AC Comfort lecture, 21 June 2016
Royal Society of Medicine

With both health and social care under increasing pressure, how will quality care for older people be ensured?

David Behan

7.30-8.30pm
Address: 40 minutes
Q&A: 20 minutes

Introduction

Slide 1

Good evening. Thank you for inviting me to speak to you this evening in this prestigious setting.

The Royal Society of Medicine has been at the forefront of medical learning, innovation and ideas for over 200 years.

I am honoured to be asked to give this lecture in memory of one of its many celebrated members, Dr Alex Comfort – physician, poet and novelist who led important research in the field of gerontology.

Promoting, advancing and enhancing the science of ageing and clinical care for older people are at the heart of the Society's work.

I believe that all of us here this evening share the same purpose – to ensure that older people receive safe, effective, compassionate, high-quality care and to encourage improvement.

The fact is, we see a lot of very good care across all areas of health and social care but we also see too much variation.

Some older people are not receiving the quality of care they need and deserve.

Often, poor quality happens at the point where different parts of the system interact.

In some cases, they don't join up as effectively as they could.

In others, pressures in one part of the system impact upon the ability of other parts to deliver high-quality care.

We know that the system is working hard to deliver care in a time of austerity.

The Five Year Forward View outlines the challenge by referring to three, key gaps that we all need to work together to address:

The health and wellbeing gap;
The care and quality gap; and
The funding and efficiency gap

It is not possible to secure a sustainable future for the NHS unless these gaps are viewed collectively. We can't address one with the others.

Put another way, we know that quality and finance go hand in hand. The Sustainability and Transformation Plans are designed to secure a sustainable and transformed NHS.

Last week at the NHS Confederation conference, the Secretary of State for Health spoke about the relationship between the size of acute trusts' deficits and their CQC ratings.

He identified that trusts with inadequate ratings had average deficits of around five times the size of those with outstanding ratings. In his words, we know that about "the most expensive thing to do is to deliver poor care".

Simon Stevens and Jim Mackey in their conference addresses also spoke about the importance this year of trusts simultaneously stabilising their finances and operational performance, and the role of system partners in supporting them to do this.

CQC is in a unique position to look across the whole health and care system in England – not only trusts but providers of adult social care and primary medical services, including GP practices.

So I would like to spend the time I have with you this evening to reflect on what our inspections of services tell us about the state of care for older people and some of the challenges for the future.

In particular, I want to share with you a message about the importance of us all working together to ensure older people receive high-quality care.

I am clear about the role that CQC must play in this as a regulator.

But regulation is only one of a number of influences on quality, and I would like to explore in my talk this evening how these influences can come together to drive improvement.

But first, I want to reflect on the changing context of care for older people.

Our ageing population and increasing demand

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There are now 11.4 million people aged 65 or over in the UK. This number is projected to rise by over 40% in the next two decades.

We also know that an estimated four million older people in the UK have a limiting longstanding illness. This represents 40% of all people aged over 65.

Two-thirds of NHS users are aged 65 and over, and of the 18.7 million adults admitted to hospital last year, 41% were from this age group.

This is set against a long-term trend that has seen greater volumes of both urgent and emergency care and elective activity over the last twelve months, with emergency admissions up 3% and consultant-led treatment up 3.9%.

We've heard today from the Royal College of Nursing and the British Medical Association about the pressure of increased demand in the hospital sector particularly affecting Accident and Emergency units.

These population changes have a significant impact on health and care services – and those services must respond to changing demand.

The supply side - a health and social care system under financial pressure

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And yet we know that the system is under significant pressure.

NHS trusts reported a deficit of £2.45 billion at the end of the financial year 2015-16. This is almost three times greater than the deficit reported in 2014/15.

For adult social care, the National Audit Office reports that central government grants to local authorities have been reduced by 37% in real terms and on a like for like basis over the last five years.

Local authorities have worked hard to protect social care budgets from these reductions, but the number of people receiving local authority funded adult social care has fallen from approximately 1.8 million in 2008/09 to about 1.2 million in 2013/14.
It has become harder to receive local authority funded care because the pressure on finances is greater.

The Government enabled local authorities to set a 2% precept which has made a contribution. This helps but is not sufficient to meet need.

We are also aware of broader pressures in terms of costs, staff recruitment and retention that contribute to fragility in the sector.

In primary care, rising patient demand coupled with funding pressures have led to patients facing longer waits for appointments and increasing difficulties getting through to their local surgeries.

The new GP strategy announced in April unveiled additional funding for the sector to assist with recruitment and to provide support for existing staff.

One outcome of these factors is increased pressure at the point where different parts of the system come together, which can have a significant impact on quality of care, particularly for older people.

For example, NHS trusts have identified that a particular area of concern is costs associated with delayed transfers of care. NHS Improvement has reported that in Quarter 3 of last year, providers saw a 10% year-on-year rise in the number of delayed transfers.

