CareQuality Commission

The state of health care and adult social care in England

2014/15

STATE OF CARE

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Contents

Half of re-inspections have resulted in improved ratings **50%** ⬆

Only 7% have deteriorated after a re-inspection 7% ⬇

Foreword

This report marks a turning point for the Care Quality Commission. For the first time we are able to draw on a growing body of evidence, across health and social care, that we have created as a result of our new inspection approach. Our inspection reports and ratings give us a unique opportunity to start building a comprehensive picture of the quality of care in England and, importantly, enable us to identify and share key elements of high-quality care in order to encourage improvement.

I am pleased that most services we have inspected have been providing good quality care for the people who rely on them. This is heartening given the challenging circumstances facing all the sectors we regulate, and particularly adult social care. Across the country we have found staff who are doing their best for the people using their services every day and night, going above and beyond to look after everyone who needs their services.

Last year I wrote that financial pressures are real but not unexpected, and they would continue into 2015/16 and beyond. This continues to be a challenge. The *Five Year Forward View* starts to map out how the health sector can respond, but adult social care is not in such a strong position. What is clear is that, across health and social care, innovation and transformation of services will be vital. Incremental cuts and efficiency savings will no longer be sufficient to meet the challenges ahead.

This is an exciting opportunity to reshape services around the people who need health and social care. Evidence suggests that person-centred care is not only better for the individual, but can be more economical for service providers. We can only be successful in achieving this step change if we all work together: people, staff, providers, commissioners, and local and national stakeholders. As the quality regulator we commit to playing our part in enabling change, not being a barrier to it.

We believe the vast majority of people in the sectors we regulate share our aim of ensuring that all people who use services receive high-quality care. However, naturally there are also some providers that are struggling to provide a high-quality service. Important elements for improvement include ensuring leaders effectively engage their staff to build ownership of quality and safety, ensuring the right staff are in place to deliver safe care, and working collaboratively across the system to address cross-sector issues.

I am encouraged by the emerging evidence which suggests that our new regulatory model is having a real impact on the quality of these underperforming services and, where it is not, that our inspectors have the confidence to challenge and take enforcement action if necessary to protect people who use services from harm.

We appreciate all the time and effort that providers have put in to work with us to co-produce an approach to inspection that enables us to paint such a rich picture of how the sectors are performing. We hope you will continue to work with us as we evolve our approach in order to ensure people receive high-quality care, as services change in response to the challenges ahead.

David Behan
Chief Executive, Care Quality Commission

Summary

Delivering quality under pressure

The health and care system in England has come under increasing pressure during 2014/15, driven by changing care needs and financial demands on all public services. Providers and staff are being asked to deliver significant efficiency savings, to meet the more complex needs of an older, changing population, while ensuring that the health and care system remains sustainable for the future. In the NHS the main focus has been on handling increasing pressures at a time when the NHS budget increased at a significantly lower rate than before. In adult social care, services have been asked to deliver more with less, as local authority funding has been reduced.

Many services have responded well, despite the increasing pressures, and managed to improve or maintain quality. We celebrate the many services across the country that are delivering high-quality care to the people they care for. Although we have not yet rated all services, more than 80% of the GP practices we have rated so far were good or outstanding. In adult social care, nearly 60% of services were good or outstanding.

Variation in quality of care

But some people are receiving care that is not acceptable: in inspections to the end of May 2015, we rated 7% of services as inadequate, which means that care is so poor that urgent improvements are needed.

The level of variation in quality that we see is also of great concern. Many people continue to experience large differences in the quality of care they receive – both between different services from the same provider and between different providers.

Just as importantly, people experience poor or variable quality depending on who they are, or what care they need. For example people with mental health needs or long-term conditions, and some minority ethnic groups, are less likely to report positive experiences in health and social care settings. Additionally, our thematic review *Right here, right now* concluded that far too many people in a mental health crisis have poor experiences of care and do not receive basic respect, warmth and compassion. This is unsafe and, when compared with the services available to people with physical health problems, unfair.

Safety is our greatest concern

Safety is a fundamental expectation for people who use services, and it continues to be our biggest concern across all of the services we rate. We have rated over one in 10 hospitals (13%) and a similar proportion of adult social care services (10%) as inadequate for safety. In primary medical services, 6% of those we rated were inadequate for safety. Additionally, there are a substantial number of services that have been rated as requires improvement for safety, because there is more they could do to ensure that they have a good safety culture.

A range of factors affect the safety of services, including a failure to investigate incidents properly and learn from them so they do not happen again, ineffective safety and risk management systems and, in hospitals and adult social care, concerns with the adequacy of staffing numbers and mix, alongside skills, training and support.

The ability to improve

Where we see poor care, we will respond and challenge providers to improve. We have evidence our approach is working. The initial results from our re-inspections so far suggest that half of services have been able to improve their ratings within six months. Our survey of providers also shows that they find our reports useful in identifying what they need to do to improve.

Where necessary we will take enforcement action to protect the people who use these services. We took more enforcement actions last year in relation to the inspections we carried out: in 7% of inspections in 2014/15, compared with 4% in 2013/14.

The environment for health and social care will become even more challenging over the next few years. Tensions will arise for providers about how to balance the pressures to increase efficiency

Summary *continued*

with the need to improve or maintain the quality of their care. Therefore, the effective use of resources will be a vital component of success going forward.

What it takes to be outstanding

Some good and outstanding providers achieve high-quality care under constrained financial conditions by managing their resources well. These providers are not simply relying on more money. In all the sectors we inspect, there are many examples of excellent leadership – leaders who are visible and who engage widely with people who use services and staff, who promote a strong culture of safety, who put in place robust governance systems and processes, and who plan their resources well. We recognise what a hard job it is that they do, and the excellent care they and their staff deliver as a result.

More than nine out of 10 (94%) of the services we have rated as good or outstanding overall were also good or outstanding for their leadership. Similarly, 84% of the services we have rated as inadequate overall were inadequately led. In health care good leadership brings together clinical staff and senior management. In all sectors good leadership prioritises person-centred care and engagement with staff and people who use services in everything it does. In our inspections we see that where leadership is strong, then safe, effective, caring and responsive care tends to follow.

Services are also more resilient when they have a culture that prioritises openness, learning and continuous improvement, supported by governance processes so that organisations and staff learn together. This is particularly true when it comes to delivering safe care.

Staffing is one driver of the ratings our inspectors have given for safety across all sectors, although this is about much more than just having the right numbers. Having the right number and mix of staff, with the right skills, at all times is integral to providing safe, high-quality care. We are conscious that there can be difficulties getting staffing right, and that there are specific challenges in some sectors, such as ensuring sufficient nurses in adult social care, GPs in primary care and consultants in A&E. In addition, there is a leadership challenge

to ensure the right staff resources are in place to meet the challenges across the system.

All sector partners need to work together to address the challenges they face, including transforming models of care, and ensure that staff are motivated to be part of this change. The NHS has published the ambitious *Five Year Forward View* which has cross-sector support. In adult social care some organisations including the Association of Directors of Adult Social Services and Care England have set out five-year visions, but these do not yet constitute a strong cross-sector agreement on how to solve these challenges. System leaders nationally and locally need to come together to spell out how they will cope with the pressures ahead and put these plans into action. CQC has a part to play in this by providing an objective picture of the quality of care across all the sectors we regulate.

The importance of data and transparency

To innovate and transform care effectively, it is vital to have the feedback mechanisms to know whether or not changes have been successful. Every provider should have good, benchmarked data for all the services it provides, to assure itself that it is providing safe and effective care and to know where improvements are needed. This is particularly important when looking to share learning effectively at a local and national level. The drive to integrate health and adult social care also cannot succeed without an improved flow of information across traditional organisational boundaries.

Across all sectors therefore, better data needs to continue to be developed that is accessible to, and used by, all stakeholders, particularly for adult social care and community and mental health services. Without this it is difficult to systematically understand the current quality of care beyond our inspections, or assess the impact that changes are having on quality of care.

CQC has an important role in working with national and local partners to support sectors and providers in building the resilience they need in the next few years to maintain their focus on quality. We have already started to promote transparency and, as

a result of our work, conversations about quality are becoming more open and honest across all stakeholders. We are also looking at the way we register and inspect, particularly those services that are new and do not fit within traditional models, and at the quality of the data we and providers collect to help understand the experiences of people who use services better. This work should help us support innovation while ensuring people who use services receive high-quality care.

Looking ahead
The sectors we regulate face significant challenges. Our concerns are amplified by our finding that many services do not yet have the leadership and culture required to deliver safe, high-quality care. To survive and thrive will require resilience, innovation and creativity, supported by great leadership. We therefore encourage services across health and social care, together with their local and national partners, to focus on:

- Building a collaborative culture that reaches out to people who use services and engages with all staff to ensure a shared vision and ownership of the quality of care they deliver.

- Being open and transparent and learning from mistakes, ensuring information and data are to hand to make good decisions and to understand what works (and what doesn't), using opportunities to learn from the best.

- Ensuring that services have the right staff and skill mix in place to ensure that care is always safe.

We are highly supportive of the *Five Year Forward View* and the recognition in many parts of the country that the best care systems are those where health and social care go hand in hand, alongside greater local leadership and improvement across care economies. However, to be truly innovative, it is important to be open to the idea that some changes will not succeed. Experience from other industries suggests that new ways of working need iteration and fine tuning before becoming sustainable. Our challenge to all health and social care services,

and the sector overall, is therefore to continue to put quality of care at the centre of change, and not fall into the trap of seeing innovation as only driven by the need to save money.

Alongside this, we encourage all partners in adult social care to come together and set out a common vision and plan for how to address the current fragility and uncertainty in the adult social care market, and ensure they can continue to provide good care.

People deserve high-quality care. It is therefore our duty to the people who use services to be open and transparent about the quality of care that we see, and not lower our expectations of quality in the challenging times ahead.

There are examples of good services sharing their experiences with those who want to improve. We believe this type of collaboration is valuable in improving the quality of care for people who use services. Many services are already achieving high quality, and we are confident from what we have seen that others can too.

94%

More than nine out of 10 of the services we have rated as good or outstanding overall were also good or outstanding for their leadership.

Introduction

This report sets out the Care Quality Commission's (CQC's) assessment of the state of care in England in 2014/15, using our new, rigorous and expert-led inspection approach and ratings system.

Our inspections and ratings

When we inspect, we ask the same five key questions of every provider or service:

- **Is it safe?**
  By safe, we mean that people are protected from abuse and avoidable harm.

- **Is it effective?**
  By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

- **Is it caring?**
  By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

- **Is it responsive?**
  By responsive, we mean that services are organised so that they meet people's needs.

- **Is it well-led?**
  By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality, person-centred care, supports learning and innovation, and promotes an open and fair culture.

The answers to these questions help us form a clear understanding of the quality of care of each provider or service. When we rate, we award one of four ratings:

- **Outstanding**
- **Good**
- **Requires improvement**
- **Inadequate**

Ratings mean we can identify and celebrate good and outstanding care, take swift action when we find inadequate care, and encourage improvement across all services.

Following a period of piloting and testing in each sector, we formally implemented our new approach as follows:

- **Adult social care services** – we started inspecting and rating in October 2014.

- **Hospitals (NHS trusts and independent hospitals)** – we started inspecting and rating in April 2014.

- **Mental health services** – we started inspecting in April 2014 and rating in October 2014.

- **Primary medical services (GP practices, GP out-of-hours services, dental care and other primary care services)** – we started inspecting and rating GP practices and GP out-of-hours services in October 2014. We started inspecting dental care services in April 2015, but we do not rate these services. We also inspect a range of other primary care services.

Many providers have worked with us to co-produce an approach to inspection that enables us to paint a rich picture of how the sectors are performing. As services change in response to the challenges ahead, we will continue to work with providers and people who use services to evolve our approach, so that it ensures people receive safe, high-quality care.

Data used in this report

The data on inspections and ratings in this report covers the reporting period 1 April 2014 to 31 May 2015 (to capture the majority of inspections completed in 2014/15).

It is important to note that, up to the end of May 2015, we had inspected only a minority of health and social care services under our new, more comprehensive approach. In the main sectors we regulate, by that date we had inspected and rated:

- 47% of acute hospital trusts
- 17% of adult social care services
- 11% of GP practices and GP out-of-hours services.

Other CQC data relates to the year ended 31 March 2015.

We chose services for early inspection on the basis of levels of risk and what we knew about the service. This means that our findings should not be extended to each sector as a whole. Also, as there is more data available to assess risk in some sectors, this means comparisons between sectors should be treated with caution. As we continue to inspect and rate all services under our new approach, we will build a more comprehensive picture and we will also have a larger sample of re-inspections from which to draw conclusions about changes in the quality of care.

Most of the analysis in this report is generated by CQC, specifically:

- Quantitative analysis of our inspection ratings of more than 5,000 services, drawing on other monitoring information including staff and public surveys, and performance and financial data, to understand which factors are most closely associated with quality.

- Qualitative analysis of a sample of 44 inspection reports that were outstanding, requires improvement and inadequate (21 in adult social care, 10 in primary medical services and 13 NHS trust reports). This sample comprised reports of inspections completed under our new methodology and published between February 2014 and June 2015. The sample was stratified by region to ensure services from the north, central, south and London regions were included and the reports for analysis were then drawn at random.

- Analysis of 13 focus groups with inspectors from our sectors, discussions with inspection managers and heads of inspection, and findings from the CQC adult social care symposium held in July 2015.

- All the findings have been triangulated with expert input from our Chief Inspectors and Deputy Chief Inspectors, to ensure that the report represents what we are seeing in our inspections.

Where we have used other data we reference this in the report.

Part 1
THE STATE OF CARE IN ENGLAND

In Part 1, we provide an overview of the sectors we regulate:

- An overview of what we have found about the quality of care in England over the last year.

- The main factors we have seen that contribute to the success of organisations providing good or outstanding care, and the barriers for those organisations requiring further improvement in their care.

- Our perspective on what health and social care organisations will have to do to become more resilient in their ability to improve or maintain the quality of care over the next five years, while they respond to an increasingly challenging health and social care environment through change and innovation.

Part 2
THE SECTORS WE REGULATE

Part 2 gives a more detailed account of the quality of care we have observed in each of the sectors that we regulate, and sets out in greater detail the impact this has had on equality in care for people who use services.

⦿ **STATE OF CARE**

Part 1
THE STATE OF CARE IN ENGLAND

Real-term reduction
NET BUDGETS −31% ⊕

400,000

Fewer people receiving publicly funded care services than five years ago

1. The challenges facing health and adult social care

This report outlines the quality of health and adult social care in England in 2014/15, a period in which both the adult social care sector and the NHS have faced significant challenges. Providers have had to become more efficient and they have had to do this at a time when the number of older people is growing faster than ever, and people's needs are more complex.

According to the National Audit Office, local authority budgets have been reduced by 37% in real terms and on a like for like basis over the last five years.[1] Local authorities have worked hard to protect social care budgets from these reductions, and the result is that statutory funding for social care has decreased by £4.6 billion in this period, which is a 31% real-term reduction in net budgets.[2] Local authorities have managed reduced funding partly through greater efficiency and prioritising spending on social care. This now accounts for 35% of their spending, compared with 30% in 2010.[3] At the same time they have made cost savings by reducing fees to providers – contributing to low pay for the care workforce and low skill levels.[4]

Local authorities have also had to prioritise care for those with the most severe need. They have tightened their eligibility criteria, cut back on what is provided in care packages and reduced spending on preventative care.[5] The steepest reductions have been in community services, such as day care and domiciliary care.[6]

The Association of Directors of Adult Social Services estimates that there are at least 400,000 fewer people receiving publicly funded care services than there were in 2009/10.[7] This means that some people who previously might have expected their care to be paid for by the local authority will have had to find alternative ways to support themselves – through self-funding, being cared for by family and friends, or having to make do without support. The UK Homecare Association estimates that there are 1.6 million adults with unmet social care needs.[8]

Although the NHS budget has largely been protected from public sector cuts, the NHS is experiencing unprecedented financial challenges. NHS providers ended 2014/15 with a net deficit of more than £800 million. Almost half of all providers were in deficit, including almost two-thirds of acute hospital trusts. This is despite the Treasury providing extra in-year funding and a transfer from capital to revenue budgets. The deficit included £349 million among foundation trusts – the first time the foundation trust sector has recorded an overspend.[9]

These financial challenges are compounded by England's changing population. It is getting older. In the last 30 years, the number of people aged 90 and over has almost tripled.[10] Health and care needs are changing too: people with multiple long-term conditions are becoming the norm rather than the exception. The number of people in England with two or more conditions at the same time is set to increase from 1.9 million in 2008 to 2.9 million by 2018.[11] This is an opportunity, as well as a challenge, as increasingly people with long-term conditions have the ability to become partners in their care and influence much more directly their health outcomes.

The population is also getting more diverse. The number of people from minority ethnic groups is rising, and in the future more of this population will be British-born.[12] This means that the population's needs from health and social care are likely to be different, and services will have to adapt to meet them.

Of course England is not alone in facing such changing care needs. International comparisons do not provide a comprehensive assessment of the overall quality of a national health service, but they help in establishing a benchmark for quality in specific areas. Two recent reports, by the Commonwealth Fund and Quality Watch, considered the relative merits of different health systems.[13, 14] They present a picture that suggests the NHS is one of the most equitable health services in terms of access. But they also say that more could be done once a person is in the system to make sure they are receiving a service that is effective. For example, the number of people who die following a stroke, or a diagnosis of breast cancer, are both higher in the UK than in comparable countries. We are not aware of any similar reports looking at international comparisons of access and outcomes in adult social care.

2. How health and adult social care is performing

2.1 Our ratings

Overall quality ratings are positive
In our new comprehensive inspection approach, we give a quality rating to most of the providers and services we inspect. We have been rolling out our new approach since early 2014 and we are starting to develop a systematic picture of the quality of care across England.

Our ratings allow us to point to and celebrate examples of excellence and highlight those services that are delivering high-quality care. Up to 31 May 2015, the majority of the 5,439 organisations we have inspected and rated have been good or outstanding, although this differs by sector (figure 1.1). Given the increasingly difficult context in which services have been operating, this is something to be

Figure 1.1 Overall ratings by sector
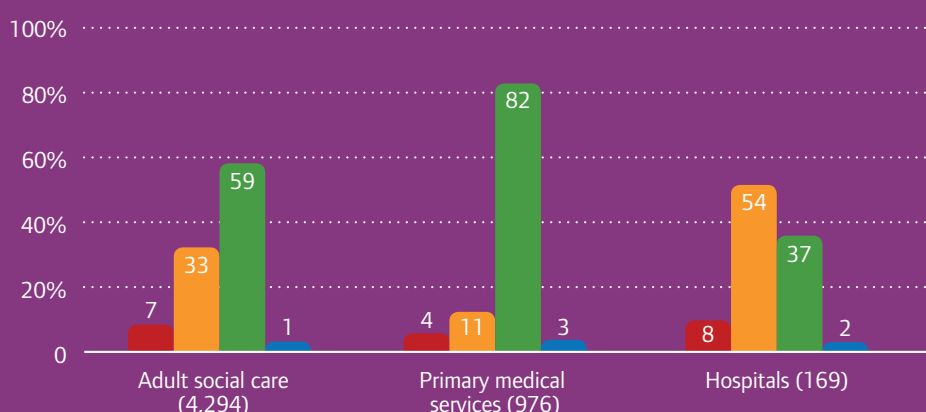
Note: Data for adult social care and primary medical service sectors is at location level. The hospitals sector ratings are a combination of location level (acute hospitals) and provider level (community health trusts and mental health trusts).
Source: CQC ratings data

● Inadequate   ● Requires improvement   ● Good   ● Outstanding

celebrated. The quality of care provided in the primary medical services sector was particularly high. Over four in five (85%) of the GP practices we have rated are good or outstanding.

