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by Tim Gardner

## Swimming against the tide? The quality of NHS services during the current parliament

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# 38%

*of voters in the Ipsos  
MORI's March 2015  
political monitor said  
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important election issue.*

The NHS is one of the key issues of public concern in the run up to the 2015 general election. Ipsos MORI's March 2015 political monitor found that 'health care and the NHS' was the most important issue for voters ahead of the election, with 38% saying it was a very important issue. This had increased from 26% shortly before the last general election.<sup>1</sup>

In part, this reflects the enduring public commitment to the principles of the NHS. But it also reflects the growing evidence and concern about strains on the service.

The Health Foundation is publishing a series of briefings and blogs in the run-up to the 2015 general election, to inform the ongoing public debate on health care policy. These materials will analyse and discuss key issues raised by political parties and others about health care policy and the NHS.

This briefing summarises trends in the quality of NHS care in England since the 2010 general election. The focus is on England because, although the United Kingdom will elect a new parliament and government in May 2015, health has been a devolved matter since the late 1990s. Elections to the Scottish Parliament, National Assembly for Wales and Northern Ireland Assembly – each of which has taken a distinct approach to the NHS<sup>2</sup> – are expected to take place separately in May 2016.

This briefing draws on five topic overviews that contain more detailed figures and references relating to key areas of quality. See [www.health.org.uk/qualityoverview](http://www.health.org.uk/qualityoverview)

## Introduction

Every year, nine out of 10 people in England will use NHS services.<sup>3</sup> How has the quality of NHS care experienced by these users changed during the last five years?

Health care is high quality if it is safe, effective, timely, person-centred, equitable and efficient.<sup>4</sup> There is no single answer as to whether quality is better or worse across every patient, in every service and in every care setting across the NHS in England. The scale and range of the activity undertaken within the NHS, as well as the complexity of what needs to be measured, do not allow this assessment. Instead, it is more useful to consider how different **aspects** of quality have changed and how this impacts on people's experiences.

The overviews on quality of care that this briefing draws on focus on five questions:

- Is the NHS getting safer?
- Are people waiting longer for health care?
- Is mental health care improving?
- Is the NHS becoming more person-centred?
- How does the NHS compare with health systems in other countries?

Three of these questions cover aspects of quality that have already been the subject of scrutiny during the election campaign; two – safety and person-centred care – have not had similar scrutiny, but justify further attention.

Where possible, changes in quality have been compared between 2009/10 (the last full year of the previous parliament) and 2014/15 (the last year of the current parliament).<sup>\*</sup> National data<sup>†</sup> are used throughout the briefings to provide an overall picture, particularly drawing on QualityWatch – a joint Health Foundation and Nuffield Trust research programme. However, nationally aggregated data mask at least some degree of unwarranted variation in quality between different parts of England and different health care providers. As highlighted most recently by the Care Quality Commission (CQC),<sup>5</sup> large variations in quality also occur within organisations, services and teams. Early results of the new hospital rating system have identified examples where outstanding and inadequate services co-exist within the same hospital trust.

## Changes during the current parliament

A number of notable advances in the quality of care within the NHS were made under the Labour government between 1997 and 2010.<sup>6,7,8,9</sup> For example, the typical waiting time for inpatient acute treatment fell from 13.6 weeks in June 1997 to just 4.3 weeks in March 2010. There were also a number of high profile instances where standards of care fell tragically short, such as at Stoke Mandeville, Maidstone and Tunbridge Wells, Mid Staffordshire and Morecambe Bay.<sup>10,11,12,13</sup>

<sup>\*</sup> The main exception is for international comparisons where, for the most part, the latest data available is for 2011.

<sup>†</sup> For international comparisons, data are for the United Kingdom, unless otherwise stated. For all other overviews in this series, the data are for England unless otherwise stated.