Providers have estimated that such delays have cost them in the region of £104m in direct costs so far this year. Lord Carter, in his review, regarded this to be a "major problem" for the NHS.

Again, this is an area where we see variation, with those trusts who understand patient flow appearing to experience fewer problems.

So the demand side is increasing, and the supply side is under pressure. We know that the result can affect people's experiences of care.
This month we published the findings of our 2015 survey of NHS inpatients. Overall, a higher proportion of respondents were aged 66 or older compared to the previous year.

We found that results were less positive than in 2014 for some questions that related to patients' experience of being discharged from hospital.

For example, over the seven years to 2014, we have seen an increase from 61% to 69% in the proportion of respondents who said they'd received written information about what they should do after leaving hospital. In 2015, we found that this had decreased to 66%: a deviation from the upward trend we'd seen.

In 2006, 43% of respondents 'definitely' felt doctors or nurses gave their family or someone close to them all the information they needed to help care for them, compared with 50% in 2014. However, again we saw a decrease in 2015 to 48%.

A large proportion of respondents said their families or someone close to them did not receive all the information they needed to help care for them - up from 27% in 2014 to 30% in 2015.

This is set against a period between June 2014 and June 2015 where there were 1.67 million 'delayed days' due to delayed transfers of care.

Services are not as integrated as they might be – providers of care must work together to improve quality.

The importance of working together

Last month's Parliamentary and Health Service Ombudsman's report of investigations into unsafe discharge from hospital found that a lack of integration and poor joint working between different aspects of healthcare can result in people being discharged without the support they need to cope at home.

Equally, lack of coordination between health and social care services can lead to lengthy delays in finding suitable care packages for elderly people with complex needs.

Earlier this month, the Public Accounts Committee looked at this issue in a session with providers and system partners.

The Committee identified the importance of leadership within a health and care community in improving older people's transfer from hospital to other care settings.

It heard of examples where partners shared a vision, ambition and plan – underpinned by strong leadership - and this improved safety and effectiveness.

One included Northumbria, where the Chief Executive of the trust, David Evans, spoke about how effective partners had been in that area to eliminate delayed discharge.

He said, that "Working more closely together and doing away with organisational boundaries in everything that we have done seems to have paid a dividend."

This message is repeated in some of our thematic reports, which I shall come on to.

So what is CQC's role in services for older people?

As I said at the start, I believe we have a shared purpose.

CQC is here to make sure that health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve.

We register, monitor, inspect and regulate services by asking five questions:

- Are they safe?
- Are they effective?
- Are they caring?
- Are they responsive to people's needs?
- Are they well-led?

We rate services to highlight where care is outstanding, good, requires improvement or inadequate.

But we have always been clear that we cannot achieve quality alone.

There are five key influencers of quality, of which regulation is just one:

- What commissioners do and how they specify quality in their contracts
- What providers do from the Board to the front line; through organisational leadership
- What regulators do

- The voice of the public and those that use services and, importantly,
- What you as professionals do, particularly in the way you promote quality

For quality and safety to improve all five influences need to operate together.

If one is dominant and the others are not operating effectively it is unlikely that there will be sustainable improvements in quality; if all five influences work together then sustainable quality will result.

In NHS acute hospitals, we inspect eight core services, including a number used by older people:

- Medical care, including care for older people
- Urgent and emergency services
- Surgery
- Critical care
- End of life care
- Outpatients and diagnostic imaging

We are committed to including a focus on care pathways and particular patient groups as part of our inspections of acute services. This could include, for example, people with dementia.

We include the voices of people who use services, their families and carers, staff and other professionals before, during and after an inspection.

In adult social care, we look at how both residential and community services for older people work with other key organisations, including the local authority, safeguarding teams and clinical commissioning groups, to support care provision, service development and joined-up care.

In our inspections of GP practices, as well as looking at the five questions, we also look at six key population groups. One of these is older people aged 75 or over.

In specialist mental health services, we look at eleven core services including wards for older people with mental health problems and community based mental health services for older people.

So what are we finding?

Our inspections of NHS trusts, adult social care services and GP practices

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Whilst we can't compare ratings specifically for older people's care across all the sectors we regulate, the picture our inspections build across the system is one of variation.

Within NHS acute trusts, we have only rated 29% of locations as 'good' for providing safe medical care, including care for older people.

65% were found ‘good’ at providing effective care for this core service, with 87% rated ‘good’ for caring, 52% for responsive and 58% for well-led.

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Within specialist mental health services, only 34% of wards for older people have been rated ‘good’ for safety.

However, 58% were found ‘good’ at providing effective care, with approximately 80% rated ‘good’ for being caring, responsive and well-led.