A substantial proportion of services have received a rating of requires improvement. This rating identifies those services that are not yet of the high standard we expect for people who use services. Our inspection reports give detailed advice on how services can improve. Services that require improvement may provide good care in many areas but they will have a number of specific areas that need attention.

Of intense concern are those services that are inadequate. They account for 7% of the services we have rated overall. We have been surprised at just how very poor some of this inadequate care is, including:

- A&E patients kept on trolleys overnight in a portable unit without proper nursing assessments.

- In a nursing home, an overpowering smell of urine and mould on the walls.

- At a hospital, medicine given without appropriate patient identification.

- Staff at a GP surgery that had not had basic life support training in the last 18 months.

- Medication not administered properly at a care home – some patients had their medicine delayed while others showed overdose symptoms.

We have increased our enforcement activity to make sure that people using services are protected and that providers are held to account for the poor care. The total number of inspections completed this year was lower than the previous year as we started our new, more comprehensive approach. However, the proportion of enforcement activity we took increased: 7% of inspections in 2014/15 resulted in enforcement action, compared with 4% in 2013/14. As a proportion of our inspection activity, this was a rise of 75%.

In each of the sectors we regulate, our ratings highlight the substantial variation in the quality of care provided to people. Additionally, in larger providers we often see substantial variation between locations or between different services provided in the same location (as highlighted in the ratings example in figure 1.2). This shows the wide range of ratings within a single hospital, across our five key questions and eight core hospital services. There are many examples of good and outstanding care, despite the significant challenges the sectors have been facing. But there are also a small minority where we have significant concerns about inadequate care and who need to do much more to improve.

Safety remains a significant concern
When we give a service an overall rating, we give equal weighting to the five key questions we ask. But people who use services naturally expect the care they receive to be safe, and so do we.

Across all sectors, services were most likely to receive an inadequate rating for safety, compared with the other key questions: 10% of adult social care services, 6% of primary medical services and 13% of hospitals. Similarly, a lower proportion of services were rated good or outstanding for safety. This confirms our early finding last year, outlined in our 2013/14 *State of Care* report, about safety in hospitals and points to similar concerns in the other sectors.

Of CQC's key questions, providers were most likely to get an inadequate rating for safety

10% 6% 13%
of adult social care services | of primary medical services | of hospitals
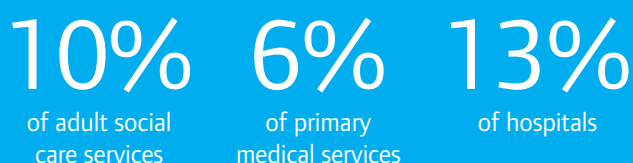
Where a service is rated inadequate in terms of safety, our qualitative analysis shows that this is often due to a range of factors, including:

- A failure to investigate incidents properly and learn from them so they don't happen again.
- Ineffective safety and risk management systems.
- Issues with staffing levels, training and support (in hospitals and adult social care).

- Unsuitable environments and poor or infrequent checks on equipment (in adult social care and to a lesser extent GP practices).

In each sector, there are many services that we have rated as requires improvement for safety (33% of those rated in adult social care; 61% of hospitals; and 25% of GP practices and GP out-of-hours services). Often in these cases, we believe that the providers concerned have the ability and the capacity to improve the safety of the care they provide. It will typically require improvements to systems and processes, such as clinical audit, that will enable the service to ensure they are delivering

Figure 1.2 Example of a ratings grid for an acute hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Requires improvement	Requires improvement	Inadequate	Requires improvement
Medical care	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Surgery	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Good	Good	Good	Requires improvement	Good	Good
Maternity and gynaecology	Good	Outstanding	Good	Good	Good	Good
Services for children and young people	Requires improvement	Good	Good	Good	Good	Good
End of life care	Requires improvement	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Inadequate	Inadequate	Inadequate
Overall	Requires improvement	Good	Good	Requires improvement	Inadequate	Requires improvement

● Inadequate   ● Requires improvement   ● Good   ● Outstanding

care safely. In contrast, an inadequate rating is a strong indication that care is unsafe, or that the organisation does not have the capacity without support to sort out its problems.

Encouragingly, where we have re-inspected organisations, there is evidence that they have responded to the concerns identified in our first inspection and made improvements to their rating for safety. But there is much more room for improvement.

Leadership is the key to long-term improvement

Of all the aspects we look at, the quality of leadership most closely correlates with the overall quality of a service. Ninety-four per cent of services that were good or outstanding overall were also good or outstanding for their leadership. Similarly 84% of inadequate services were inadequately led. This suggests that the way in which an organisation is led, and the culture and values that influence it as a result, have a huge and far-reaching impact on the overall quality of care that people receive. Good leadership, at all levels of an organisation, is required to deliver care that is consistently safe, effective, caring and responsive.

In all the sectors we inspect, there are many examples of excellent leadership – leaders who are visible and who engage widely with people who use services and staff, who promote a strong culture of safety, who put in place robust governance systems and processes, and who plan their resources well.

But we also see where leadership is simply not yet good enough. As we believe leadership is the key to long-term improvement, we are concerned by the wide variation in the quality of leadership. While the majority of services were rated good or outstanding on our well-led question (61% in adult social care, 44% in the hospitals sector and 85% in GP practices), a minority were rated inadequate (8%, 8% and 4% respectively). Our qualitative analysis has highlighted common factors among those providers that provide outstanding leadership – these are outlined in section 5.

2.2 What the public say

What people who use services think about the care they receive is of vital importance. We have found that the views of people using services, collected through surveys, can be one of the best predictors of the rating for a GP practice or hospital. The same goes for the views of staff. We set out the evidence for this in section 5.1 below.

When surveyed about their perceptions of the NHS overall, 61% of people thought it was offering good services nationally; 74% agreed that local NHS services in general are good.[15] When asked to rate their personal experience of NHS hospital care, 84% said they were satisfied. Although the results of the survey, if applied to the total patient population, could imply that more than 2 million people are dissatisfied with their care, it does suggest that when people come directly into contact with staff and professionals in the NHS, most are likely to have a positive experience.

In 2013/14 two-thirds (65%) of people in receipt of services funded wholly or in part by social services reported being extremely or very satisfied with the care and support they receive (a similar proportion to those satisfied in 2012/13).[16] The data for 2014/15 will be published by the Health and Social Care Information Centre in October 2015.

These positive results reinforce our own assessments of whether services are caring. For this, we look at people's one-to-one interactions with staff, including whether they are treated with dignity, respect and compassion. The highest ratings in all sectors were achieved for this key question. Eighty-five per cent of services were good or outstanding in adult social care; in the hospitals sector it was 95%; for GP practices it was 97%. However, as outlined in section 2.4, while overall the public say they are satisfied with their care, there are some specific groups of people who report less positive experiences.

CQC has seen some examples of truly outstanding care

An NHS mental health trust with outstanding leadership had good community links and showed innovation in the way it helped people on their recovery journey.

Inspectors were made aware of maths and English tutors who provide individual tutorials to help patients improve literacy and numeracy skills. And there was a 'real work programme' to help people develop skills for their recovery journey – this included a range of roles patients can apply for, such as ward representative, grounds keeper, a ward-based cleaner or shopkeeper.

Patients were involved in the design and delivery of their services and there was a range of ways in which they could have their say. The service also had strong community relationships, and a police liaison officer held sessions on wards to help patients feel safer.

Inspectors at a domiciliary care service saw a service that was not only designed to meet people's individual needs, but also to meet their aspirations – their achievements were celebrated and their views were at the heart of the service.

Staff were taught the principles of person-centred care. They were trained to use individualised care plans and life map tools – and each member of staff had to create their own, so that they fully understood how it worked.

People were treated by compassionate staff and the service worked closely with the community, particularly a local partnership with a deaf academy to help young people in their transition to independent living. People were enabled, with dignity and respect, through positive risk-taking. For example, one person who had never used public transport before was supported to achieve this independently.

An outstanding NHS foundation trust has shown innovative practice to meet the needs of its local population, led by a team that has good relations with its Council of Governors and a range of leadership programmes for staff at different levels.

The trust had a quality improvement strategy with measures for improvement from ward to board – and a quality dashboard was reviewed by the board to help understand variation throughout the hospital. With an open and transparent culture and a real commitment to learn from mistakes, the trust was recognised as outstanding for its leadership.

Staff showed a sense of pride in their work – and in the trust. Strong service planning and delivery meant better outcomes for patients. For example, patients identified as needing end of life care were prioritised – rapid discharge was ensured to their preferred place of care within six hours. A bereavement team worked closely with police to provide support to relatives where sudden deaths were involved.

People at the hospital could use a multi-faith centre that catered to the needs of the local population, including a non-denominational room.

The trust demonstrated good practice in its emergency department with the flow of patients, while the acute medical unit has led the way in embracing the national four-hour target as 'everyone's business' – and not just an issue for the emergency department.

An outstanding general practice had a strong community reputation and this was recognised by inspectors. The practice is in a rural area where regular contact with local schools helped avoid ambulance call-outs or attendance at accident and emergency departments.

GPs understood the needs of their patients and the community and they went out of their way to provide extra support; several examples were seen where people were supported in their own homes or helped on visits to sheltered housing, rather than move into a care home. This was a result of joint working with local carers.

Patients benefitted from integrated person-centred care pathways – arrangements were made for home visits with district nurses and carers. Care was coordinated and patients could see a GP without making an appointment, and GPs tried to treat illnesses and minor injuries themselves rather than refer to a hospital.

Comparing the positive results above with our overall quality ratings reveals the importance of our comprehensive inspection approach. Alongside whether a service is caring, our inspections look at whether services are safe, effective, responsive and well-led. Many of these aspects are not visible to people who use services. For example, people who receive care from a service that has a good culture of safety (one that prioritises openness and learning from mistakes) will probably not experience or see this directly (unless, for example, they receive poor care and make a complaint). This is why our inspections include sector specialists and Experts by Experience (people with personal experience of using, or caring for someone using, the type of service). The inspections bring together a wide array of evidence from national and local data, what we hear from staff and people using services, as well as our own observations

2.3 What we have found

Here, we give an overview of what we have found in each of the main sectors. Our more detailed findings for each sector are set out in Part 2 of this report.

Adult social care

The adult social care market is responding to the challenging environment we described above in a number of ways. For instance, some mid-sized services are closing while new, larger services open. It may be that larger services can achieve economies of scale that are not achievable for smaller services. Our registration data shows a decrease in the number of residential homes in 2014/15.

At the same time, the average number of beds has increased. Figure 1.3 shows our registration data for size of nursing home in 2010 and 2015. There has been an increase in the largest homes and also in those with a very small number of beds (up to 10). Similarly, while overall the number of residential homes is decreasing, the only increase we have seen is in homes with more than 50 residents.

We have also seen an increase in the number of domiciliary care agencies during the same period.

Figure 1.3 Trends in nursing home bed capacity
September 2010 and March 2015
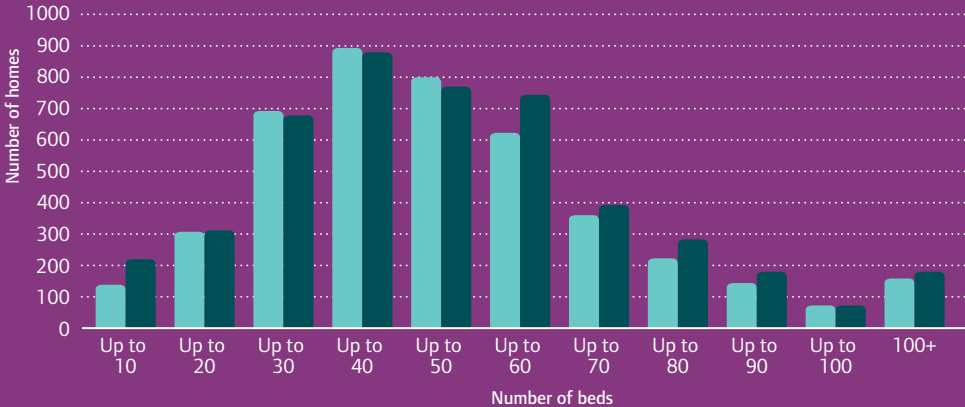
Source: CQC ratings data

● September 2010   ● March 2015

Up to 31 May 2015, we had inspected and rated almost a fifth (17%) of adult social care services. Almost three in five (59%) of these received a good or outstanding rating overall (figure 1.4). Around a third (33%) of services were rated as requires improvement.

In the majority of cases our inspectors have seen that staff involve and treat people in their care with compassion, kindness, dignity and respect. More than four in five (85%) of services were rated good or outstanding for caring.

Of utmost concern are the 7% of services that we rated inadequate. Where providers fail to meet legal standards, we act quickly to ensure that people are protected and services improve. In 2014/15 overall (including under our old inspection approach) we issued 937 Warning Notices to providers, telling them they needed to make urgent improvements.

Our biggest concerns relate to the safety of services (where 10% were rated inadequate) and to the quality of leadership within services (where 8% of services were rated inadequate for the well-led key question).

Our ratings show that nursing homes provide a poorer quality of care than other adult social care services (figure 1.5). This confirms our findings in previous years. Just under half (46%) of nursing homes rated up to 31 May 2015 were rated good or outstanding and one in 10 (10%) were rated inadequate. However despite around two-thirds of locations rated so far in domiciliary care, residential homes and community social care (which includes Shared Lives schemes) being good or outstanding (68%, 65% and 68% respectively), there is room for improvement across the whole of the adult social care sector.

While we recognise the pressure that the system is under as it transforms itself to meet the needs of a growing, ageing population at a time of considerable financial strain, it is still vital that the care delivered is of a quality that people have a right to expect.

By May 2015, we had rated a fifth of adult social care providers. Three in five got a good or outstanding rating

59%

Figure 1.4 Adult social care ratings by key question

	Inadequate	Requires improvement	Good	Outstanding
Overall	7	33	59	1
Safe	10	33	57	<0.5
Effective	5	32	62	1
Caring	1	14	83	2
Responsive	4	28	67	1
Well-led	8	31	60	1

Source: CQC ratings data

● Inadequate   ● Requires improvement   ● Good   ● Outstanding
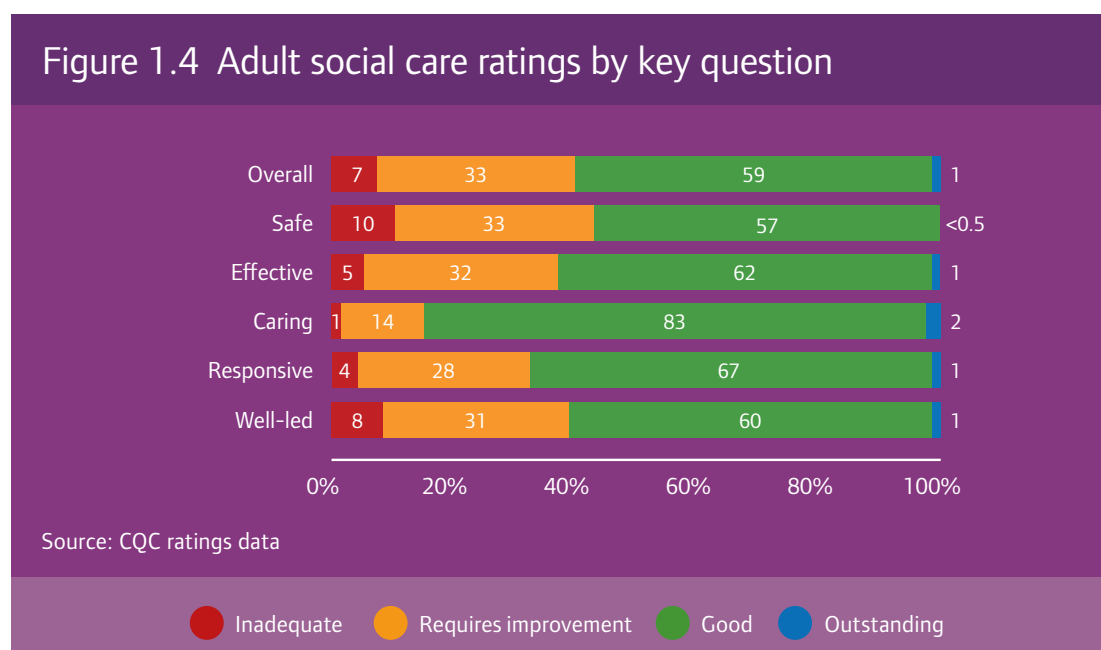
Figure 1.5 Adult social care ratings by service type

Service type	Inadequate	Requires improvement	Good	Outstanding
Community social care (212)	4	28	67	1
Domiciliary care agencies (675)	5	27	67	1
Residential homes (2,211)	6	30	64	<0.5
Nursing homes (1,275)	10	45	46	<0.5
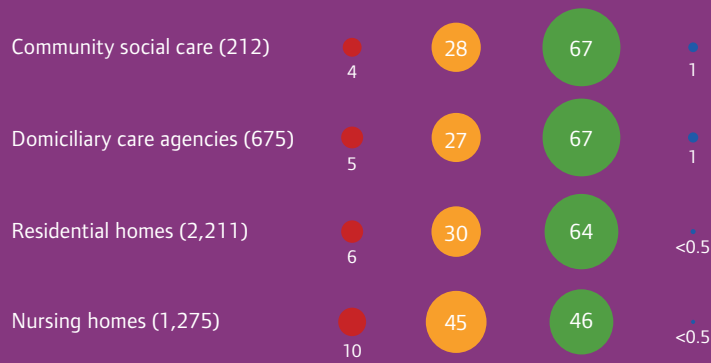
Source: CQC ratings data   Percentages

Figure 1.6 Acute hospital overall core service ratings

Core service	Inadequate	Requires improvement	Good	Outstanding
Critical care	5	27	65	3
Maternity & gynaecology	4	34	60	2
Children & young people	3	36	60	0
End of life care	6	38	52	4
Outpatients & diagnostic imaging	10	45	45	0
Surgery	6	50	43	1
Urgent & emergency services	9	49	38	4
Medical care	7	59	32	2

0%   20%   40%   60%   80%   100%
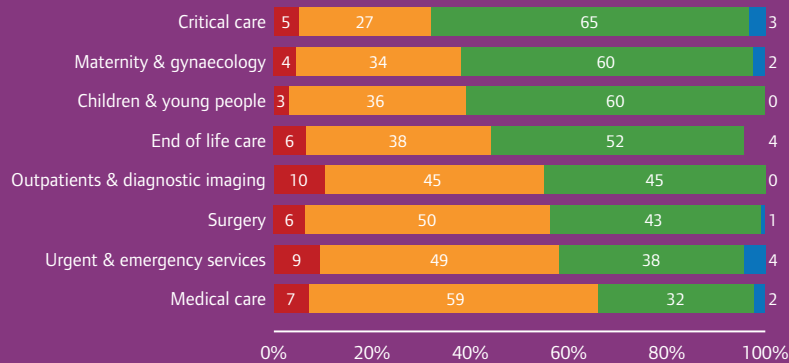
Source: CQC ratings data
Note: Chart ordered by proportion good/outstanding highest to lowest.

● Inadequate   ● Requires improvement   ● Good   ● Outstanding

Hospitals and trusts, including mental health

For this report, the definition of hospitals and trusts includes secondary and tertiary acute health care, mental health care, community health care and ambulance services.

