010. It is now widely acknowledged that the twin pressures of rising levels of healthcare activity and constrained funding have contributed in large part to growing waiting lists.

Over halfway through a decade of austerity, both health and social care still face unprecedented financial challenges: the Department of Health’s budget will increase by just over £4 billion in real terms between 2015/16 and 2020/21. This is not enough to maintain standards of care, meet the demand caused by increasing levels of hospital activity and deliver the transformation the NHS needs.

It is therefore possible that the coming years will see a similar ‘delayed decline’ occurring in aspects of quality that are currently doing well, such as patients’ experiences of healthcare, or waiting times for diagnostic tests. There must therefore be no cause for complacency about the positive measures highlighted in this report. If additional funding is not forthcoming, the Government will need to be honest with the public about how access to care and quality standards will be affected.

Trade-offs made in response to competing pressures could have catastrophic consequences

Often, the different elements of quality are complementary – providing safe care is also effective, for example. But there also can be tensions between them. The findings presented in this report suggest that safe and effective care is still being delivered, but that this is happening at the expense of timely access to care.

Maintaining high-quality care must also be seen in the context of other pressures facing the health service, such as the financial crisis affecting NHS providers, problems in recruiting and retaining staff, and the ever-changing policy and regulatory environment.

Individual trade-offs to maintain care quality, or elements of care quality, in this context may be understandable – most patients might accept waiting longer to ensure they receive safe and effective care. But the consequences of making the wrong decisions in managing competing pressures can be catastrophic. For example, at Maidstone and Tunbridge Wells NHS Trust, reconciling the management of HCAs with the fulfilment of the four-hour A&E target and financial targets were responsible for lapses in care.

With the NHS and social care under enormous pressure, and timely access to care already forfeited in many cases in exchange for safety and effectiveness, it is likely that more trade-offs will be made to maintain other elements of care quality or to manage financial or other performance. This could make the NHS vulnerable to serious lapses in care in future.

Failure to invest in quality will affect patient care

Many of the success stories highlighted in this report have been the result of careful and targeted investment. This is not just about funding, but rather investment in the wider sense – recruiting and retaining a workforce with the right skills and values, developing the NHS's capability to undertake intelligent analysis and quality improvement, designing new and better ways of delivering care, harnessing new knowledge and technology, and reinforcing a relentless focus on quality through policy and regulatory frameworks.

Achieving this investment in the face of considerable pressures will be a challenge. But failure to do so will rob the NHS of the quality gains patients deserve and expect to be achieved.

Improved data is part of the solution

With good-quality comparable routine data being so patchy across health and social care, better availability of data and linked datasets looking across different care settings would be an important first step towards enhancing our understanding of care quality.

While data can shed light on areas we know too little about, or join up areas of care to give us a more rounded view, it must go hand in hand with efforts to translate the findings into actionable strategies to improve healthcare.

This is not a new message from the QualityWatch programme, but it remains a vital area for future development and should also not be forgotten when assessing competing pressures.

3.3 Our verdict on care quality

Our analysis has shown that, in the face of considerable pressures, there are positive stories about care quality that run counter to recent prominent headlines suggesting that the NHS is in freefall.

However, while the achievements highlighted in the report are worthy of celebration, there is no room for complacency. The NHS and social care enter 2017 amid the tightest funding settlement for decades. Healthcare activity continues to rise, and the pressures on the health and social care systems show no signs of abating.

The next 12 months will prove a crucial test for the resilience of the health and social care system. Without continued investment in health and social care, we cannot confidently predict that improvements sustained thus far will continue to be made, or that the deterioration highlighted in this report will be reversed.

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