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Between 70-90% of community based mental health services for older people have been rated ‘good’ for all five questions.

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To date, our overall ratings for adult social care services for older people show that 73% of domiciliary care locations we have inspected are ‘good’, versus 66% of care homes and 55% of care homes with nursing.

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In GP practices, our ratings show that services for older people are overwhelmingly good. 81% of practices inspected have been rated ‘good’, with a further 6% ‘outstanding’.

Ratings of services are vital, but care for older people is complex. I will now explore what we call our thematic reviews.

Our thematic reviews

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We know that many older people have complex care needs and follow a pathway through health and social care services via multiple providers and different care settings.

As the population grows much older, and people have more complex needs, so the connections between health and care services become more important.

Our programme of thematic reviews looks at the way services work together to make sure people's care meets their individual needs.

I am going to talk about five key reviews we’ve recently carried out into dementia, end of life care, people’s involvement in their care, care in a local area and integrated care for older people.

In October 2014 we published, ***Cracks in the pathway***, which reviewed people's experiences of dementia care.

We looked at 129 care homes and 20 hospitals and examined how people's care needs were assessed, how care was planned and delivered, how providers worked together and how the quality of care was monitored.

We found that variation in the quality of care was a key theme.

Transitions between services needed to be improved, including better information sharing between care homes and hospitals and greater access to support from a range of health and social care professionals.

When people were admitted to hospital via A&E there was too much focus on a person's physical health needs. Supporting both the physical health and mental wellbeing of a person – as well as managing known risks such as falls and urinary tract infections – can help reduce avoidable admissions to hospital and unnecessary long stays in hospital.
A wealth of guidance exists, and yet it is likely that someone living with dementia will experience poor care at some point while living in a care home or being treated in hospital. Not possible, but likely.

We now include a separate section in our hospital inspection reports that shows how well the hospital cares for people living with dementia.

In May this year, we published ***A different ending***, our review addressing inequalities in end of life care.

This was an extensive review that focused on the experience of people who may be less likely to receive good care at the end of their life because of their age, diagnosis, ethnic background, sexual orientation, gender identity, disability or social circumstances.

We found that individuals in these groups had unique needs and considerations and that these must be understood for people to receive personalised care that reflected their wishes and choices in the last phase of their life.

One in three CCGs surveyed for the review had not assessed the end of life care needs of their local populations, and where the illness was not cancer – such as advanced heart disease, respiratory disease and dementia – staff were not always having conversations with people early enough about their end of life care. Family members that we spoke to told us they felt marginalised.

Our report called for leaders of local health and care systems to work together to develop a plan for delivering good quality, equitable end of life care for everyone in their community.

Also in May, we published ***Better care in our hands,*** a review of how well people are involved in their own care and what good involvement looks like.

Newly analysed evidence from our national reports, inspection findings and other sources identified that people over 75 years old felt that they were less involved in their care than other groups of adults.

We recommended that providers better coordinate people's involvement in their care as they moved between services and that care plans should be written with people, for people - with their wishes and preferences clearly identified and monitored.

These three reports showed some common themes where providers of care for older people can take action:

- Leadership from commissioners and providers of care;
- Transition between different care settings;
- Involving people to express their needs and views; and
- Personalisation of care.

Between February and May this year, we published a number of reports exploring how we could use inspection findings and other data to build a picture of what care is like for people who use health and social care services in a local area.

We looked at the experiences of care that different parts of the population, including older people, had within a local area. Again, similar themes emerged around the impact that providers working together had on people's positive experiences of care.

For example, to help inform our report on Salford, we spoke with older people about their experiences of person-centred, integrated care.

Better experiences were associated with having positive support from a GP and good information sharing between services. This strongly supports work taking place across services in the area to develop an integrated care programme for older people.

In our report on North Lincolnshire, we outlined how the area was planning to make changes to services for the frail and frail elderly in order to provide people with a more joined-up experience of care.

The changes would sit alongside better support at home, treatment in the community to avoid the need for urgent hospital treatment or early admission into care or nursing homes, and a reduction in the time people spend in hospital if they do have to be admitted.

And finally, in the next few weeks, we will publish ***Building bridges, breaking barriers***, our report on integrated care for older people. This follows a review of how different services are organised and coordinated for older people, and how this affects the quality of care that they receive.

We look forward to sharing our findings and working with providers, people who use services and system partners to act upon them.

Ensuring the views of older people are heard

We value the views of older people.

Throughout our work we ensure that their voices and those of their loved ones are at the heart of what we do.

We want them to be empowered with knowledge of the quality of care they have a right to expect. We want them to consider CQC ratings and inspection reports as part of an informed decision-making process when choosing care.

We want them to be encouraged and enabled to share their experiences of care with CQC, both during inspections and on an ongoing basis. We want them to be involved in our work and to help inform decisions we make about how we regulate and inspect services.