While typically there are fewer changes in the registration of hospitals and trusts than in other sectors, we are seeing signs of this changing as they start to respond to the *Five Year Forward View*. For example, some hospital trusts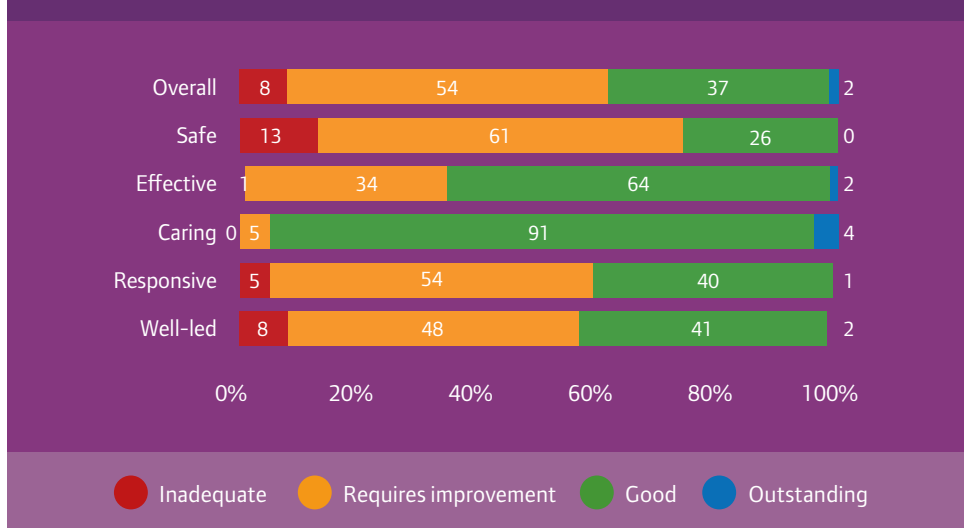 are registering as providers of care homes. We expect to see increasing diversity in the way hospital care is provided, as more hospitals look to reshape their services with other partners in their area, including through the *Forward View* 'vanguard' areas.

We have rated over half of all acute trusts; this includes 169 hospitals.[*] The overall ratings in the sector showed a lower proportion of good and outstanding hospital ratings (38%), compared with primary care and adult social care ratings.

However, considering only these aggregated hospital ratings hides significant variation at the

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[*]   Hospitals in this context include NHS and independent hospital sites, and mental health and community healthcare providers.

Figure 1.7 Hospitals key question ratings

Key question	Inadequate	Requires improvement	Good	Outstanding
Overall	8	54	37	2
Safe	13	61	26	0
Effective	1	34	64	2
Caring	0	5	91	4
Responsive	5	54	40	1
Well-led	8	48	41	2

Legend: ● Inadequate ● Requires improvement ● Good ● Outstanding

level of individual core services. In each acute hospital inspection we look at eight core services (where they are provided) and give each a rating which is then aggregated to give the overall hospital level rating. Figure 1.6 shows the wide variation in the quality of different services. There is a 34 percentage point gap between the proportion of critical care services rated good or outstanding compared with the proportion of medical services with those ratings. This suggests, as outlined in section 2.1 above, that experiences for people can vary significantly depending on the care services they need within a hospital, on top of the variation in quality that exists between hospitals.

As in the other sectors we regulate, hospitals achieve the best ratings for the caring key question (95% of those we have rated were good or outstanding for caring), while the safety of care is our biggest concern (13% of those rated were inadequate) (figure 1.7). We explore this in more detail in section 5.

Primary medical services including GP practices

The vast majority (85%) of the 976 primary medical services (including GP practices, out-of-hours and urgent care) we rated in 2014/15 were providing good or outstanding care. At a challenging time for primary care, there are many practices finding innovative ways of meeting the needs of their local population, and this is something that should be celebrated. Fewer than one in eight (11%) of the GP practices we inspected required improvement.

A small proportion (4%) of GP practices were rated inadequate. While this is a relatively small number of those we have rated so far, the quality of care we have observed in some practices has been truly shocking and a significant cause for concern. Where we have rated practices as inadequate, this is often underpinned by a poor safety or leadership rating (figure 1.8) – issues we return to in section 5.

In the primary medical services sector we also inspect a wide range of other services, including dentists, prison health care, remote clinical advice, urgent care services, mobile doctors and independent consulting doctors. Not all of these are rated. However, our inspections to date suggest these services are performing well, with limited need for enforcement action. We see many examples of good practice. We will have more ratings data relating to out-of-hours care and urgent care next year.

Although we are not seeing significant changes in the numbers of registered providers in this sector, we have started

to see new and innovative providers entering the market. For example, we recently registered the first online-only GP service. We are also seeing signs that there are an increasing number of multi-site practices, resulting from some mergers and acquisitions between acute healthcare providers and GP surgeries, and through consolidation or federation of GP practices. A relatively high proportion of the larger practices, with more GPs, have received good ratings, and some small practices have struggled, particularly those where the GPs are professionally isolated and lack local structures that enable them to connect with peers. It will be important to see how the market continues to develop.

2.4 The quality of care people receive

While our findings about the quality of care in different sectors show that many services offer good care, there are some groups of people who are at risk of receiving consistently poorer care because of who they are. This can be seen in access to services, and in people's experience and outcomes.
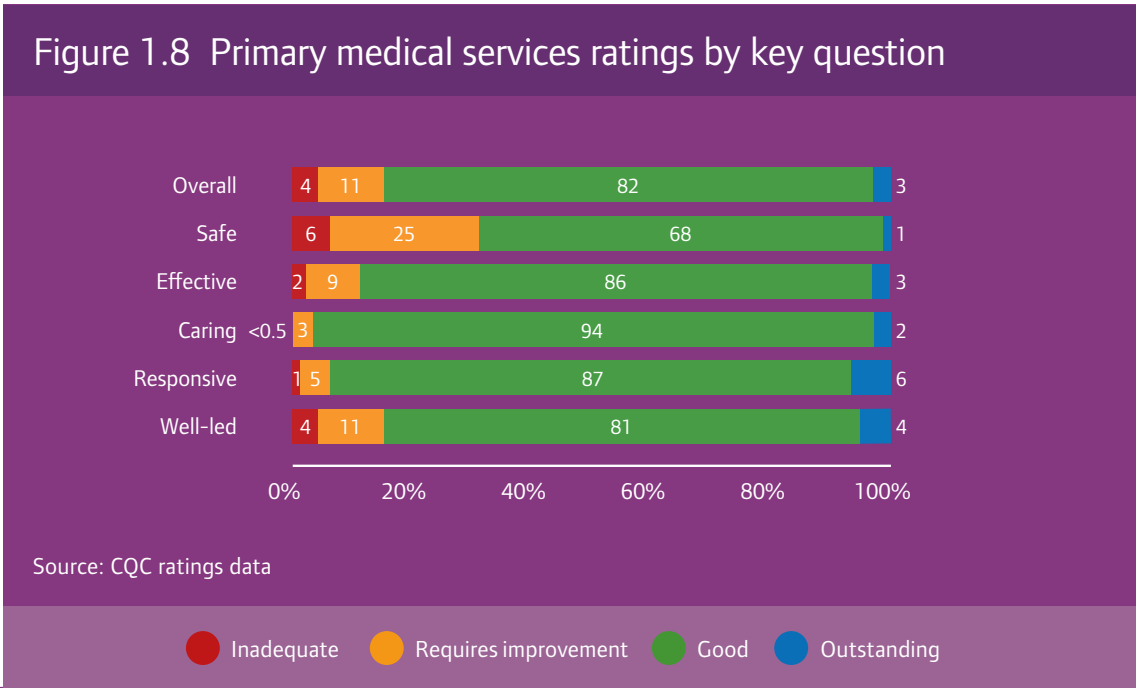
Access

In adult social care, the changing eligibility criteria have had an impact on different groups, and in different parts of the country.

Older people (those aged 65 and over) have been hit harder by reductions in local authority eligibility criteria, compared with other adults. More than 42,300 fewer older people in England received local authority-funded adult social care in 2013/14 compared with the previous year, a 4.7% reduction. The equivalent figure for those aged 18-64 was 12,500, a 2.9% reduction.[17]

Support and ability to navigate the health and social care system, through information and referrals, is also vital for accessing care. Analysing our 2014 NHS inpatient survey, we found that people with long-term conditions – particularly people with mental health conditions – were less likely than others to say they had received information and support to access other services on discharge from hospital. Similarly, people in Black and minority ethnic (BME) groups were less likely to report that they had this help on discharge.

Figure 1.8 Primary medical services ratings by key question

	Inadequate	Requires improvement	Good	Outstanding
Overall	4	11	82	3
Safe	6	25	68	1
Effective	2	9	86	3
Caring	<0.5	3	94	2
Responsive	1	5	87	6
Well-led	4	11	81	4

Source: CQC ratings data

● Inadequate   ● Requires improvement   ● Good   ● Outstanding

National social care surveys also report that people from BME groups are less likely to say that it is easy to find information about services available to them.[18]

As outlined in section 1, local authorities have chosen to set different levels of eligibility depending on local priorities. However, the Care Act 2014 seeks to reduce some of the variation in eligibility, and this could lead to very different challenges depending on the local authority. Office for National Statistics population data suggests that demographic changes will not impact on each area equally: the projected increase between 2015 and 2025 in the population aged 65 and over varies from 9% (Blackpool) to 44% (Milton Keynes).[19] Similarly the projected increase in people aged 85 and over varies from 6% (Barking and Dagenham) to 69% (Wokingham). It is likely that these areas will face different challenges when seeking to balance budgets while ensuring needs are met.
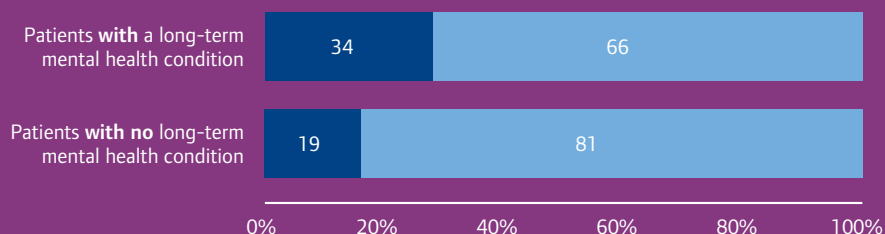
Experience and outcomes

While the public typically say they have positive experiences of care, people with a long-term condition are less likely to report having a good experience of using acute hospital services. This is particularly true for those who have a long-term mental health condition. Figure 1.9 shows the proportion of people who rated their overall experience of attending accident and emergency at least seven out of 10, and those who rated it six out of 10 or less. It highlights a gap of 15 percentage points between those who have a long-term mental health condition and those who do not.

Similarly, we found that all trusts must also do more to ensure that children with a physical disability, a mental health condition or a learning disability are receiving care that meets their specific needs. Through our first national survey of children and young people who received inpatient and day care in hospital, we found:

- Reports of patient experience were poorer for children with a physical disability, a learning disability or a mental health condition across all the survey questions analysed. Children with these long-term conditions were more likely to be negative about the information provided by staff and the quality of their communications with staff. This included questions about whether staff talked with them when they were worried and whether staff always listened to them.

Figure 1.9 2014 A&E survey: patient experiences of A&E based on whether they had or had not self-identified as having a long-standing mental health condition

Patients **with** a long-term mental health condition: 34 | 66

Patients **with no** long-term mental health condition: 19 | 81

0%   20%   40%   60%   80%   100%

Source: National survey of patients in A&E 2014

● Score up to 6 (poorer experience)   ● Score 7 and above (better experience)

- 45% of parents and carers of children with a physical disability, and 49% of those with children with a mental health condition or learning disability, said that staff were definitely aware of their child's medical history. This compared with 59% of parents and carers whose children did not have these needs.

- 49% of parents and carers of children with a physical disability, and 48% of those with children with a mental health condition or learning disability, felt that staff definitely knew how to care for their child's individual needs. This compared with 72% of parents and carers whose children did not have these specific needs.

Looking at adult social care, the annual survey of people receiving local authority funding for care also suggests that Asian/Asian British and Black/Black British people using these services are less likely to be satisfied with services. They are also more likely to say that they have a lower quality of life than people in other ethnic groups, and more likely to say that they found it difficult to access information about services that may be helpful to them.

We also found differences in our acute inpatient survey about communication between hospital staff and patients in different equality groups – people with long-term conditions and from some Black and minority ethnic groups were significantly

Mental health crisis care

Alongside inspections of individual health and care services, we carry out in-depth reviews of important issues facing the sectors to build our understanding of quality of care.

In 2014/15 we looked in detail at people's experiences of help, care and support during a mental health crisis. We published our findings in our report *Right here, right now.* There are clear variations in how services in local areas respond to people in crisis. A person's experience depends not only on where they live, but which part of the system they come into contact with. We concluded that services for people with mental health conditions are often unsafe and unfair – a situation that is completely unacceptable.

Two in five (42%) of respondents to our call for evidence told us they felt the care they received failed to provide the right response and didn't help to resolve their crisis. Far too many people said the response they received failed to meet their needs and lacked basic respect, warmth and compassion. Services must recognise that the risks from emotional harm are just as real, and potentially life-threatening, as those from a

physical injury. Our findings highlighted that all services involved in mental health have work to do in improving how their staff respond to people in crisis.

Crisis resolution home treatment teams are a vital element of managing mental health crisis events. However, a University College London review, which analysed the work of approximately a third of all crisis teams in England, found that almost a quarter (23%) scored the lowest possible mark for whether they could provide a 24-hour service. There are similar issues in acute hospitals. Local areas must recognise that the nature of a crisis means that services provided between 9am and 5pm will not be sufficient. It is both unsafe and unfair that people with a mental health crisis are often not able to access the services they need when they need them.

We are currently carrying out further thematic reviews to explore people's experiences of end of life care, and the extent to which care is integrated for older people. We are due to publish these in 2016.

less likely to say that they had been given helpful information on discharge. The survey also showed that people with a mental health condition and people aged 16-35 are significantly less likely to feel treated with dignity and respect while staying in hospital. Some other equality groups are also significantly less likely to report being treated with dignity and respect, although the differences are smaller. There has been little change in these findings about dignity and respect since the last CQC analysis of equality using our NHS Inpatient Survey in 2011.[20]

These findings show that services need to look carefully at whether they are providing equally good care for everyone. Acute hospitals need to engage locally with people from all of these groups to understand the reasons for these survey results and to put in place plans to address the root causes. Our analysis of information returns from adult social care services shows that, while almost all services say they have equality and diversity policies, far fewer – less than 30% – say they have carried out work in the last year to meet the needs of some specific equality groups, such as lesbian, gay, bisexual and transgender people. We would encourage services to consider whether they are offering all people using their services a good experience of care.

In some inspections we have heard that useful data may be collected but there is little to show how it is used to improve service delivery. In other cases staff are not clear what value the data has. Data can be used to identify specific areas where quality can be improved. It should also be part of the process to ensure that the services offered meet the needs of the local population – particularly where people with characteristics protected under the Equality Act 2010 have poorer access to, experiences of, our outcomes from care.

The National Information Governance Committee report to CQC's Board suggests that, in many cases, inspectors are uncovering evidence of both good and poor practice in information governance and making clear links to how this has an impact on the experience of people who use services. It reasserts that services need to engage with different groups within their communities to understand why some equality groups continue to report poorer experiences and outcomes and to take steps to address this. This is particularly important as some of the groups apparently being served less well are likely to increase in future as a proportion of the overall population.

Figure 1.10 Change in ratings on re-inspection

Deteriorated 7%

Stayed the same 43%
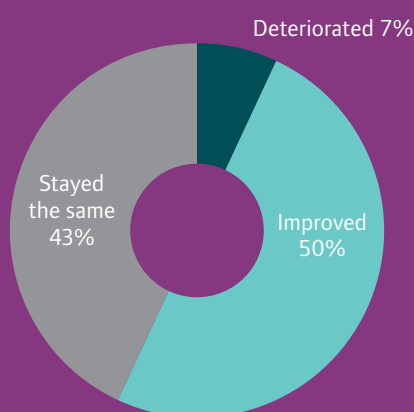
Improved 50%

50%

Half of re-inspections have resulted in improved ratings

Source: CQC ratings data

Based on 123 re-inspections (both focused and comprehensive). Improved means at least one key question improved and none deteriorated. Deteriorated means at least one key question deteriorated and none improved.

3. Encouraging improvement

CQC's new expert-led inspections are more robust and comprehensive than previous approaches. They are designed to get a more rigorous, complete picture of the quality of care at a service and the issues, if any, that providers need to tackle. In a survey in January 2015 of people who had had a new approach inspection, 83% agreed that the new inspections helped them to monitor the quality of care they provide. A core part of CQC's purpose is to encourage improvement. Our inspection reports clearly set out what we have found against each of our five key questions, and services should be using them, and the feedback we give during the inspection itself, to focus on what they need to do to improve.

3.1 CQC's inspections are leading to service improvement

In our annual survey of providers in October/November 2014, almost three-quarters said that our inspection had helped to identify areas of improvement (73%) and that the inspection reports were useful (72%). Just over two-thirds
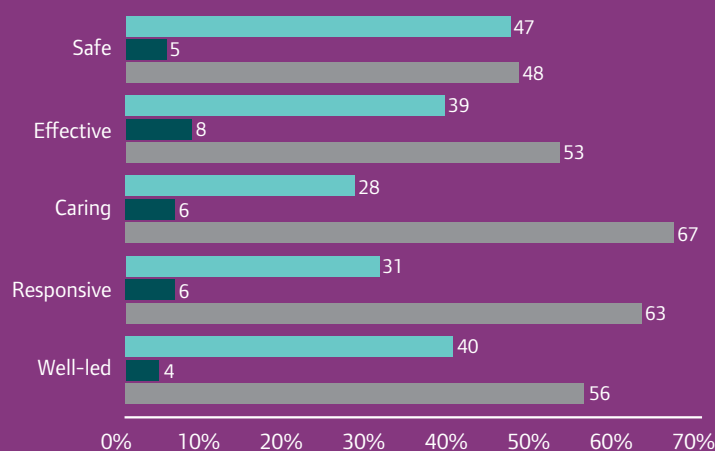
(68%) of providers said they thought that outcomes for people who use services were improved as a result of our inspection activity. This suggests that CQC is playing a central role in encouraging improvement across the system.

Up to 31 May 2015, we had re-inspected 123 rated services, mostly where we were following up concerns about the quality of care in the first inspection. The majority of these related to adult social care, although there were a handful of re-inspections in other sectors (seven NHS acute services, and one GP practice).

Half of the re-inspected services had improved their ratings (figure 1.10). Fewer than one in ten (7%) had deteriorated further. All of these re-inspections will have happened within a year of the original rating, suggesting that improvements can be relatively rapid.

Figure 1.11 shows the areas in which improvements have been made in adult social care re-inspections. Almost half of re-inspections found that the issues relating to safety had improved sufficiently to lead to a

Figure 1.11 What happens to key question ratings on re-inspection in adult social care?

Key question	Improved	Deteriorated	Stayed the same
Safe	47	5	48
Effective	39	8	53
Caring	28	6	67
Responsive	31	6	63
Well-led	40	4	56

Source: CQC ratings data, based on 115 adult social care re-inspections

● Improved ● Deteriorated ● Stayed the same

higher rating. For well-led, a higher rating was achieved in 40% of re-inspections. This is encouraging given the relatively short period of time in which these improvements were made. The chart shows the change from all initial ratings, some of which will have been 'good', which explains why a number of ratings will not have changed and some may have deteriorated compared with their original rating.

Re-inspections drive improvement
Peterborough and Stamford Hospitals NHS Foundation Trust

Peterborough and Stamford Hospitals NHS Foundation Trust has focused on strong leadership to move from requiring improvement to a good rating in just over a year.

When we visited in March 2014 we found some services that required improvement for being safe, effective and responsive to the needs of patients. We advised the trust to address important issues, including its complaints backlog, support for staff in raising concerns, and the number of admissions to inappropriate wards. We also asked the trust to improve the experiences for people using children's services, A&E and end of life care.