The broad political consensus on the need to tackle the fiscal deficit meant that the period 2010-2015 was always going to present considerable challenges for the NHS, regardless of the outcome of the 2010 general election. While the coalition government has met its commitment to protect overall real terms (adjusted for inflation) NHS spending from wider cuts to public spending, the increase in NHS funding has not kept pace with rising demand.<sup>14</sup> Demographic changes have meant the need for health care has risen and become increasingly complex; however, NHS spending per person has been virtually flat (increasing by 0.13% a year on average in real terms) between 2009/10 and 2015/16.<sup>15</sup> Over the same period, the government has pursued a far-reaching, controversial and evolving programme of NHS reforms, initially set out through the ‘Liberating the NHS’ white paper<sup>16</sup> (and subsequently the Health and Social Care Act 2012) and, latterly, in the wake of the Francis Inquiry into failures of care at Stafford Hospital.<sup>17</sup>

Funding constraints and reorganisation in the NHS do not necessarily translate into shortfalls in quality of care, but they do make the task of improving quality more challenging.<sup>18</sup> Given this context, for the NHS to have at least sustained and, where possible, to have built on the advances in quality made between 1997 and 2010 might have been a limited, but realistic, expectation for the 2010 to 2015 parliament.

### Changes in quality

Measuring quality of care is a complex issue, and measurement is necessarily partial. It is not possible to say definitively whether overall quality of care in the NHS got better or worse between 2010 and 2015. Less than two years after implementation of the ‘Liberating the NHS’ reforms in April 2013, it is also not yet possible to attribute particular changes to policy and legislation to measured changes in quality during this parliament. Some analysis has been undertaken of particular policy changes,<sup>19,20</sup> but much more evidence is needed to assess what impact the reforms have had.

As figure 1 (on page 3) shows, there are two sides to every story and measures that could be viewed as an overall proxy for how well the NHS is performing are incomplete and potentially misleading. There are many different sources of information about quality, but none offers a comprehensive and definitive view. As such, despite using nearly 300 indicators to monitor changes over time in the quality of services provided by the NHS in England, we do not claim that the QualityWatch programme is definitive.<sup>21</sup>

Information about some aspects of quality is still too limited. For example, very little is currently known about the safety of care outside acute hospitals,<sup>22</sup> despite Jeremy Hunt’s ambition for the NHS to become the safest health system in the world.<sup>23</sup> While the government has created ‘the biggest ever financial incentive’<sup>24</sup> to develop co-ordinated care and support through the Better Care Fund, there is still no way of measuring people’s experience of integrated care.<sup>25</sup> Measuring and monitoring quality in community health services remains ‘a dangerous blind spot’,<sup>26</sup> and we have a very limited idea of the quality of pharmacy services, even though more of the population over the course of a year use pharmacists for medical advice than visit A&E.<sup>3</sup> Indeed, in 2010 it was estimated there was no nationally-collected quality data for around £20bn of NHS spending, and limited reliable data on child and maternal health, older people, mental health and social care.<sup>27</sup>

Figure 1: Two sides to every story

## On the one hand... ...but on the other

More people are now waiting over four hours in accident and emergency (A&E) departments, breaching the government's target...<sup>27</sup>

...**BUT** while timely access to urgent and emergency care is important, most people access the NHS through their GP or community pharmacy, and there is little information about quality in these settings.<sup>29</sup>

In 2014, an international survey ranked the UK's health system first out of 11 comparable countries...<sup>29</sup>

...**BUT** the UK does not compare well on some key outcome measures,<sup>30</sup> and overall rankings have been criticised as potentially misleading.<sup>31</sup>

The CQC is taking action against more providers of NHS care over concerns about quality...

...**BUT** this is largely due to the more rigorous inspection regime developed in response to the Francis Inquiry.<sup>32</sup>

A recent survey suggests that public satisfaction with the NHS is now lower than it was in 2010...<sup>3</sup>

...**BUT** the same survey also found that confidence in the safety of NHS hospitals is higher than ever, and more people think the NHS puts quality at the heart of everything it does.<sup>3</sup>

NHS staff are now marginally more likely to be satisfied with the quality of care they are able to deliver...

...**BUT** more staff report having suffered from work-related stress in the previous 12 months, which has been shown to have a negative impact on patient experience and outcomes.<sup>33</sup>

Most political parties want health and social care services to be integrated around the people who need care...