We are fortunate to work with many organisations that represent older people and their loved ones.

Two examples include:

- Our *Tell Us About Your Care* partnerships, where we work with Age UK, Carers UK, the Relatives and Residents Association, Patients Association and others to increase our access to older people's experiences of care.

- Our partnership with Mumsnet and Gransnet, through which we reach hundreds of thousands of family carers and older women. In 2014 we surveyed the 'sandwich generation' of women – and men – caring for children under 17 and ageing parents. Carers UK estimate that there are 2.4 million people in this situation. We found that choosing a care home for a parent, spouse or older relative was the most stressful life event, more so than getting divorced, moving house or choosing a school.

We are also expanding our Experts by Experience programme, which includes older people and unpaid carers supporting older people.

Organisations that work with, and represent, older people are members of our co-production and advisory groups who help us on policy and research.

So what will be our focus for the future and how can we work together to achieve it?

Our strategy for 2016-21

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Last month we published our strategy for the next five years.

It sets out our priorities to deliver a more intelligence-driven approach to regulation, promote a single, shared view of quality and improve our efficiency and effectiveness.

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We will use information from the public and providers more effectively to target resources where the risk to the quality of care is greatest and to check where quality is improving.

We will work with others to agree a consistent approach to defining and measuring quality, collecting information from providers, and delivering a single vision of high-quality care.

Recognising the relationship between quality and finance, we are working with NHS Improvement on our approach to assess trusts' use of resources.

We will work more efficiently, achieving savings each year, and improving how we work with the public, providers and professionals.

Supporting innovation and new models of care

Our strategy also sets out how we will encourage improvement, innovation and sustainability of care, supporting the aims of the Five Year Forward View.

Key to that is how we build our capability to register and inspect new models of care.

These models are driving an innovative response to the pressures facing the system by reorganising the delivery of services around conditions or population groups, or by bringing together hospitals, GP practices and care homes to deliver care.

There is some important work going on in this area around older people's care.

A report out earlier this month, jointly published by NHS Confederation, NHS Clinical Commissioners, NHS Providers and the Local Government Association, highlighted examples of how new models of care focused on preventative initiatives were making early achievements in reducing emergency admissions for people over 65, reducing delayed transfers of care, and enabling GPs to dedicate more time to frail older patients.

In October this year, the King's Fund – in conjunction with City University – will launch a new learning network for care homes, housing and social care. Aimed at care home managers, housing professionals, local authorities and health professionals from all settings, the network aims to support collaboration and partnership-working within six localities and to create a critical learning and development space for anyone working at the interface with home care

We welcome these innovations.

Encouraging improvement

CQC wants be a catalyst for change that improves the quality of care older people receive.

We will do this not only by driving improvement where care is poor, but by identifying excellence and showcasing solutions to the challenges faced by the health and social care system.

Last year we published ***Celebrating good care, championing outstanding care***.

We wanted to showcase some of the best practice we'd seen from good and outstanding providers and share their ideas.

A number of themes emerged as drivers of good care:

- Care is person-centred, designed around the individual and includes their involvement
- The line-of-sight from senior leadership to the frontline staff and services is important
- Good care includes the provider checking on how well they are doing
- A care system that works together

We recently published statistics on improvements in the adult social care sector.

We all know that social care at its best can support older people to transform their quality of life.

If you look at the providers who have been rated outstanding, we see the same themes around person-centred care, leadership, accountability and working together with other services.

A number of care homes rated outstanding have now come together to form an 'outstanding club': a really positive example of the sector taking responsibility for excellence.

The purpose of the club is to share the very characteristics that make them outstanding so others can learn, grow and develop.

Some of these themes were also echoed in this month's report from NHS Confederation, Local Government Association, Association of Directors of Adult Social Services (ADASS) and NHS Clinical Commissioners on health and care integration.

Among its findings was the need for local leaders to work together to design services around the individual and their outcomes, involving people in decisions based on what is important to them.

Conclusion

So we know that regulation plays a key part in encouraging providers to improve.

Where we see inadequate care, we will tackle it. Where we can showcase excellence, we will. Providers tell us that our inspections help them to identify areas for improvement.

But for high-quality care for older people to be achievable and sustainable, it relies on a commitment from everyone – professionals, providers, commissioners, regulators and the voice of the public and people using services – working together.

So I would like to leave you with the message I started with – and a question:

CQC has a vital role as a regulator of health and care services in England in ensuring older people receive high-quality care. It lies at the heart of our approach and strategy. We are doing this:

- By providing an independent, professional assessment of quality at provider and thematic level;
- By being proactive in supporting new care models; and
- In leading on the development of a single, shared view of quality and efficiency

The question I would like to leave you with, is what role can you best play and how can the RSM best ensure that the system all pulls together?

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Thank you for listening.

ENDS