In May 2015 we returned to find a trust with a newly formed senior management team that had worked hard to address our concerns, doing a great job to engage all staff.

The culture at the trust had improved and staff spoke positively of the management team. Senior managers were visible around the wards, and staff members were being given more autonomy and responsibility in their roles.

As a result of this leadership, patient pathways had been re-designed through a new medicines admission unit to improve patient flow and experience. Children and young people had been consulted to see how their services should be improved. And A&E waiting times had been reduced.

Complaints handling had also improved – on the day of inspection there had been no outstanding complaints for the previous 30 days.

3.2 Special measures and enforcement action

Where services are found to be inadequate, we normally apply a process of 'special measures'. This sets out a clear timeframe within which we expect the service to improve, assessed by a re-inspection. We will also take enforcement action where we find that a fundamental standard of care (as set out in legislation) has been breached.

In 2014/15, CQC took 1,179 enforcement actions. This included 63 non-urgent cancellations of registration, and 27 urgent suspensions of registration, or urgent variations or imposition or removal of conditions. These actions were taken because of the risks we felt were posed to those using these services (figure 1.12). Where we cancel registration, this means the provider can no longer run the service – an alternative provider needs to take over the service or an alternative service must be found. We are aware these cancellations, and particularly urgent closures, can have a significant impact on the people using those services – especially where the service is a person's home, such as a care home. We will always take the action necessary to protect people from an unacceptable level of risk of harm, while making sure that together with the service, the commissioner of the service, and other stakeholders – the people who use the service are considered first.

Figure 1.12 CQC enforcement action in 2014/15, 1 April 2014 to 31 March 2015

Enforcement action	Adult Social Care directorate	Hospitals directorate	Primary Medical Services directorate
Special measures total	n/a*	21	10
Warning Notices published	937	33	67
Non-urgent cancellations of registration	53	0	10
Urgent procedure for suspension, variation or conditions of registration**	17	7	3
Non-urgent variation or imposition or removal of conditions	37	0	0
Fixed penalty notices issued	10	0	0
Number of prosecutions	3	0	2
2014/15 overall enforcement actions	1,057	40	82

* Special measures for adult social care only started on 1 April 2015.
** This means urgent suspensions of registration, or urgent variation or imposition or removal of conditions.
Source: CQC enforcement data

3.3 Sharing learning

We also want to make sure that services have access to the information that will help them improve. We gather examples of good practice that we can share across the system. For example, in March 2015 we published *Celebrating good care, championing outstanding care* as a way of sharing what we found on inspection. It provides case study examples that are aligned with our key questions to make it easy for services to read about outstanding practice in areas relevant to them. Similarly, the National Information Governance Committee's report to CQC's Board includes examples of good practice across three sectors.

We understand that the first two trusts we rated as outstanding (Frimley Park and Royal Salford) are now encouraging and receiving visits where other providers come to understand how they have achieved their rating. We hope that increasingly this will happen across sectors.

We have a role to play in encouraging others to improve, and we are committed to making it easier for providers in all sectors to learn about the excellent work that is being carried out across England.

4. Ensuring safe, high-quality care in a period of change

Health and adult social care services are already working in a challenging environment. We have outlined how, despite these challenges, the majority of services deliver a good or outstanding quality of care, even though there is still a lot of room for improvement, particularly with regard to safety.

During the remainder of 2015/16 and beyond, providers will face an even more difficult operating environment. There is a shared understanding that to achieve more with less, without compromising on quality, it will be necessary to bring about radical and innovative changes in how care is provided. If these changes do not happen, tensions are likely to arise between balancing the pressures to increase efficiency with the need to improve or maintain the quality of their care.

The variation in the quality of care we see so far cannot all be explained by the availability of resources. Some services

achieve excellent quality of care under constrained financial conditions. This should mean that others can do so too. Services will have to work collaboratively across their local areas, and with their staff and people who use services.

4.1 The scale of the challenge in adult social care

During the last two decades, the challenges facing the adult social care sector have not been exposed to the same public and political debate as health care. There is currently no widely shared vision for how the sector should change and adapt.

Having made significant savings over the last five years, partly through efficiency improvements and partly through restricting access to services by reducing the eligibility for publicly funded social care (figure 1.13), there may now be less room for generating

further savings. The new national eligibility criteria for publicly funded care introduced in the Care Act 2014 will also reduce commissioners' ability to limit access in the way some have done so far. This is likely to have significant implications for the ability of services to improve or maintain their quality of care while trying to maintain financial viability.

Commissioners, providers and people who use services are expressing growing anxiety about the 'underfunding' of adult social care and the impact this will have on quality and on the supply of care.

- The UK Homecare Association estimates that the state funded domiciliary care sector ran at a deficit of £514 million in 2013/14. It predicts it will run at a deficit of £753 million over the

2016/17 financial year. It anticipates there will be more providers leaving the market and handing back substantial volumes of state funded packages on the grounds of insufficient fee levels.[22]

- The National Care Forum reports that all providers are concerned about insufficient local authority fee levels and the consequences of underfunding of adult social care.[23]

- According to the Association of Directors of Adult Social Services finance survey, when contemplating the next two years, directors of social services are doubtful that planned savings can be achieved. They are increasingly concerned about the impacts of savings, that fewer people will get access to services and that the size of personal budgets will decrease.[24]

Figure 1.13 Components of total savings in adult social care, 2008/09 to 2013/14

Change in spend (real terms at 2012/13 prices)

£ million
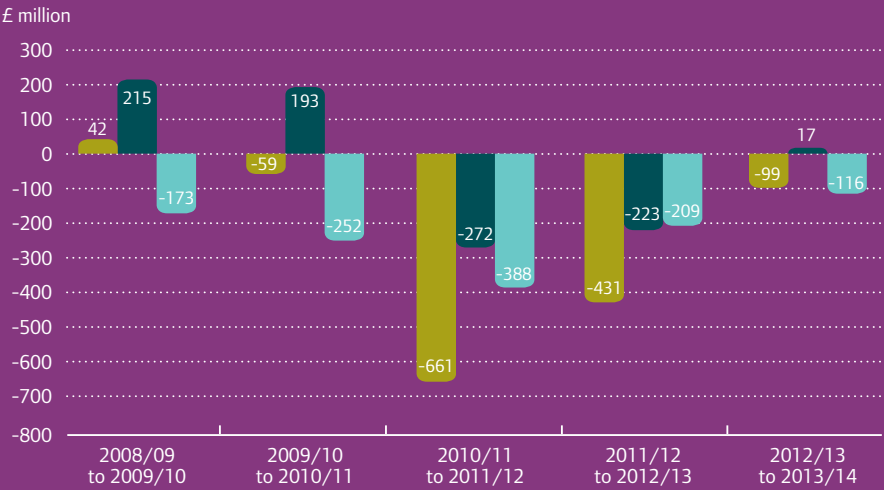
Source: National Audit Office [21]

Chart includes spend and activity data for day care, home care, residential care and nursing care for all groups.

● Total change in spend   ● Spend change due to price changes   ● Spend change due to volume changes

- Carers UK reports that, of 4,500 carers responding to their survey, 55% said they are worried about the impact of cuts to care and support services over the next year.[25]

- The King's Fund have said, "In our view it is not credible to maintain that current standards of care can be sustained (let alone improved) without the funding needed to deliver this."[26]

- The National Audit Office's auditors have increasing concerns about the financial health of single tier and county councils. In 2014/15, they expressed concern about more than half (52%) of authorities and their ability to deliver their medium-term financial strategy.[27]

The organisations attending CQC's adult social care symposium echoed these concerns.

Unpaid, informal care by family, friends or charities has always played an important role in the adult social care sector. However, current data shows that such informal care cannot provide a long-term substitute for publicly or privately funded care. Existing trends imply that the gap between the number of people needing unpaid support, and the number of people available to provide it will be around 15,000 in 2017 and 160,000 by 2032.[28] This is because existing levels of unpaid care given by adults to their parents, covering 20 or more hours a week, are expected to remain steady, while demand for care will continue to rise quite quickly.

The adult social care market is also facing significant pressures that drive up costs for providers. Apart from the likely rises in care costs from the greater complexity of people's needs, staff cost pressures next year will increase further with the introduction of the national living wage. Combined with a likely future increase in the cost of borrowing due to eventual interest rate rises, this potentially puts providers in an increasingly tight financial position during a period where commissioners of services are looking to reduce fees.

4.2 The scale of the challenge in health care

The healthcare sector is also facing an increasingly challenging period, but for different reasons. The NHS *Five Year Forward View*, published by the national NHS organisations including CQC, and backed by the Government, is a common vision for reforming the system over the next five years. It commits to meeting the triple challenge of improving health and improving quality, while achieving efficiencies. It also commits to making progress on specific priorities such as mental health, cancer outcomes and maternity services.

The King's Fund *Quarterly Monitoring Report* for July 2015 states that 66% of provider organisations are forecasting a deficit in 2015/16, with 89% of acute hospital trusts expecting to overspend.[29] Moving forward, Monitor, the NHS Trust Development Authority and NHS England have made it clear that running large deficits is not acceptable, which means that there will be more pressure to achieve financial balance.

The *Forward View* sets out an ambitious programme of developing new models of care through its vanguard programme, which includes bringing together health and housing, and working with greater devolution of how services are managed, as in Greater Manchester. There is a shared understanding that to achieve more with less, without compromising on quality, it will be necessary to bring about radical and innovative changes in how care is provided. Inevitably, such changes are hard to predict, and create uncertainty and variation in how different services respond to these challenges over the next five years.

4.3 The relationship between quality and finance

So far, our analysis to correlate CQC ratings with some financial indicators shows no obvious link between overall quality and more money. For example, our analysis of the potential drivers of quality in adult social care does not show a statistically significant relationship between the local authority hourly rate for domiciliary care and the quality of domiciliary care services in that local authority area (figure 1.14), or between the average local authority funding for every older member of the population and quality of older people's care services in an area.

Figure 1.14 Ratings of domiciliary care agencies by average hourly cost

Source: CQC ratings data; Personal Social Services: Expenditure & Unit Costs, England, 2013/14

Note: We have so far rated only a minority of services. We have produced 95% confidence intervals for the average values by rating, as these values will fluctuate until all services have been inspected. The error bars in each chart show the width of these confidence intervals. If the confidence intervals do not overlap then the differences between the values are statistically significant. In this instance there is not a statistically significant difference.

● Inadequate   ● Requires improvement   ⬤ Good/Outstanding

We understand that, beneath the headline figures, the story is likely to be more complex and the data we currently have is limited. For example, local authorities in London and the South East typically pay higher rates to providers of care, but this may be offset by the higher rents and wage costs associated with these regions. Also, the data we have used is the average hourly local authority rate and not necessarily that paid to the particular domiciliary care agency we have rated.

For NHS trusts, an analysis of our ratings showed a weak but significant correlation between better financial performance (defined as having a budget surplus or small deficit) and better quality ratings. The trusts rated outstanding or good had an average deficit of £2 million, which was significantly less than the average deficit of £32 million for trusts that were rated inadequate.[30]

This is in line with the theory that safer, better care does not necessarily cost more, and suggests that in many cases good leadership is able to plan for high-quality care alongside good use of resources. Further evidence comes from the Carter Review commissioned by the Department of Health. This review looked at the potential for making efficiency savings in hospital budgets. This review has identified many opportunities for greater efficiencies that are likely to maintain or improve the quality of care while reducing spending overall. While we recognise some aspects of good care, such as ensuring safe staffing, will have a cost attached, there is a growing body of evidence that higher quality care enables resources to be used more effectively.[31] However, it will be important to continue to monitor closely the relationship between quality and money as budgets become tighter.

An inspector's view

"The directors, the manager and the staff from different levels around the organisation were all working towards the same thing, which was not only making sure people were receiving good care, but everything they did they were able to evidence why they did it, how they did it and how they improved as well. That was really good and it impacted right across the organisation at every level of management, staff and people who use services as well."

5. Building strong leadership, resilience and innovation

In the challenging environment for health and adult social care, financial resources are not the only answer. For health and social care services to be able to ensure the quality and safety of the care they provide, they will need strong leadership and resilience. They will need to find ways to encourage innovation and creativity, while keeping the quality of care for people who use services at the centre of their work.

To understand what lies behind outstanding and inadequate ratings overall – and specifically the key issues of safety and leadership – we carried out further qualitative analysis. This included analysis of more than 50 inspection reports and 13 focus groups with inspectors. These findings were triangulated with discussions with Chief Inspectors and Deputy Chief Inspectors and published literature relating to leadership and safety to corroborate the findings. Therefore, while this section is based on qualitative rather than quantitative data, we can be confident that the findings are robust, and that the areas for improvement are important.

We have identified three key areas of focus for improvement in quality:

- Leaders using engagement to build a shared ownership of quality and safety

- Staff planning that goes beyond simple numbers and includes skill mix, deployment, support and staff development

- Working together to address cross-sector priorities.

All of these can only be achieved by developing a culture where all members of staff take pride in the quality of their work and feel that quality is their responsibility.

5.1 Engaged leaders building a shared ownership of quality and safety

Our analysis shows there are five critical aspects to the good leadership we see:

- Effective engagement and communication with staff and people using services

- The skills, experience and visibility of management

- A strong and positive organisational culture

- Learning when things go wrong

- Governance processes to support openness and transparency.

Effective engagement
We found that engaging with staff and people who use services is a central factor in being well-led across all sectors. Services that prioritise quality and safety have created an environment where staff are encouraged to be involved in recommending new ways of working and suggesting ways to put the organisation's values into practice. In these organisations, an emphasis is put on learning and staff development.

In outstanding services, we see that leaders make sure that staff feel they have a part to play in decision-making and that in large organisations there is multi-disciplinary teamwork. Our hospital inspections also tell us that where we have rated a provider as inadequate for being well-led, there is usually poor alignment between senior clinical staff and senior non-clinical management. In high-quality adult social care services we have seen examples of all staff, including managers and trustees,

being encouraged to contribute ideas to improve the quality of life for residents.

Services that encourage feedback and are tailored to people's individual needs are more likely to be rated outstanding for well-led. They use creative methods to encourage people to speak up about their care, and any concerns that people raise are addressed. In adult social care services, examples of innovative care methods include individualised care plans, life maps that capture important information about a person's life (such as family, key events and dates) and working with local community groups and agencies. Outstanding GP practices often have strong patient participation groups, genuinely respond to the needs of the local population, and reach out to diverse groups such as people with a learning disability and people who are homeless.

There is a positive correlation between whether staff would recommend the NHS trust they are working for and CQC's quality rating for that trust. Figure 1.15 shows that the average score given by staff of good or outstanding trusts is significantly higher than the score for trusts that are rated requires improvement or inadequate. Similarly, there is a correlation between how staff rate their trust on "good communication between staff and senior management" and our quality rating.

There is also a relationship between our ratings and patient satisfaction, based on findings from our NHS inpatient survey. For the question about inpatients' overall experience of a trust's services, outstanding and good providers received an average score of 8.2 out of 10, compared with trusts requiring improvement and rated inadequate, which scored 7.9 out of 10.

Figure 1.15 NHS acute trust ratings and average scores from the 2014 NHS staff survey: 'Would you recommend this trust?'
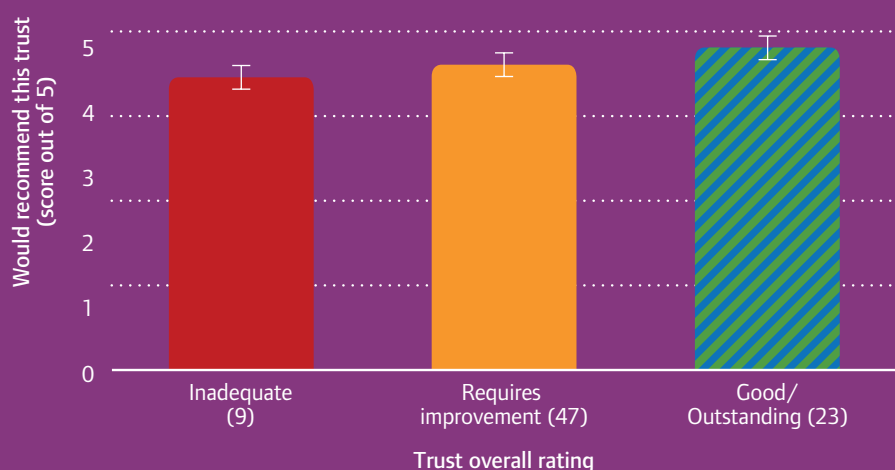
Source: CQC ratings data, NHS staff survey 2014
Note: We have so far rated only a minority of services. We have produced 95% confidence intervals for the average values by rating, as these values will fluctuate until all services have been inspected. The error bars in each chart show the width of these confidence intervals. If the confidence intervals do not overlap then the differences between the values are statistically significant.

● Inadequate   ● Requires improvement   ⊘ Good/Outstanding

Handling complaints

One important opportunity to listen to people is when they complain. Our review of complaints handling in health and social care, *Complaints matter* was published in December 2014. This exposed a wide variation in the way complaints are handled and identified, and that much more could be done to encourage an open, transparent culture where staff and managers welcome concerns and learn from them. For example, our inpatient survey shows that only a quarter (26%) of patients either saw or were given information about how to complain to the hospital. While most providers have complaints processes in place, people's experiences of the system are not consistently good.

It is CQC's view that services should encourage and embrace complaints, as they present a valuable opportunity to improve. Our report accepted that a cultural shift will require everyone involved in health and social care to stop seeing complaints as negative, because as long as we do there is an incentive for services to be less open about seeking feedback. Complaints may signal a problem, but this information can help save lives and learning from concerns will help improve the quality of care for other people.

According to data from the Health and Social Care Information Centre (HSCIC), the total number of reported written complaints received by NHS providers in 2014/15 was around 207,000, the equivalent of more than 560 a day.

The total included 121,000 written complaints about hospital and community health services (an increase of just under 6% on the previous year) and an estimated 86,600 relating to family health services (including GP and dental services). Note that for family health services we cannot compare with previous years because there has been a large increase in the number of GPs and dental practices returning data to the HSCIC.[32]

There is no single organisation that collates the number of written complaints received by social care providers in the same way as HSCIC does for NHS providers. However, the Local Government Ombudsman has also reported an increase in complaints received – 16% of around 20,000 complaints received in 2014/15 related to social care, compared with 13% in 2013/14.[33]

We ask about complaints handling as part of our comprehensive inspections. Every inspection report now has a section on how providers manage this type of feedback. We have committed to celebrating good approaches to complaints handling and setting out where improvements need to be made. We are also working hard to make it easier for people to share their experiences with us, and ensuring we can use their information and provide feedback on any action we have taken as a result. These measures, taken together, should help to promote and embed transparency in complaints handling across all sectors.

Skills, experience and visibility of management

Our inspections show that leaders having the right skills, and being visible and accessible to all staff is important. In adult social care, where services are well-led there is usually consistency of leadership with good recruitment and retention of managers. Visibility of managers is also very important – if the manager knows the people receiving care and gets involved with some of the frontline care work, including evening work, staff see this to be very supportive.

In the hospitals sector, alongside good leadership, the competence of managers at all levels and the culture of their teams are very important for driving overall quality. Similarly, in GP practices, the skills and experience of the practice manager make a big difference to the overall leadership of a practice – providing appropriate training and development for the practice manager is therefore integral to ensuring a practice is well-led.

Fit and proper person requirement

In late November 2014 the fit and proper person requirement was introduced for directors of NHS trusts. The duty requires providers to have systems and processes in place to ensure their directors, or equivalent, are fit and proper at the time of recruitment and on an ongoing basis. Since then we have been reporting on how providers meet this requirement in all our trust reports. From April 2015 the fit and proper person requirement has applied to directors of all providers registered with CQC.