...**BUT** we do not know whether health and care is becoming more integrated, since no measures currently exist to give us insight.<sup>34</sup>

Our analysis, drawn from the five more detailed overviews that accompany this document, concludes that:

Rates of health care associated infections have remained low during this parliament

In the last three months of 2014, 92.6% of people were seen within the four-hour A&E target

Funding for children and young people's services has been cut, treatment thresholds have increased and waiting times are very long

- **The NHS has done extraordinarily well to maintain and improve quality across a range of areas in the face of growing pressure from increased demand and financial constraints.** But progress on improving quality has stalled in some areas and may even be starting to unravel, while information gaps in a range of other areas mean we simply do not know whether quality is getting better or worse.
- **Progress continues to be made in tackling some key harms in hospitals, but we still know very little about safety in other settings.** Recent reductions in health care associated infections represent a significant achievement for the NHS, and rates have remained low during this parliament. While evidence suggests more incidents are now being reported in hospitals, it is likely there is significant under-reporting in primary care (which is the source of only 0.2% of reported incidents, despite being where 90% of all patient contacts with the NHS occur). Some warning signs are also emerging from the NHS workforce, with work-related stress and staff perceptions of a blame culture continuing to rise. Wide variations in safety are also apparent both between and within NHS organisations.
- **Access to care is still substantially better than 15 years ago, although waiting times have become longer in some areas.** As demand for services has increased, both performance against a range of waiting time targets and patient-reported access to primary care have deteriorated, but most people continue to be seen within target times. For example, in the last three months of 2014, performance against the four-hour A&E target was the lowest it had been in the last 10 years, but 92.6% of people were still seen within the target time. The NHS has consistently achieved the target that patients referred by a GP for suspected cancer should be seen by a specialist within 14 days, despite the number of referrals increasing from 678,823 in the first nine months of 2009/10 to 1,156,897 in the same period in 2014/15. People's satisfaction with the opening hours of their GP surgery has reduced, but more than three quarters of people remain very or fairly satisfied.
- **Some mental health services have improved, but many people with mental health problems are still not receiving high quality care.** The availability of services for people with common mental health problems has substantially improved since 2010, and the number of people recovering continues to grow. More people are accessing treatment for severe mental health problems, but fewer receive coordinated care or social care. Services have become more coercive and there is little information on the outcomes they achieve. There is an unacceptable gap in information about quality in services for children and young people. These services have been subject to substantial funding cuts in spite of increased demand, and are seeing thresholds for treatment increasing, mixed appropriateness of services and very long waits for specialist services. This is a key area for concern.

Our current inability to measure person-centred care hinders wider progress

'League tables have simply not proved a satisfactory way to compare entire complex health care systems' (National Quality Board, 2010)

- **We still cannot measure how well the NHS puts people at the centre of their care:** Since 2000, successive governments have made commitments to person-centred care, but we lack coherent and consistent indicators across all areas of care. There have been improvements in a number of areas but in others there has been little real improvement. Sobering accounts of failings in care, such as at Mid Staffordshire and Morecambe Bay, reveal that – at least in isolated places – it is possible for a culture to persist where services fail to place patients at the heart of care. One in five inpatients still report that they are not always treated with dignity and respect and more than 40% are not involved as much as they want to be in decisions about their care. In other areas, such as coordination, we don't have any reliable measures to assess and track progress. It will be difficult to show real improvement in this area without coherent and consistent measures across all dimensions of person-centred care and across services and populations of patients.
- **The NHS compares well internationally across some measures of quality, but there is considerable scope for improvement.** Information from international comparisons is best used to stimulate further questions and improvement. Rankings can be over-simplistic and they risk being misleading when taken at face value. The UK's health system provides universal health care coverage for its population, with high levels of equity of access to care for equal need. It also fares well compared with international peers on a number of reported measures of experience and access. However, the UK's comparative performance against key health outcome measures, such as infant mortality and deaths that could be prevented by effective health care, are less positive. In 2010, evidence suggests that nearly a quarter (24.7%) of deaths under the age of 75 could have been prevented by the provision of appropriate health care, compared to 19.8% of deaths in France (which had the lowest amenable mortality rate of the 19 comparator countries considered in this analysis).<sup>35</sup>

## Conclusions

The NHS has worked hard to protect quality during this parliament, but there are some worrying signs that fatigue is starting to set in. If the gap between spending and demand continues to widen, preventing these hard-fought achievements from being eroded will be one of the defining challenges of the next parliament.

We suggest three areas where the policy framework for quality requires further consideration.