The aim of the regulation is for providers to ensure their current directors are fit to manage the quality and safety of the services they are providing. CQC was not asked to investigate individual fitness, maintain a list of those found unfit (in effect, a 'blacklist'), or replace existing employment and legal processes. Historical issues of concern are only considered in so far as they may impact on current fitness.

To date we have not identified a breach of this regulation. There is emerging evidence on the impact the requirement is having, both directly and indirectly, particularly a deterrent effect. The evidence that we have available both from hospital inspections and dialogue with the sector suggests that the requirement is starting to drive culture change. Trusts have reviewed their processes and tightened them where necessary. We believe this may have deterred certain individuals from applying for director posts and it may have deterred trusts from appointing individuals about whom concerns may have been raised. However, it is not yet possible to assess this objectively.

Information about how the fit and proper person requirement is working in other sectors will be included in next year's report, once we have a more comprehensive picture of how services are implementing this requirement.

Duty of candour

In late November 2014 the duty of candour was introduced for NHS trusts, and from April 2015 it is a requirement for all providers registered with CQC. Since November we have been reporting on performance against the duty of candour in all our inspection reports for trusts.

An initial analysis of our hospital inspection reports shows that there is knowledge and awareness of the regulation, especially among senior managers; that specific structures and systems are starting to be put in place to support adherence to duty of candour requirements (including staff training); and that we have seen positive evidence of trusts meeting the regulation, including providing an apology to patients involved in serious incidents.

Information about how the duty of candour is working in other sectors will be included in next year's report, once we have a more comprehensive picture of how services are implementing this duty.

Investigating serious incidents

In our review of the quality of investigations into serious incidents involving patient care in acute hospitals, due to be published later in 2015, we conclude that while investigation of serious incidents is often seen as one of the most important elements of the patient safety process, this can be counterproductive if not done well.

The implementation and roll-out of root cause analysis investigation techniques across the NHS has had the unwanted side-effect, in some cases, of being under pressure to meet timescales at the expense of the quality of the investigation. This suggests, and is supported by the findings of our review, that the categorisation of serious incidents has become inconsistent with the original purpose, which was to identify significant opportunities for learning to reduce or eliminate the risk of the same thing happening again.

Indeed in a third of the investigation reports we reviewed it was not clear from the description of the incident or recommendations of the investigation that the incident met the criteria for a full investigative response. Other approaches to meet the needs of the patient and identify learning may have been more appropriate.

We have observed a high number of investigations that show a lack of skill and expertise in the methodology used; that do not identify the underlying systems issues that led to the incident; or that leave the reader with unanswered questions. There was also limited evidence that patients and families were engaged in the process, or that clinical and other staff were sufficiently involved.

We are encouraged that more attention is being paid to the response to, and learning from, safety incidents now than ever before. We have seen the number of serious incidents reported into the National Reporting and Learning System increase. However, it is important that providers develop expertise and invest in the tools needed to properly investigate, so that the right lessons are learned and shared.

A strong and positive organisational culture

Well-led services have a positive organisational culture that is open and transparent, and a culture where the vision and values are embedded and really understood by staff across the service. In a service where there is pride and enthusiasm among staff, which is echoed by people using the service, this is often indicative of both good leadership and a safe culture. Similarly, the best managers promote an open door policy and they welcome feedback. They are open to challenge and willing to take on suggested changes.

Many services point to their open door policy and their organisational vision and values in our conversations with them. But we have found that this alone is not enough to be well-led. Staff need to see these policies role-modelled by their managers, or they can feel undervalued and disempowered.

A culture of bullying, or staff feeling unable to speak up and report problems or incidents, is often a problem in services rated as inadequate for leadership or safety. Despite the focus on changing NHS culture since the publication of the Sir Robert Francis's Freedom to Speak Up review in 2013, it is still the case that around a quarter of NHS staff (22%) report having experienced harassment, bullying or abuse from their managers or other colleagues (according to the 2014 NHS staff survey). It seems that, although providers may have come some way to improve issues that flow from a poor organisational culture, they have not solved all the problems and need to work harder to do so.

Inclusion is an inspiration
Inclusion Healthcare Social Enterprise in Leicester

Inclusion Healthcare Social Enterprise in Leicester is an inspiring and innovative primary healthcare service that is providing outstanding quality in its services.

Inspectors discovered countless positive stories showing how Inclusion went out of its way to consider the needs of patients, whatever their circumstances. At its heart was strong leadership and there was a positive culture that ensures patient safety is paramount.

Healthcare assistants reminded patients about hospital appointments – and they also offered to go with them. Staff have explained how they support people experiencing a mental health crisis, including monitoring their repeat prescriptions, and the practice has also contributed to funeral costs and memorials for homeless patients.

The kind and compassionate care witnessed was part of the service's patient-centred culture and was also demonstrated in the way staff cared for refugees and people with a learning disability, and their work with hostels, prisons and young offenders institutions.

Learning when things go wrong

Services need to act when things go wrong, capture what happened and what the learning is, and then cascade the learning to prevent it happening again. In last year's *State of Care* report we issued a challenge to providers to make safety a priority in their services. We said there was too much variation when it came to safety and that too many providers had not got to grips with the importance of getting it right. As outlined in section 2, safety remains our biggest area of concern. A priority for improving this is being able to learn from mistakes.

In services rated good and outstanding, we find that staff are encouraged to report incidents. Any subsequent investigations are fair and transparent, focused primarily on learning rather than blame. Risks are identified early, discussed openly in an agreed structure and, in larger organisations, escalated where appropriate.

In these services, staff have clear lines of responsibility and are knowledgeable about their roles. NHS trusts that we have rated outstanding for safety also actively engage their staff in audits of patient outcomes and sharing learning from safety incidents across all teams, not just in the team where an incident occurs. All of this is bolstered by good communication between managers and those delivering care.

Outstanding services train staff on how to respond to near misses and what to do after one to embed learning. They are also able to respond to external information, such as complaints and safety alerts, and use these to identify risks and improve people's safety. This is more common in hospitals, but is important across all sectors.

In services rated inadequate, reporting and investigation of incidents is often delayed from the outset and approached

Deprivation of Liberty Safeguards

As part of our inspections of hospitals and care homes, we monitor the implementation of the Mental Capacity Act 2005, including the Deprivation of Liberty Safeguards (DoLS). In our 2013/14 DoLS annual report, we were concerned that similar themes had repeated over the previous five years. This included persistently low numbers of applications to deprive a person of their liberty, and a continuing lack of understanding and awareness of the Mental Capacity Act. In the report, we also noted the huge increase in applications following

the ruling of the Supreme Court in March 2014, which clarified when a person is being deprived of their liberty.

During 2014/15 the number of DoLS applications continued to increase – there has now been a 10-fold increase in applications since 2013/14. This has led to significant pressure on local authorities that are responsible for processing the applications, with a large backlog in applications. As of March 2015, more than 70,000 applications were not yet finalised or had been withdrawn.

The use of DoLS in hospitals and care homes also continues to vary. For example, we have found variation in staff training and understanding of DoLS and providers' policies about DoLS. Overall, while we have found examples of providers meeting requirements, there are also clear examples of poor practice. Full findings from our monitoring activities will be published in our 2014/15 DoLS annual report later this year.

inconsistently. In particular, due to their size, hospitals can have specific challenges, especially where senior managers are not visible and accessible to frontline staff. This can be exacerbated when trusts have no clear escalation protocol or issues have to be raised through certain staff. In these circumstances there is often poor feedback from reporting incidents. In some hospitals rated inadequate, staff have told us they are discouraged from reporting incidents due to fear of repercussions or not wanting to unsettle colleagues.

Governance processes that support openness

Finally, underpinning the success of organisations that provide good or outstanding care are good governance tools and processes to support leadership at all levels. These give organisations the ability to share learning and act on issues and concerns, and they were common to all services rated outstanding for being well-led.

Analysis included in the National Information Governance Committee's report earlier this year showed that there is a common set of important issues across all sectors that all services need to make sure they are managing well – such as completeness of records, protection of personal information, sharing information among teams caring for people, using information to monitor and improve care, and having effective systems to oversee information governance across the organisation.[34] Across all the sectors we regulate, services who were good or outstanding for safety had processes in place to minimise risk and to report incidents when they happen. Staff were able to explain to us how they manage and reassess risk to keep people safe from harm. Similarly, services rated good

or outstanding for well-led ensure that systems and processes for good quality care, such as risk management and complaints handling, are consistent and properly audited.

Good governance processes will typically mean that more information is captured. Therefore, on our inspections we do not automatically assume that an increase in reported safety incidents is a cause for concern – often it can indicate a greater openness by staff and management to reporting problems.

In contrast, in services we rated inadequate there were a range of governance issues that undermined the organisation's quality and safety – from poor data quality (such as inaccurate care plans and medication records) or a lack of staff meetings, to little or no responsibility for complaints or mistakes. In some trusts, difficulties with capturing data about patients as a result of their IT systems had an impact on the reliability of information to help staff deliver effective care. Additionally, in some NHS trusts the system used to record risks only captured issues at trust level, rather than by hospital or location. This meant that their executive team were unaware of incidents happening in particular locations, and this made it difficult to identify patterns. In other trusts we found staff using guidance and policies that were out of date because of a lack of appropriate auditing.

Services that are rated inadequate also tend to have ineffective or unaudited systems for managing risk, or no system at all. The statutory requirement to notify CQC of serious incidents is also managed poorly in those services rated inadequate.

5.2 Quality depends on getting staffing right

We have found that staffing is a core factor in our inspectors' assessment of safety across all sectors. Importantly, however, this is not simply about having the right number of staff, but having the right mix of staff, with the right skills, to meet the needs of the people cared for at all times. CQC does not set standards for staffing levels, and we would never reach a judgement on the basis of number or ratios of staff alone. We always look at it in the context of the effectiveness of the provider's systems for determining and ensuring a safe level of suitable staff for the needs of the people using their services, and their approach to mitigation of the risks when staffing is not as planned. This is in line with advice from the National Quality Board, including their 10 expectations around safer staffing, and the guidelines set out by NICE on safe staffing in acute hospitals.

Adult social care staffing
In adult social care, good services had well-planned rotas in place, which ensured sufficient staffing levels and skill mix to allow for safe, high-quality care 24 hours a day. As a result they also relied much less on external agency staff. In contrast, poor performing services had more prominent issues with staffing levels, often due to poor planning. There are examples where at weekends staffing levels worsened in those services rated as inadequate or requires improvement.

The right number of staff and the right mix of staff, with the right skills

Nothing is too much trouble
Elmcroft Care Home in Maldon, Essex

Elmcroft Care Home in Maldon, Essex, is a care provider that has learned from problems and improved its service – its approach to staffing exemplifies this.

Previously the subject of enforcement action by CQC, Elmcroft is now a good care provider. The provider had a process underway to make the permanent manager the registered manager and inspectors saw that staff knew how to keep people safe – they could identify if people are at risk of harm or abuse.

Feedback about staff from people living in the home was positive. Inspectors were told, "Nothing is too much trouble for them." And one relative of a person cared for at the home said, "They're really on the ball in attending to residents' needs."

CQC saw that the number of agency staff had reduced, more permanent staff had been recruited, and there were always qualified nurses on duty. Staff tried to maintain the independence of the people they cared for, while being aware of any individual risks.

Nurse staffing

The Royal College of Nursing (RCN) reported this year that too often, workforce and safe staffing discussions focus on numbers alone. CQC and the RCN agree that safe staffing is about having the right number of people with the right level of skills to make the right clinical decisions at the right time.

While the NHS has seen an increase in the number of nurses employed (just over 319,000 full-time equivalent nurses, midwives and health visitors in March 2015 compared with just under 314,000 in March 2014, and up from just under 312,000 in March 2010[37]), the loss of senior nurses across the NHS in England (as noted by the RCN) means that the health service is losing skills and experience, ward leadership and those who can mentor and lead the next generation of nurses. This loss of knowledge and experience is a cause for concern, particularly when we consider it in the context of skill mix and safety.

In *The fragile frontline*, the RCN reported workforce band data from the Health and Social Care Information Centre that shows that between April 2010 and October 2014 the more experienced senior nursing posts (bands 7 and 8 which include matrons, nurse consultants and nurse team managers) have decreased disproportionately when compared with other bands (figure 1.17). Although numbers of nurses in senior bands have been increasing again since mid-2013, they remain lower than before. As a result, the NHS has 2,800 fewer senior nurses than it did in April 2010.

As well as the pressures of maintaining adequate staffing levels, adult social care services are generally struggling to recruit the right staff. The vacancy rate across all positions in the sector is 5%, which is between one and a half and two times the national average. And turnover rate is around 25% a year for adult social care positions, compared with 15% nationally across all sectors.[35] Recruiting and retaining nurses in adult social care is particularly difficult, with vacancy rates as high as 20% in domiciliary care and 11% in residential care.[36] Figure 1.16 shows the high turnover of nurses in nursing homes and residential homes, and high nurse vacancy rates in nursing homes, residential homes, and particularly in domiciliary care.

Staffing in the NHS
In acute trusts, our inspectors found problems with staffing levels in services rated good and outstanding as well as those rated requires improvement or inadequate, although they were more common in services rated inadequate. Our 2014 NHS inpatient survey corroborates this, showing that more than 40% of respondents said that there were sometimes, rarely or never "enough nurses on duty to care for them".

Trusts are working hard to provide seven-day services and to secure safe staffing levels. However, there are significant gaps in some staff groups. For example 8% of organisations surveyed by Health Education England in January 2014 reported between 100 and 250 nurse vacancies, in part due to a limited pool of qualified nurses to recruit from.[39]

Figure 1.16 Nursing vacancy and turnover rates in adult social care, August 2015
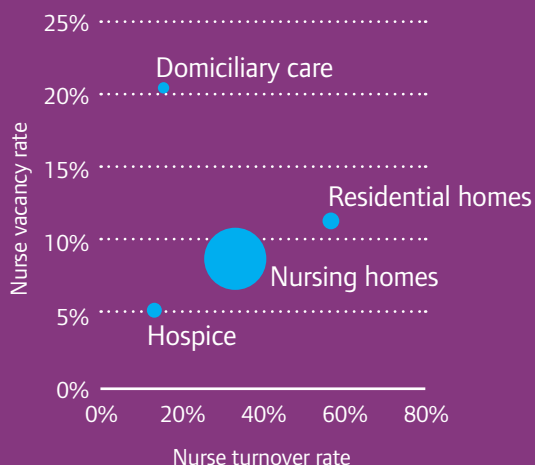

Source: Skills for Care National Minimum Dataset for Social Care

The size of the circles represents the relative size of the nursing workforce in these services. Note that the category of residential homes (that is, mostly 'non nursing' homes) do sometimes employ nurses.

Trusts continue to use agency and bank staff to fill the gaps. There was a 27% growth in spending on temporary staff between 2012/13 and 2013/14[40], and this trend continued into 2014/15. NHS England, Monitor and the NHS Trust Development Authority have put measures in place to reduce the spend on agency staff in the NHS, but persistent staff shortages will take time to address.

Despite this difficult picture, we found that in trusts we rated good and outstanding, rotas were well planned and there was less reliance on agency nurses. There were still times when staffing levels and skill mix fell below the levels that trusts said they needed to properly care for the number of patients concerned and the severity of their conditions. When this happened, a number of our inspection reports showed that risks to patient safety grew, and there were often more medication incidents, even in trusts we rated good and outstanding. However, these trusts prioritised measures to meet patient demand; for example, developing seven-day support

Figure 1.17 Qualified nursing, midwifery and health visiting staff (full-time equivalent) in NHS hospitals and community services, April 2010 to October 2014
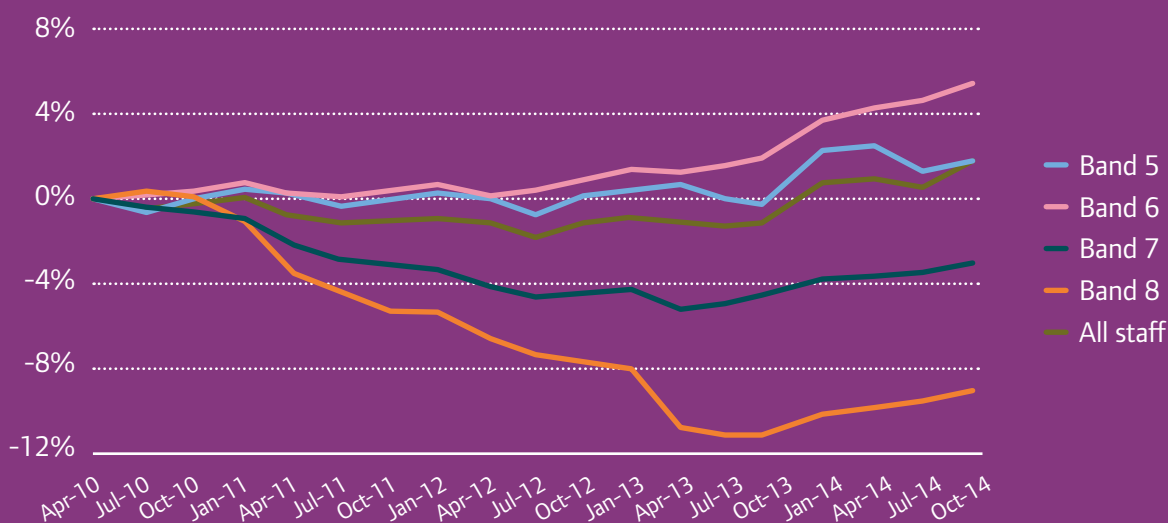
Source: Royal College of Nursing [38]

from consultants, access to out-of-hours consultant-led care and 24-hour availability of diagnostic imaging equipment and operating theatres.

In trusts rated inadequate the number of staff, skill mix and level of experience varied considerably, but generally numbers fell significantly below the levels the trusts said they needed to manage the patients in their care. This was especially the case during the night and at weekends, often due to a lack of medical staff in A&E. There was a tendency to rely on agency and bank staff in trusts rated inadequate, and where suitable staff could not be found departments ran without adequate staff in place.

Mental health trusts are also experiencing staffing challenges. In response to this NHS England issued a safe staffing framework for inpatient mental health wards in June 2015.[41] In producing this guidance NHS England found wide variation in costs and levels of staff recorded in inpatient settings, noting that deficits in qualified staff may be contributing to the variation in money spent. It further found that higher levels of qualified staff were associated with reduced levels of aggression among patients, thereby supporting the link that proper staffing leads to safer patient care.

A culture of developing staff
While staffing levels and skill mix are central to getting safety right, our analysis shows that staff training and staff development are also important. Outstanding adult social care services have training programmes for staff, and a culture that encourages all staff to continuously improve. This is complemented by staff support and development, with regular appraisals and supervision. In contrast, services rated inadequate often have training programmes that are inconsistently delivered or poorly monitored, an overall lack of performance management and periodic supervision for staff.

Staff training and staff engagement also impact on quality in the hospitals sector. The importance of this has been highlighted repeatedly in external research. In February 2015, the Health and Care Professions Council identified it yet again.[42] In outstanding trusts, staff tend to feel well-supported from many different sources – for example, consultants take the extra time to explain a particular situation to junior doctors or nurses, alongside ongoing training, assessment of competencies and feedback on performance.

In trusts that are rated requires improvement or inadequate, although staff generally felt that they were supported by immediate management, there was a lack of direct contact with more senior levels of leadership. Our analysis also suggests that in some departments of trusts rated inadequate there was limited uptake of mandatory training, insufficient performance management and limited priority placed on embedding training into everyday staff activities. This improved slightly with trusts that require improvement, as staff felt generally better supported and engaged.

> Outstanding adult social care services have training programmes for staff, and a culture that encourages all staff to continuously improve.

5.3 Working together on cross-sector priorities

This report sets out what we believe health and adult social care services should focus on to ensure they have the resilience to improve and maintain quality while responding to the challenges ahead. However, services doing this on their own is unlikely to be enough. It will require both national and local coordination and collaboration. We believe the most important actions are:

- Working together to ensure the sustainability of health and adult social care.

- Developing all sectors' ability to recognise safeguarding issues, through good staff training and shared learning.

- Ensuring that data is collected to enable a good understanding of what works.

Collaborate to ensure sustainability
The challenges faced by the health and adult social care sectors have renewed efforts from all stakeholders to work together across traditional boundaries.

The NHS *Five Year Forward View* has led to an important step up in the coordination and collaboration of national stakeholders in carrying out their roles to a common vision for the NHS. This is now being replicated in the vanguard areas to develop new models of care across acute, primary, community and social care services. Many local areas – starting with Greater Manchester, and now followed by areas across the country – have also begun to set out how they plan to use the possibility of greater devolution of resources to integrate their approach to health care, adult social care and public health, as well as housing and other services.

These are exciting opportunities for new approaches that offer better quality care while potentially being more efficient. We support and are part of this collaborative approach, while using our independence to provide an objective assessment of the quality of care against which changes are taking place. As part of the *Five Year Forward View*, with NHS England we co-chair the National Quality Board, working together with our national partners to set out a common understanding of quality, how we measure it, and what future priorities should be for quality improvement. We also provide our insights into quality and our perspective as an independent regulator in the other areas of the *Forward View*, such as new care models, efficiency and productivity, workforce and improvement (following the formation of NHS Improvement and the new Independent Patient Safety Investigation Service).

In April 2015 we started to monitor the largest providers of adult social care in England, with the aim of identifying early risks to their financial and business sustainability. We are doing this so that the people using their services are not disadvantaged by unforeseen large provider collapses, as has happened previously (see market oversight box). And from April 2016 we will start to pilot an approach to assessing the use of resources in NHS trusts alongside our inspections on their quality of care.

> **An inspector's view**
> "Leadership is the main steer, if there is a good manager in place who knows the service, is passionate about the service, then if they get that right, the rest of it's going to be right. The vision goes throughout service."

Finally, from this year onwards we are exploring ways in which we can assess and comment on the quality of care in a local area, beyond each individual service, to assist the shift towards integration and care models crossing traditional boundaries.

These are positive steps towards greater collaboration across services and sectors. From our inspection findings in adult social care, alongside conversations with providers, commissioners and people who use services and their families and carers, we are concerned that, unlike for the NHS, so far no common, coherent vision has emerged for the future of adult social care. This is inevitably a more complex task, involving more devolved commissioning responsibilities, a significantly mixed private and public market, and large diversity of service types and providers. Some organisations, including the Association of Directors of Adult Social Services and Care England, have set out five-year visions. But this does not yet address the need for a common vision that all stakeholders can jointly work towards, and we believe is needed to provide the current fragility of the adult social care market with a more sustainable, resilient platform for the changes ahead.

We therefore call on all adult social care partners to come together, and set out such a common vision and plan of work, including how services can be encouraged and supported to improve.

Strengthening safeguarding
CQC has a specific role to protect children and adults using services and who are unable to speak up for themselves, as well as a particular responsibility to people who are disenfranchised or who lack the

Market oversight

CQC launched its new market oversight function in April 2015. Its roots are grounded in the events of 2011 when the financial problems faced by Southern Cross, at the time England's largest care provider, exposed the potential risks faced by thousands of people across the UK in the wake of the collapse of a major social care provider.

We have a duty to oversee the financial health of care organisations that local authorities would find difficult to replace if they left the social care market. It empowers us to give an early warning if it seems that they are likely to fail, and that services will be affected. By doing so we will assist local authorities in carrying out their statutory responsibilities to ensure continuity of care.

Those covered by our market oversight scheme are not necessarily at risk of failing, but are recognised as being difficult to replace if they do fail. This may be because they operate a large number of homes, or have a significant regional presence or specialism.

We have published guidance for providers on our market oversight of adult social care: www.cqc.org.uk/content/market-oversight-adult-social-care

mental capacity to protect themselves. This is outlined in our safeguarding statement.[43] Safeguarding is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the person's wellbeing is promoted. However, this is not a substitute for the provider's responsibility to provide safe and high-quality care.

As part of our inspection process we make sure those who lead regulated services fulfil their responsibility to have the right systems and processes in place to offer assurance that people are safe from abuse and neglect.

We receive concerns from the public who are worried about the care that people are receiving. These relate to safeguarding issues or the quality of care received. Some of these concerns come only to us, while the majority are sent to multiple organisations. When concerns are only sent to CQC we share these with partners such as local authorities where necessary, to ensure they are followed up by the organisation best placed to handle them.

Additionally, providers must tell us when they identify that someone in receipt of their service has been abused or neglected, or when an allegation of abuse has been made. Some providers are telling us about incidents that they believe are abuse or neglect through safeguarding reports, but which are more about the quality of care or care management. However, more work is required to improve their understanding of what to report and how.

Safeguarding children

Concerns about safeguarding and the importance of multi-agency working were raised in the review of child protection services carried out by Professor Eileen Munro, whose recommendations form the

How we inspect the safeguarding of children

We recently carried out a review of services in Rotherham, a town that had national focus due to the extensive evidence of child sexual exploitation. CQC's children's services inspection team assessed all health providers in the local authority area for the effectiveness of safeguarding arrangements, along with health services for looked after children. At the same time, CQC's specialist hospital team inspected Rotherham NHS Foundation Trust using our new methodology. CQC took the step of joining these two teams from different inspection programmes together because of the known previous issues in Rotherham.

Both teams found that improvements needed to be made to child safeguarding and that some agencies still did not understand their roles or responsibilities in this area. Partners who provide contraceptive and sexual health services in particular play a potentially critical role in identifying children at risk. We made 24 recommendations and will monitor the local action plan that results from these.

While this was a challenging inspection for Rotherham with a very large team of inspectors on site, the feedback was positive. They appreciated the very thorough and in-depth review of how they safeguard children and felt the findings provided an accurate reflection of their services. In addition, it enabled CQC to trial a methodology of joint inspectorate review that can be refined and implemented in other areas where there may be a greater level of concern.

basis of our multi-agency programmes. Serious case reviews continue to highlight service failures across all agencies in protecting children. Kate Lampard's report on the lessons learned from the Savile inquiries raised the profile of risks to children from people in positions of trust or power. More recently, the widespread risks to children were highlighted by the Alexis Jay inquiry into child sexual exploitation in Rotherham.

The children's inspection team is continuing with its national programme of child safeguarding and looked after children inspections. It has developed a proposed methodology for a five-year joint programme with Ofsted, looking at how local areas are meeting the needs of children with special educational needs and disabilities. A public consultation for this will be launched in the autumn.

Safeguarding adults

We outlined in last year's *State of Care* that the Care Act 2014 statutory requirement for local authorities to have safeguarding adults boards (SABs) would impact on them and the sector. The Act clarifies CQC's role in safeguarding and, although we are not members of SABs, we are partners to their work. Our inspection staff work at a local level with local authority safeguarding teams.

We will work with services to clarify expectations around their responsibilities to safeguard people using services and continue to take timely and robust action where we find that people have been abused or neglected or where there is that potential.

In hospitals we have found a mixed picture in the way safeguarding issues are recognised and reported. Although the statutory guidance to the Care Act (October 2014) does not define adult safeguarding thresholds[44], some local authorities have

established thresholds. This is causing confusion among healthcare staff. Staff training levels for safeguarding across trusts was not always at the required level for all staff, especially in A&E and services for children and young people. We found that in trusts rated as good or outstanding, statutory and mandatory training levels were good, with clear plans to address any gaps.

Safeguarding training is also a concern across our primary care inspections. In particular, our inspectors comment that adult safeguarding training is being overlooked in a number of services, with some services solely focused on child safeguarding. A GP practice rated as outstanding for safety worked across sectors on implementing a safeguarding training programme at a residential care home. This was following a major safeguarding concern where a practice had not picked up on injuries sustained by patients at a residential care home. It is apparent that dental practices do not always understand their responsibilities under the Mental Capacity Act, which can lead to safeguarding issues.

Similarly, in adult social care our inspections have highlighted the impact that a lack of robust training can have on people who use these services. Some services tell us they only have enough money to do essential training, with a lot of online or DVD training being undertaken. Poor training results in staff not taking the right action. There is a mixed picture across the sector about the culture of safeguarding and knowledge of when to report. We are concerned about incidents, for example physical assaults by people using dementia services, where the provider has not identified themselves that the incident was a safeguarding issue and needed action.

Understanding effectiveness with better data

Providers and local and national bodies in health and social care need to work together to better collect and exploit data. There is little evidence that this is receiving the same degree of investment as other initiatives to improve care. Every provider should have good, benchmarked data for all the services it provides, and the data to assure itself that it is providing safe and effective care. This is important to get right because our inspectors are making clear links between the experience of people who use services and how well information is handled and used to improve care. Without it:

- Providers of care may not always have a good awareness of the impact that their service is having, which calls into question whether they, and their commissioners, can be assured that the care they provide is safe, compassionate and effective.

- Staff and their leaders will find it difficult to make robust evidence-based decisions, underpinned by high-quality information.

- People who use services cannot access consistently high-quality information about the safety and effectiveness of the services from whom they receive care.

These are some of the reasons why CQC fully supports the work of the National Information Board (NIB) and the vision to bring greater digital maturity to health and social care.

At the moment we are able to collect and publish information to support providers in making better use of available data. We do this through our Intelligent Monitoring, provider information returns and data

An inspector's view

"They are keeping on top of it, the management team know what is going on… so they know, they can tell you we have had a problem with staffing numbers we have had a lot of sickness and this is what we are doing about it… they are then making sure they are keeping on top of whatever improvements have been made to make sure they are being sustained."

packs. We also follow key lines of enquiry during inspections under both the effective and well-led key questions. We do this to test how well the provider uses data to underpin good decision making, at both the level of the person using the service and at a corporate level.

From next year we intend to take a provider's compliance against new data quality standards into account in our judgements of NHS services. These standards are being developed jointly by the Health and Social Care Information Centre, Monitor, the NHS Trust Development Authority and CQC, informed by Dame Fiona Caldicott's work as National Data Guardian. They will include improvement in the timeliness, accuracy and completeness with which data is entered into electronic records and made accessible to carers and patients. We will also continue to work with our NIB partners to transform health and care services through data and technology and have a lead role in implementing Personalised Health and Care 2020, the government framework for action in this area.

However, if the quality of data were improved it would lead to improvements across all sectors for providers, commissioners, the public and our partners:

- It would enable professionals and leaders to access higher quality data about safety, the experience of people using services, and the outcomes that matter to people using services.

- It would enable professionals to collaborate on continuous improvement with the confidence that they have the data they need to monitor progress, for instance benchmarking data.

- It would be easier to detect unwarranted variations in the quality, equity and efficiency of health and care services. This insight could in turn be used to spread good practice and tackle underperforming services.

The English health and social care sector is not alone in its need to harness data better, and there are emerging examples from other industries and other countries that we can learn from. Our concern is that if we continue to fail to prioritise this, we are never going to be able to get a fair and accurate picture of the real issues affecting the system at national, local and provider levels. Providers and national bodies need to work together to make this happen. With better data we can encourage continuous improvement, detect and respond to unwarranted variation and explain to the public the impact of the changes we are making.

An inspector's view

"That is the first time I have ever seen that kind of thing in any care home ever, where a manager will see a story about a care home in the news, she'll write a quick précis about it and the staff sit and talk about it and say what we can learn from this one. Now that to me is innovative, creative practice."

6. Conclusions

In this report we have highlighted that, despite the increasingly challenging circumstances they are facing, services across health and social care are mostly delivering high-quality care. The majority of the services we have inspected have been rated good, and a number have been found to be outstanding. Where services are performing well, this is often as a result of good leadership.

There remains, however, significant variation in the quality of care across services, and some people still experience an unacceptable quality of care. We are particularly concerned about whether services are routinely ensuring the safety of people who use their services, and whether they are able to provide a consistent quality of care for the varying needs of different groups of people in their area. Where we see unacceptable care, we are increasingly taking enforcement action to protect people using services. We are encouraged, however, by the evidence that services are able to improve following our inspections, and by the positive feedback from providers about how our reports help them improve. Completing our inspection programme in 2016/17 will give us a baseline of all services from which we will be able to measure progress.

Looking ahead, the sectors we regulate face significant challenges. Specifically, in adult social care our concern is that the market could become increasingly fragile over the next few years, while in the NHS our questions are more concerned with whether providers can address the variation in quality while also reshaping care models to provide a more efficient, joined-up service. These concerns are amplified by the finding that many services do not yet have the leadership and culture required to deliver safe, high-quality care that is resilient to the inevitable changes ahead.

The projected shortfall in NHS and adult social care funding creates a powerful impetus for innovation and change in the ways that care is provided. We are highly supportive of the *Five Year Forward View* and the recognition in many parts of the country that the best care systems are those where health and social care go hand in hand. However, to be truly innovative, it is important to be open to the idea that some changes will not succeed, and experience from other industries suggests that new ways of working need iteration and fine-tuning before becoming a sustainable system. Our challenge to all health and social care services, and the system overall, is therefore to continue to put quality of care at the centre of change, and not fall into the trap of seeing innovation as only driven by the need to save money.

Alongside this, we encourage all partners in adult social care to come together and set out a common vision and plan for how to address the current fragility and uncertainty in the adult social care market, and ensure they can continue to provide good quality care to all people using their services.

Soon after this report is published, we understand the Government's spending review will set out plans for mitigating the impact of the national living wage on the care sector. We know that the sectors we regulate are expected to undergo rapid change, and under these conditions there is a risk that the quality of care could become increasingly variable. We will encourage innovation, and work with providers to ensure that this is done in a way that protects the interests of people who use services. Change is vital, but it should not come at the cost of quality, in the short or long term.

We understand that services are already under significant pressure. To survive and

thrive, sustaining the safe, good quality care that people who use services expect, will require resilience, innovation and great leadership. We therefore encourage services across health and social care, together with their local and national partners, to focus on:

- Building a collaborative culture that reaches out to people who use services and engages with all staff to ensure shared vision and ownership of the quality of care they deliver.

- Being open and transparent and learning from mistakes, ensuring information and data are to hand to make good decisions and to understand what works (and what doesn't), using opportunities to learn from the best.

- Ensuring that services have the right staff and skill mix in place to ensure that care is always safe.

We will continue to enable and encourage all services to improve by providing an honest assessment of the quality of care we see, advocating for better data, and celebrating and sharing learning from outstanding services.

People deserve high-quality services. It is therefore our duty to the people who use services to be open and transparent about the quality of care that we see, and not lower our expectations of quality in the challenging times ahead. There are examples of good services sharing their experiences with those who want to improve. We see this type of collaboration as valuable in improving the quality of care for people who use services. Many services are already achieving high quality and we are confident from what we have seen that others can too.

Part 2
THE SECTORS WE REGULATE

The majority of the organisations inspected and rated are good or outstanding – so far, CQC has rated:

47%
of acute hospital trusts

17%
of adult social care services

11%
of GP practices and GP out-of-hours services

> **Adult social care**

> **Hospitals**

> **Mental health**

> **Primary medical services**

> **Equality in health and social care services**

Adult social care

Key points

- The adult social care sector is under pressure and there are issues around the sustainability of provision, due to the increasing complexity of people's care needs, significant cuts to local authority budgets, increasing costs, high vacancy rates, and pressure from local commissioners to keep fees as low as possible.

- Despite this pressure, our inspections to 31 May 2015 showed that almost 60% of services were providing good or outstanding care.

- It is concerning, however, that up to that date 7% of services were rated inadequate. Safety is our biggest concern: of those we inspected, a third required improvement for safety and 10% were rated inadequate for safety. In these services, contributory factors were staffing levels, understanding and reporting safeguarding concerns, and poor medicines management.

- The vast majority of services were caring, with 85% receiving good or outstanding ratings. This is supported by high satisfaction rates of people who use adult social care services.

- Having a consistent registered manager in post has a positive influence on the quality of a service and helps to make sure that people receive care services that are safe, effective, caring and responsive. The outstanding leaders we see are characterised by their passion, excellence and integrity, collaboration with their staff and the provider, and their determination to ensure people's views and wishes are at the centre of their care.

Introduction

Adult social care in England supports people aged 18 or over that have a wide range of care needs. We regulate and inspect:

- More than 17,000 care homes that offer accommodation and personal care for people who may need help to look after themselves. Of these, around 4,700 also provide nursing care.

- More than 8,200 domiciliary care services, which support people with personal care in their own homes.

- Around 2,200 other social care services provided in the community, for example Shared Lives and supported living where people are supported to choose where they live and the particular services they need.

- More than 300 hospices.

The demand for social care is increasing. The numbers of people aged over 85 (the group who are most likely to need care) and older people with a disability are projected to rise sharply in the coming years (figure 2.1).

This rising demand is coming during a time of increased financial strain and concerns around sustainability for the adult social care sector.

Over the past five years there have been significant cuts to local authority budgets, and as a result the level of public funding available to adult social care has decreased significantly. Figure 2.2 shows the impact of this. Commissioners of adult social care services are under pressure to keep fees as low as possible to enable them to manage increasing demand with reducing budgets.

The national living wage, to be introduced from April 2016, will put further pressure on the budgets of providers and/or commissioners. Analysis for the review that led to the national living wage found that, of all work sectors, social care offers the greatest cause for concern, because wages in the industry already start from a low base and productivity improvements can be difficult to realise.[45]

On top of these pressures, adult social care providers struggle to recruit the staff they need. Vacancies and turnover in the sector are high. For nurses, vacancy rates can be as high as 20% in domiciliary care and 11% in residential care.[46]

Figure 2.3 shows the interaction of high turnover of nurses in nursing and other care homes, and high nurse vacancy rates. It is clear that nursing homes are the most severely affected. Adult social care providers agree that these vacancy and turnover rates are too high, and that there is an urgent need

Figure 2.1 Future projections of numbers of older people
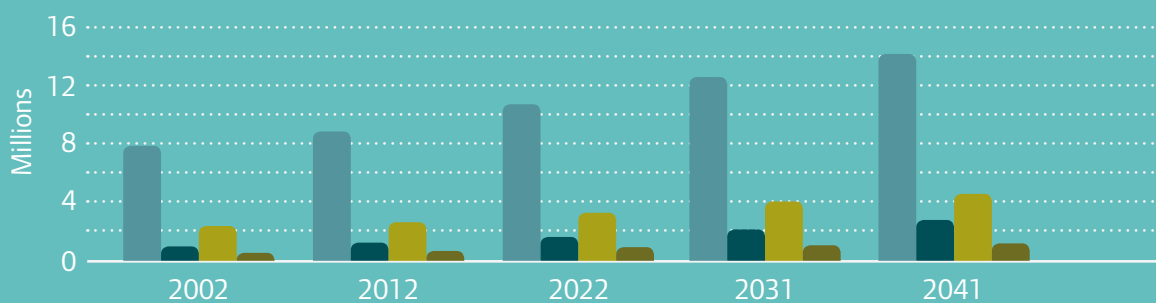
Source: PSSRU Personal Social Services Research Unit 2006: Future Demand for Long Term Care, 2002 to 2041: Projections of Demand for Long Term Care for Older People in England

- Numbers of older people (65+)
- Numbers of older people (85+)
- Numbers of older people with some disability
- Numbers of older people severely disabled

to share and use best recruitment and retention practices throughout the sector. However, provider representatives at CQC's adult social care symposium in July 2015 said that the sector struggled to compete with the NHS in retaining their nursing staff. Our register of providers shows how the social care market is responding to these pressures of demand and resourcing. Over the last five years, there has been a 42% rise in the number of domiciliary care agencies, coupled with a 10% reduction in the number of residential homes (and a 6% reduction in the number of beds) (figure 2.4). We also see a trend of smaller services being replaced by newer, larger ones. Our register shows that the only category of residential homes that has increased between 2010 and 2015 is homes with more than 50 beds. The number of nursing homes with more than 50 beds has also increased over the same period, whereas the number with between 20 and 50 beds has decreased.