**First, the gaps in national quality data are unacceptable.** Lord Darzi's *NHS Next Stage Review* (2008) made clear the role of measurement and national data in improving quality.<sup>36</sup> In 2010, the subsequently formed National Quality Board highlighted major gaps in nationally-collected quality data, setting out that:

'By 2015, the vision is to ensure that patients and professionals have ready access to meaningful information about the full range of services that the NHS provides, supported by high quality underpinning data.'

Maintaining and improving quality, particularly in mental health, will be a defining challenge of the next parliament

This vision has not materialised. Major data gaps are many: they afflict the ministerial priorities of both the Secretary of State for Health (patient safety) and the Minister for Care Services (integration of care); the quality of whole areas, such as community services and child and adolescent mental health, is largely unknowable. This has real effects. It impedes staff in improving care, allows unwarranted variation to flourish, restricts commissioners' ability to understand the quality of the services they are commissioning (a particular concern in community services), and limits the ability of patients to make informed choices. In addition, at a time of financial constraint, it means we are unable to know the full picture of the impact of austerity on the quality of key areas of care for vulnerable people.

There has been progress in some areas, but this risks being too small and incremental. The next government needs to give resource and priority to the development of a wide range of new national indicators, particularly prioritising child and adolescent mental health and safety outside hospitals, as well as supporting local organisations to build their own analytical capability and use of local measures.

**Second, addressing data gaps needs to be just one part of a comprehensive strategy for improving quality in the NHS in England.** There is much to be welcomed about government policy in response to the Francis Inquiry, the six independent reviews to examine key issues raised by the inquiry, and most recently the whistleblowing review and Morecambe Bay inquiry.<sup>12,13,37,38,39,40</sup> However, the proliferation of quality initiatives against a backdrop of large-scale organisational change reiterates the need for a single coherent strategy that sets out the role of the national NHS bodies and how their actions will support **local** efforts to improve quality.

The NHS is being asked to improve quality and efficiency at pace, both through systematic improvement within every service and through whole system transformation. To make progress on both of these fronts, and as highlighted in our recent report *Constructive comfort: accelerating change in the NHS*,<sup>41</sup> NHS services in England need on-the-ground support: expertise in the issues and changes local areas are grappling with, as well as moral support for taking risks and making changes. For example, a comprehensive improvement strategy could set out how essential management, and quality improvement, skills and capability can be made commonplace across the NHS, backed by strategic support and leadership, and a transformation fund to support change.

**Third, the national approach to assessing and managing performance needs to be overhauled.** The government's approach to using data for improvement and assessment has gone backwards over the course of this parliament, reverting from an approach based on a broad range of outcomes to a focus on a much narrower set of targets and waiting times.<sup>16</sup> This is shown by the government's failure to realise its intention to replace the four-hour A&E target with a more balanced set of quality measures, while progress against the 57 indicators in the NHS Outcomes Framework (described as 'the primary assurance mechanism to assess the progress of NHS England') is barely reported.<sup>42,43</sup>

The direction set out by the government in 2010 was broadly right: the national NHS system can help local quality improvement far more by focusing on outcomes rather than a narrow set of targets such as the four-hour A&E target. Providers of NHS care need to be assessed not only on their short-term performance, but also on their long term outcomes, their approach to learning and quality improvement, and their contribution to improving the health of local communities.

After the election there is likely to be a new ‘mandate’ to the NHS for 2016 onwards. This provides the best opportunity of the entire parliament to make a break from the current reliance on performance management to improve quality – it must not be missed.



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Errors or omissions remain the responsibility of the author alone.

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Tim Gardner joined the Health Foundation in October 2014 as a Senior Policy Fellow.

Before joining the Health Foundation, Tim spent 10 years at the Department of Health, working on policy and legislation in a variety of roles. Most recently, Tim was a Senior Policy Advisor in the NHS Strategy and Delivery Unit where he advised on a range of projects including the Dalton review, the Better Care Fund and the government response to the Francis Inquiry.

Before that, Tim worked on a range of areas, including primary care, cancer and mental health as an NHS performance manager in the Department's Recovery and Support Unit. He was Secretary to the NHS Management Board and Assistant Private Secretary to the Chief Medical Officer, and also spent three years at the Department for Education advising on policy on children's services.

Tim has an MSc in Health Policy from Imperial College London.

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