Overall quality

By 31 May 2015, we had rated 18% of residential care homes, 27% of nursing homes, 8% of domiciliary care services and 10% of other community services. This gives us an early picture of adult social care, but it is important to note that we have been prioritising those organisations where we already had concerns.

Despite the challenges facing the sector, our ratings so far show that overall most services were providing good or outstanding care. One per cent of these services were outstanding and 59% were good (figure 2.5). The outstanding services that we see have a culture of care that both puts the views and wishes of each person at the centre of their care, and supports staff to deliver that care. Values are embedded in the organisation and demonstrated in practice. Managers make sure their staff receive continuous development and training, and they carry

## Figure 2.2 Number of adults receiving local authority-funded social care services
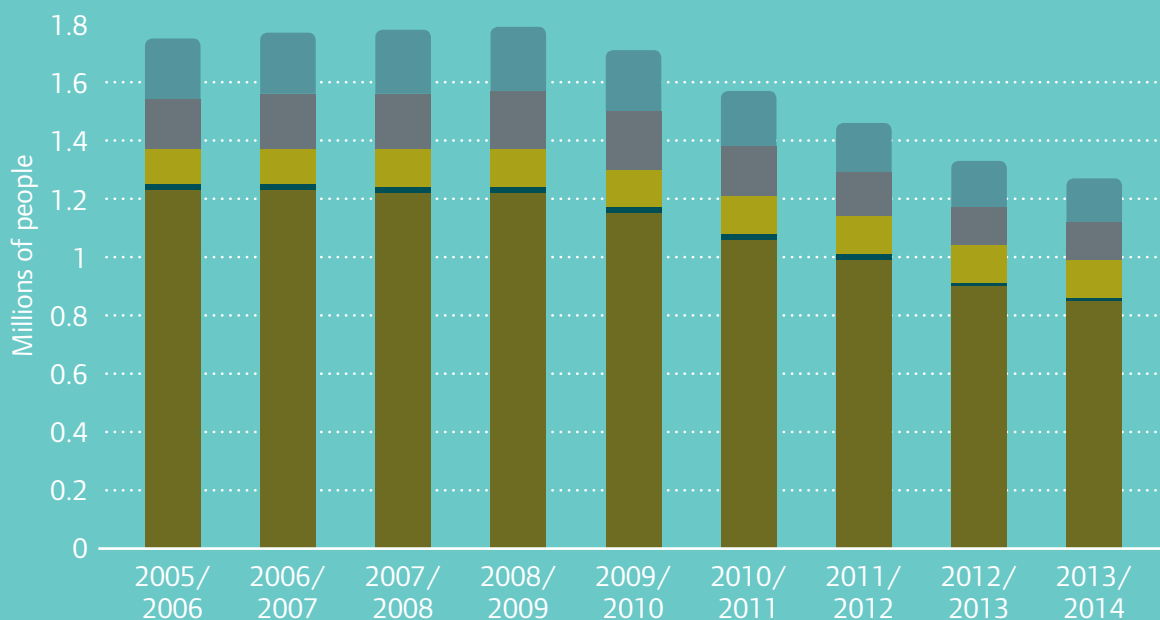
Source: Health and Social Care Information Centre; National Audit Office

- 18 to 64 with a physical or sensory disability
- 18 to 64 with a mental health problem
- 18 to 64 with a learning disability
- 18 to 64 other
- 65 and over

out regular audits so that shared learning can prevent future risks to people's safety, health and wellbeing. Staff involve people using the service and their family and carers to develop care plans. They keep plans close at hand and regularly reviewed so that the care being delivered is always reflective of people's needs.

Despite this majority of good care, overall 33% of services required improvement. And there were 320 services that we rated inadequate, which equates to 7% of all those we rated. While we recognise the pressure that the system is under, it is vital that the care delivered is of a quality that people have a right to expect. Where providers are failing to meet legal standards, we act quickly to ensure that people are protected and services improve. In 2014/15 we issued 937 Warning Notices to providers, telling them they needed to make urgent improvements.

Figure 2.3 Nursing vacancy and turnover rates in adult social care, August 2015
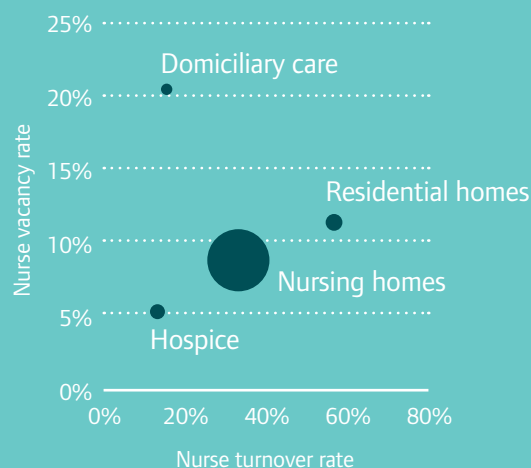
Source: Skills for Care National Minimum Dataset for Social Care

The size of the circles represents the relative size of the nursing workforce in these services. Note that the category of residential homes (that is, mostly 'non nursing' homes) do sometimes employ nurses.

Figure 2.4 CQC register of adult social care locations by type of service
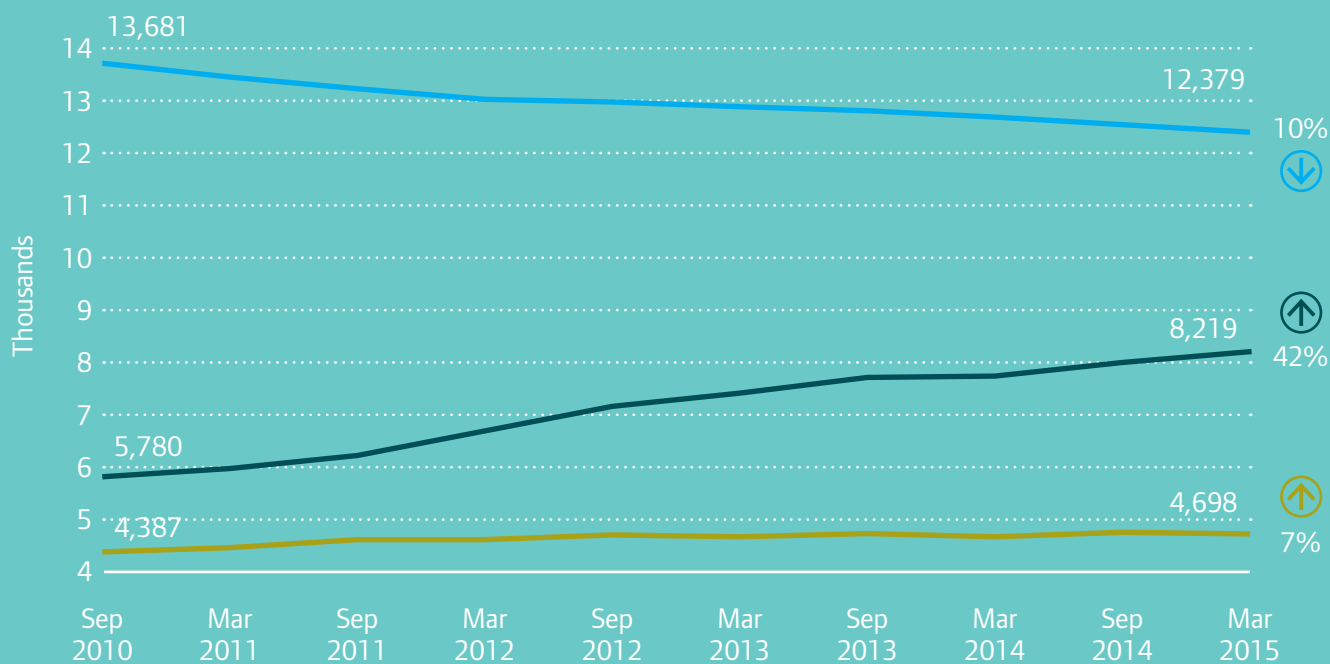

Source: CQC registration data

Nursing homes — Residential homes — Domiciliary care agencies

There is evidence that our new inspection regime is already leading to improvement. The re-inspections we have carried out so far have led to 40% of inadequate ratings at service level changing to a higher rating. Twenty-eight per cent of requires improvement ratings at service level have improved on re-inspection

The quality of care in residential care homes, domiciliary care agencies and community services is broadly the same – around two-thirds of services were rated good or outstanding (figure 2.6).

The quality of care in the hospices and Shared Lives locations that we have rated has been good. Up to the end of 31 May 2015, eight out of 27 hospices were rated outstanding, and 17 were good. Of the 14 Shared Lives inspected, 12 were good.

Figure 2.5 Overall ratings for adult social care services

Source: CQC ratings data

- ● Inadequate
- ● Requires improvement
- ● Good
- ● Outstanding
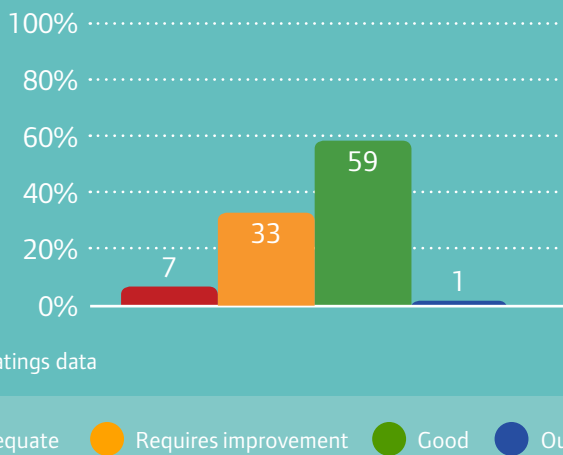
An inspector's view

"It was how the people were supported. There were high levels of staff training; the training was just immense really, with staff doing refresher training throughout the year."

More than just a job
Home Instead, West Lancashire and Chorley

Home Instead, West Lancashire and Chorley is an outstanding domiciliary care service where the leadership and culture is a key to its success.

The managers have explained how they try to hold true to the principles (kindness, respect, dignity and compassion) in all that they do. This culture was instilled in the staff too and CQC inspectors saw this for themselves.

Personal touches reflected this. One care worker told a CQC inspector how she ordered books by a particular poet from a library because she was aware that someone in her care told her she loved the writer. Staff were highly motivated and proud of their service, and there were strong links with external organisations and the local community.

A member of staff told the inspector that Home Instead was special because it focused on the little things that matter most, like spending time with people and offering companionship. One person cared for by Home Instead summed up their experience, "I think it's more than just a job to them."

People receive notably poorer care in nursing homes. Only 46% of those we rated were good or outstanding, and 10% of nursing homes were rated inadequate compared with 6% of residential homes that do not provide nursing. Previous editions of our *State of Care* report have identified findings of poorer care in nursing homes, and our new more comprehensive inspections confirm this.

For the homes we have rated, smaller care homes (both nursing and residential) tend to provide a higher quality of care than medium-sized or larger homes (figure 2.7). Again, this corresponds with our findings in previous years, despite the ongoing trend towards larger homes. However, in contrast to the overall picture, we are seeing small nursing homes performing better than small residential homes without nursing. Note, though, that this finding is based only on the inspections conducted so far, and the service profile of smaller homes may differ from larger homes, with for example many more smaller homes providing services for people with a learning disability.

Our very early analysis of domiciliary care services indicates that smaller agencies, that is those providing care to fewer people, tend to achieve higher ratings. However, we need to look at more data before we can say whether there is a correlation.

There are many good adult social care services in every region in England (figure 2.8). However, there are some differences. In the inspections to 31 May 2015, the South East, Yorkshire and Humber, and London contained a higher proportion of services rated inadequate than elsewhere. We will need to carry out further analysis to understand more about these regional differences.
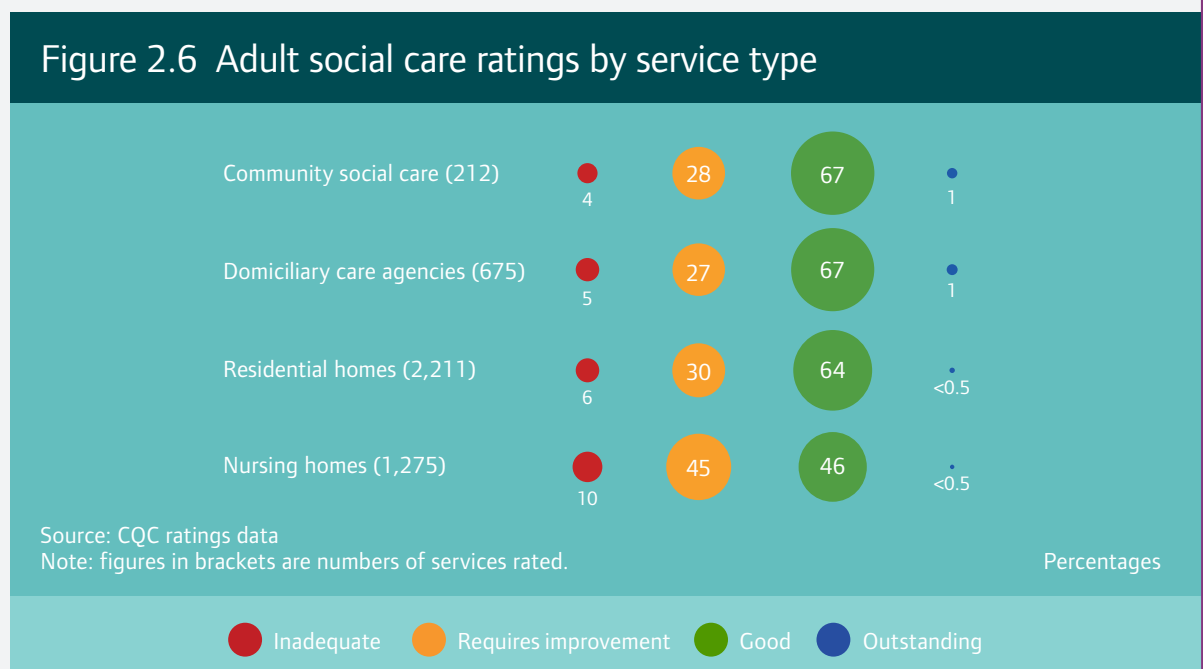
Themes by key question

Most adult social care services in England were caring: of those we have rated, 85% were good or outstanding for caring (figure 2.9). Our biggest concerns relate to the safety of services (where 10% were rated inadequate) and to well-led (where 8% of services were rated inadequate).
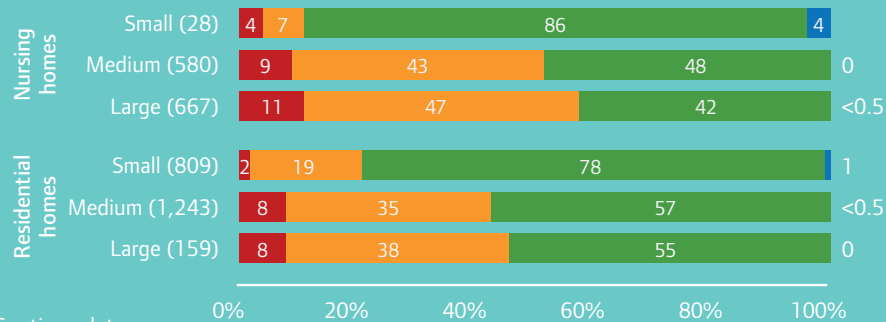
This profile was similar for all the different types of adult social care. Whether nursing homes, residential homes, domiciliary care or community services, the highest ratings were for caring, and the highest proportion of inadequate ratings were for safe and well-led.

Safe
While 57% of the services we have rated were good or outstanding for safety, there were 33% that required improvement and 10% that were rated inadequate. It is no surprise, therefore, that safety

Figure 2.6 Adult social care ratings by service type

Community social care (212)   4   28   67   1

Domiciliary care agencies (675)   5   27   67   1

Residential homes (2,211)   6   30   64   <0.5

Nursing homes (1,275)   10   45   46   <0.5

Source: CQC ratings data
Note: figures in brackets are numbers of services rated.

Percentages

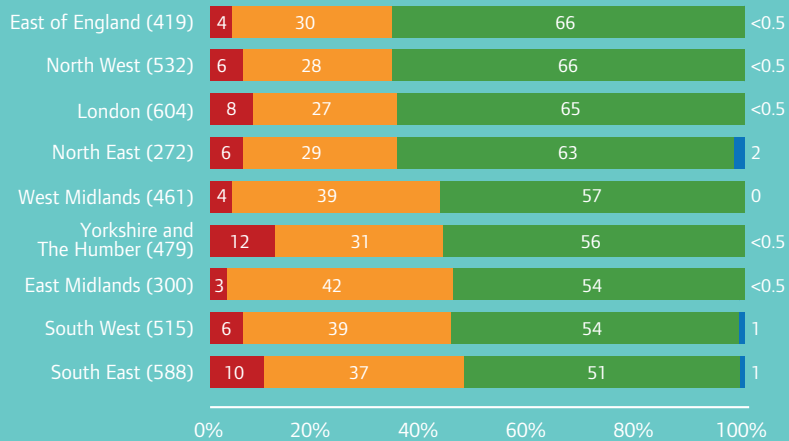● Inadequate   ● Requires improvement   ● Good   ● Outstanding

Source: CQC ratings data
Note: figures in brackets are numbers of services rated. Up to 10 beds is categorised as 'small', 11–49 beds is 'medium' and 50+ beds is 'large'.
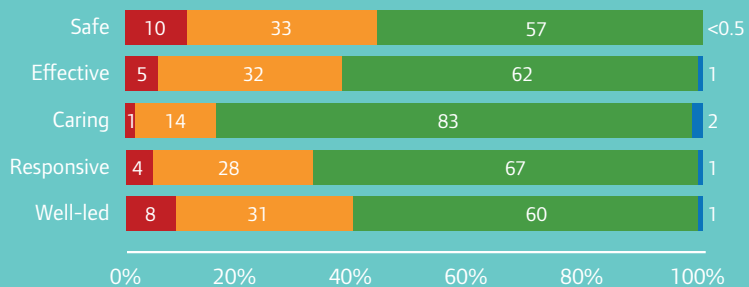
Figure 2.8 Overall rating by region

	Inadequate	Requires improvement	Good	Outstanding
East of England (419)	4	30	66	<0.5
North West (532)	6	28	66	<0.5
London (604)	8	27	65	<0.5
North East (272)	6	29	63	2
West Midlands (461)	4	39	57	0
Yorkshire and The Humber (479)	12	31	56	<0.5
East Midlands (300)	3	42	54	<0.5
South West (515)	6	39	54	1
South East (588)	10	37	51	1

Source: CQC ratings data
Note: figures in brackets are numbers of services rated.

Figure 2.9 Ratings for all adult social care services

	Inadequate	Requires improvement	Good	Outstanding
Safe	10	33	57	<0.5
Effective	5	32	62	1
Caring	1	14	83	2
Responsive	4	28	67	1
Well-led	8	31	60	1

Source: CQC ratings data

● Inadequate   ● Requires improvement   ● Good   ● Outstanding

is the area that we have had to re-inspect the most often. Our inspectors see a number of issues that affect people's safety:

- The number of staff on duty is inappropriate and services cannot show an analysis of people's needs that justifies their staffing.

- Organisations are not appropriately recognising and recording incidents as safeguarding issues; this is sometimes a staff training issue.

- Services rated inadequate and those requiring improvement show weaknesses in follow-up and learning after accidents and incidents.

- There is a lack of knowledge about risk management and reporting of risks.

- Medicines are not administered properly, and some are out of date and not stored correctly.

- Care homes that are rated inadequate or requires improvement are often "smelly" or "dirty" compared with those rated good, which are often "spotlessly clean".

- Essential checks of equipment and the safety of the living environment are either not carried out or acted on, or they are treated as a tick-box exercise.

- A blame culture is associated with poor performance, but a culture of openness and transparency has a high impact on safety – and good performance is associated with management that encourages staff to raise concerns.

Effective
Of the services we rated, 63% were good or outstanding for the effectiveness of the care and support given to people. Thirty-two per cent required improvement and 5% were rated inadequate. Our early findings show that community services achieved the highest ratings for effectiveness, with 72% being good or outstanding compared with only 51% of nursing homes.

As part of our assessment of whether services are effective, we look to see whether staff understand the difference between lawful and unlawful restraint practices. This includes how to get authorisation for a deprivation of liberty. In March 2014, the Cheshire West ruling widened the scope of the Deprivation

of Liberty Safeguards (DoLS) and, subsequently, in 2014/15 there were 10 times the number of DoLS applications to the supervisory body compared with the previous year – mainly from care homes to their local authority. This has resulted in a large backlog: by the end of March 2015, more than 56,000 applications received in 2014/15 had not been finalised.[47] Later this year we will publish our separate report on the use in 2014/15 of the Deprivation of Liberty Safeguards.

Caring
In the vast majority of cases, our inspectors see staff who involve and treat people in their care with compassion, kindness, dignity and respect. We rated 85% of the services we inspected as good or outstanding for caring.

These findings are supported by the satisfaction ratings of people using services whose care is funded by a local authority. In 2013/14, 90% of people said they were quite, very or extremely satisfied with their care. Furthermore, over the last four years there has been an increase in people who said they are very or extremely satisfied (from 62% to 65%), and no increase in the small minority saying they were not satisfied (4%).[48]

Responsive
When we ask whether services are responsive, we look at whether services are organised so that they meet people's needs. Despite the pressures that the adult social care sector is under, more than two-thirds (68%) of services were rated good or outstanding for their responsiveness. However, we see that nursing homes struggle more than other services to respond to the needs of the people they care for, with only 58% of good services.

Well-led
Of our five key questions, it was the well-led rating that was most closely aligned to the rating of the service overall.

Sixty-one per cent of adult social care services were rated good or outstanding, and a further 31% required improvement. However, this means that 8% of those we inspected had inadequate leadership.

Our inspectors see a number of common themes underpinning a poor rating for well-led:

- Difficulties in recruiting and retaining managers.

- A lack of capability in some managers, and managers that are not sufficiently visible to staff or the people using the service.

- Poor engagement with staff and people who use services, with managers not aware of, or close to, the day-to-day issues in the service.

- A poor culture in the organisation that does not bring everyone together to share learning and promote improvement.

- Managers that do not proactively support staff development.

- A lack of systems and processes to monitor the quality of care being given to people.

- Financial management that over-emphasises profit to the exclusion of care improvement.

Our findings are starting to show, and the sector also recognises, that a vital aspect of being well-led in adult social care is having a registered manager consistently in post. This has a positive effect on quality: a good manager can inspire staff with the right values, promote a culture of care and compassion, and make a real difference to people's lives. Services that went for six months or more without a registered manager had considerably lower ratings than others. In addition, services with two or more registered managers leaving in a 12-month period had a slight tendency towards lower ratings than those with less managerial turnover.

We have also explored with our inspectors what they see that makes outstanding leadership. Central to successful leadership is putting people at the heart of services and creating an environment where they really matter to the staff and managers who care for them. Our inspectors say that in the services that deliver excellent care, providers and managers:

- Promote an open culture, where any issues can be raised freely by people who use services or staff and are addressed quickly.

- Work well with local care partners and have strong links with the wider community.

- Develop a culture of continuous improvement – seeking to recognise, celebrate and share good practice.

An innovative provider that puts people first
Equal Partnerships, North Tyneside

Equal Partnerships provides personal support to people who have a learning disability and live in their own home in the North Tyneside area.

This is an innovative care service that could demonstrate the ways it puts people first, such as involving them in the recruitment of new staff. And Equal Partnerships runs a flexible staff rota that allows people living at the home to choose what they want to do.

This service provider was dynamic. Rated outstanding by CQC, its staff supported people with a learning disability who live at home to have flexibility in their lives, just like anyone else.

Equal Partnerships had a dedicated staff team for each person it cares for, and they worked out a weekly plan based on what the individual wants to do each day.

The recruitment policy at Equal Partnerships specifies that people using the service should always be involved in the interview process. Inspectors saw that initial interviews and a shortlisting process were always inclusive. One relative explained, "They put people first. When my son needed a new key worker, they let him write his own advertisement and run the interview. They support, but they don't take over."

Being creative with person-centred care
Prince of Wales House, Ipswich

Prince of Wales House in Ipswich is an innovative and creative care services rated outstanding by CQC. It gives personal care for up to 49 older people, including specialist care for people with dementia.

Inspectors described a clear commitment by managers to continually improve and they were impressed by the strong and visible leadership. Described as a 'whole team approach', staff were motivated by a strong culture of inclusivity and work in a vibrant and friendly environment.

The culture at Prince of Wales House was an important factor. Staff told inspectors that the management inspire confidence and that they lead by example.

The care was person-centred with a planning process that considered individuals and their views and preferences. Inspectors saw 'My Story' booklets that give a detailed biography of a person's life so far – these are being developed to include people's current interests and relationships, with the clear message that their lives do not stop when they move into this care service.

Our challenge to the adult social care sector

- Use our inspections and assessments to help your service to improve. We are here to help you take the steps towards improvement.

- Recognise the importance of recruiting strong leaders, and give them and their staff the support, training and professional development they need to carry out their roles.

- Services must have a registered manager consistently in post, as this has a crucial influence on the quality of a service. We take action when services that require a registered manager do not have one.

- The sector is under pressure and there are issues of sustainability, due to increasing demand and costs. There is variation across different types of service and across regions. Sector-led improvement needs to focus on reducing that variation, so that everyone using

social care can be confident of receiving safe, compassionate and high-quality care.

- Providers and commissioners should review our findings so far on the quality of different types of care provision, alongside market trends such as larger care homes. It is of utmost importance that responses from local services to financial pressures do not increase the risks to people's health, safety and wellbeing.

- Recruitment and retention of staff, particularly of nurses and care support workers, remain a serious challenge in the adult social care market – one that the whole system, including Health Education England, needs to tackle. We should build on the positive work happening across the country to promote adult social care as a career that makes a difference to people's lives, with a particular focus on reducing the nursing vacancy rate.

Hospitals

Key points

- We have seen some examples of outstanding care despite increased demand for services and challenging efficiency savings. However we have also seen some very poor care. We are concerned that there is too much variation in the standards of care provided within and between trusts.

- The differentiating factors between trusts that are rated outstanding and those rated inadequate are their ability to monitor and act on issues that are identified, sharing the learning from incidents, having a strategy that is communicated and understood by all staff, and promoting a culture of openness.

- We have concerns about the leadership and culture in many trusts. Consistent, good care throughout an organisation can only be achieved by excellent leadership and inclusive staff engagement.

- Of the five key questions we ask of services, safety remains our biggest concern for the sector.

- Staffing levels and skill mix remain an issue in many hospitals.

Introduction and context

Acute healthcare providers in England deliver emergency treatment, medical care, surgical intervention and diagnostic services. Last year, in the NHS alone, there were 22.3 million A&E attendances, a rise of 25% over the last 10 years. There were also 5.5 million emergency admissions to hospital, an increase of 8% since 2011/12. The sector is expected to adapt processes and pathways to better manage the increasing demand, at the same time as achieving ambitious efficiency savings.

We inspect and rate all NHS hospitals and independent hospitals in England. We use a national team of expert hospital inspectors, clinical and other experts (specialist advisors), and people with experience of receiving care (Experts by Experience).

Last year, we prioritised the inspection of NHS acute trusts where our Intelligent Monitoring system showed indications of concern. We began our new approach to inspection in September 2013. By 31 May 2015, we had inspected 47% of acute trusts in England, and inspected several twice due to specific concerns.

We will have inspected all acute trusts by March 2016 and all specialist trusts by June 2016. In autumn 2014, we extended our approach to include independent hospitals as well as NHS trusts. Independent hospitals are now rated in the same way as NHS hospitals, at both hospital and core service level. We have found that our inspection approach works equally well in this sector although – despite some notable developments that are starting in the Private Healthcare Information Network – independent hospitals are still not consistently able to provide robust, comparable data on the quality of care that we can take into account alongside observation, interviews and documentation.

Despite the very real challenges facing acute hospitals and the complexities of how they deliver services, we have seen how outstanding innovation is improving patient care. We have been pleased to give outstanding ratings to two trusts: Salford Royal NHS Foundation Trust and Frimley Park NHS Foundation Trust.

However, we uncovered some very poor care and as a result put a number of NHS trusts into special measures in 2014/15 to ensure they improve.

Fourteen trusts were in special measures at the start of 2014/15, 11 of which had been put into special measures in July 2013 following the Keogh reviews. During 2014/15 a further seven trusts were placed in special measures on the recommendation of the Chief Inspector of Hospitals, following an inadequate rating (figure 2.10).

Five of the initial group of trusts exited special measures following re-inspection by CQC in 2014/15. A further three trusts have subsequently exited – two following re-inspections and one (Heatherwood and Wexham Park) following acquisition by Frimley Park. The outcomes of re-inspections of several more trusts are pending.

Commitment to an open reporting culture
Salford Royal NHS Foundation Trust

Salford Royal NHS Foundation Trust is an integrated provider of hospital, community and primary care services, including the University Teaching Trust. We rated the trust as outstanding.

We found strong leadership, the commitment to be transparent and learn from mistakes, and good staffing to be the foundations of their outstanding rating.

The trust was particularly good at learning from incidents and from patient experiences. A strong, open reporting culture means that incidents were investigated robustly and lessons and action plans are implemented and monitored.

For example, the clinical governance programme, led by the director of nursing, was very strong. Ward clinical standards were assessed through the trust's nursing assessment and accreditation system that measured the quality of care delivered by teams. The score for each ward was then displayed for patients to read. Staff also spoke positively about ensuring that patients received safe, clean and personal care every time.

Quality improvement was a clear focus for the trust through collaboration across all staff groups and a clear vision and strategy. Staff spoke positively about the engagement of the management team, which enhanced a culture of innovation.

Wards were well staffed and staff worked flexibly to ensure any shortages were covered. The trust had some of the best scores in the country on the staff survey, and these views were clear to see during the inspection.

Overall ratings

With almost half of all NHS trusts inspected by 31 May 2015, plus a rapidly increasing number of independent hospitals, we are building up the strongest ever picture of the quality of services in acute settings. Last year we reported that there was too much variation in the standards of care between trusts. This year, our further inspections have confirmed this.

Between the launch of our new approach and 31 May 2015, we have inspected and rated 150 NHS and independent acute hospitals. Of these, two

(1%) were rated outstanding, 51 (34%) were good, 85 (57%) required improvement and 12 (8%) were rated inadequate (figure 2.11).

The overall ratings in the sector show a lower proportion of good and outstanding ratings, compared with primary medical services and adult social care. However, the aggregated ratings at trust level mask the substantial variation among individual hospitals, and similarly for the variation of individual core services within a single hospital.

Continuous improvement
Basildon and Thurrock University Hospitals NHS Foundation Trust, Essex

Strong leadership, alongside innovative staff development, continues to help change the culture at Basildon and Thurrock University Hospitals NHS Foundation Trust in Essex.

The trust was placed in special measures in June 2013, but within a year it had improved significantly and was rated good by CQC, with a recommendation to come out of special measures. We then conducted a follow-up inspection in March 2015, and the trust continues to improve.

The trust has a strong, visible and respected leadership team with a vision to have "care and compassion at the heart of everything we do". Many of the staff spoke about the executive team with enthusiasm and respect.
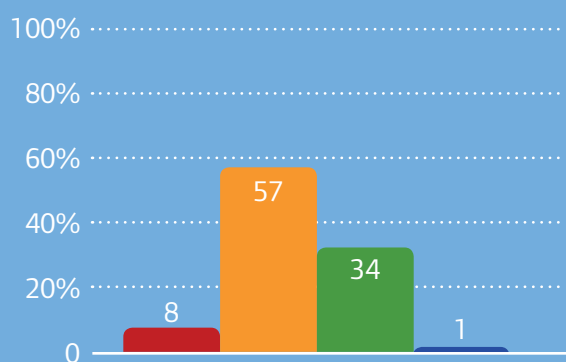
Staff development and support was highlighted in our latest inspection. A new initiative to help develop medical staff in A&E to progress their career to consultant level was seen to be a very innovative response to a national shortage of emergency department medical staff.

Staff were also very aware of their responsibilities and were engaged with the trust's processes. Those working in the medical care areas were very well prepared for major or emergency incidents.

The trust was committed to continuous improvement, for example increasing skill mix and staffing levels in the critical care unit, in order to build on the achievements demonstrated so far.
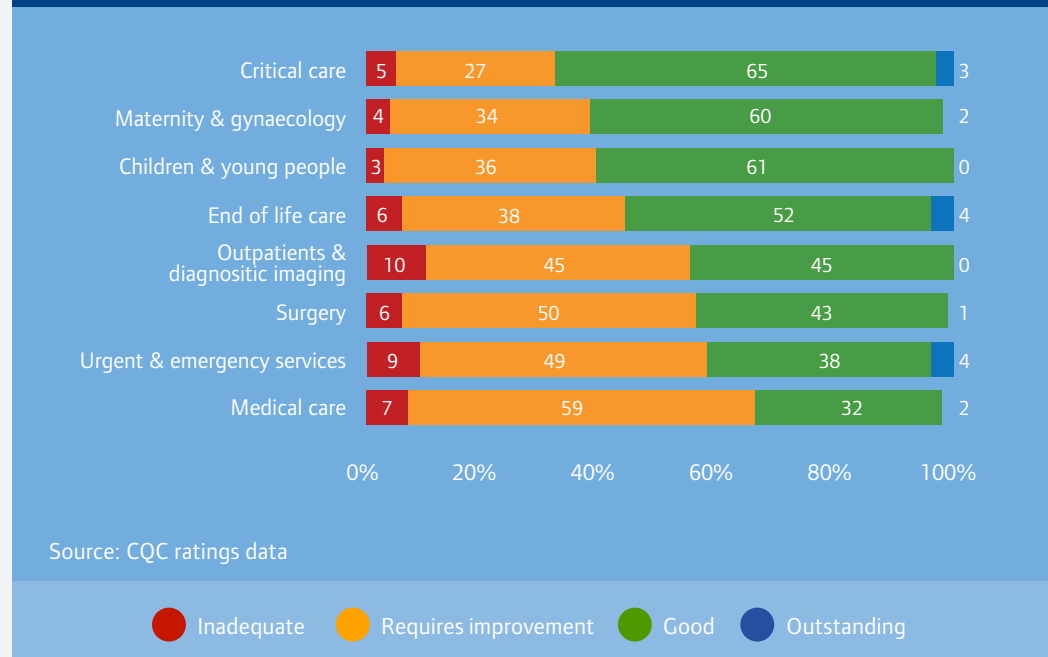
Figure 2.10 Trusts in special measures – April 2014 to August 2015

	Entry	Exited April 2014 March 2015	Exited April 2015 – August 2015
Basildon and Thurrock University Hospitals NHS Foundation Trust	July 2013	●	
George Eliot Hospital NHS Trust	July 2013	●	
Buckinghamshire Healthcare NHS Trust	July 2013	●	
North Lincolnshire and Goole NHS Foundation Trust	July 2013	●	
East Lancashire Hospitals NHS Trust	July 2013	●	
United Lincolnshire Hospitals NHS Trust	July 2013		●
Burton Hospitals NHS Foundation Trust	July 2013		
Tameside Hospital NHS Foundation Trust	July 2013		
North Cumbria University Hospitals NHS Trust	July 2013		
Sherwood Forest Hospitals NHS Foundation Trust	July 2013		
Medway NHS Foundation Trust	July 2013		
The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust	October 2013		●
Colchester Hospital University NHS Foundation Trust	November 2013		
Barking, Havering and Redbridge University Hospitals NHS Trust	December 2013		
Heatherwood and Wexham Park Hospitals NHS Foundation Trust	May 2014		●
University Hospitals of Morecambe Bay NHS Foundation Trust	June 2014		
East Kent Hospitals University NHS Foundation Trust	August 2014		
Wye Valley NHS Trust	October 2014		
Hinchingbrooke Health Care NHS Trust	January 2015		
Norfolk and Suffolk NHS Foundation Trust	February 2015		
Barts Health NHS Trust	March 2015		

Source: CQC ratings data

Figure 2.12 Acute hospital overall core service ratings

Core service	Inadequate	Requires improvement	Good	Outstanding
Critical care	5	27	65	3
Maternity & gynaecology	4	34	60	2
Children & young people	3	36	61	0
End of life care	6	38	52	4
Outpatients & diagnositic imaging	10	45	45	0
Surgery	6	50	43	1
Urgent & emergency services	9	49	38	4
Medical care	7	59	32	2

Source: CQC ratings data

● Inadequate ● Requires improvement ● Good ● Outstanding

What we see in trusts that are rated outstanding

- A culture of openness built around embedded values.
- Strong leadership and teamwork at all levels of the organisation and engagement with staff in identifying and implementing improvements.
- A clear vision and long-term plan for the trust and for individual services.
- Joined up working with the public, ensuring patients and carers are always placed at the centre of care, and are actively engaged and consulted on new developments.
- A culture of consistently focusing on patient safety and learning from errors.

What we see in trusts that are rated inadequate

- Failure to carry out basic safety checks and effectively learn from errors.
- Low staffing numbers and poor skill mix, which affect the trust's ability to deliver safe care.
- A culture where frontline staff are unable or unwilling to raise concerns about patient care.
- Poor patient flow, inappropriate admissions and delayed discharges.
- Day-to-day crisis management rather than long-term planning.
- A history of the leadership team taking false assurance from inadequate information.
- Poor leadership and teamwork in clinical teams that is not being addressed effectively.
- Weak relationships with external stakeholders.

In each acute hospital inspection we look at eight of these core services (where they are provided) and aggregate them to give each separate hospital a rating. The hospital ratings are in turn aggregated to give an overall trust rating. A trust can therefore include many services that are good (or outstanding) but overall be rated, for example, requires improvement because there are enough services with lower ratings to affect the overall rating.

We find significant variation within trusts – for example, we may find good children's services in trusts that are otherwise rated inadequate. Because of this variation in the quality of care across their services, many trusts do not achieve an overall rating of good or outstanding.

Figure 2.12 shows the quality of care in the eight core services. Nationally, critical care offers the highest quality (68% were good or outstanding), while the strongest need for improvement is in medical care (34% were rated good or outstanding).

Urgent and emergency care has the joint highest proportion of outstanding ratings (4%) but also the second highest proportion of inadequate ratings (9%).

The quality of medical care and surgery are the strongest indicator of the quality of the hospital overall, with these services most closely aligned to the hospital rating.

At trust level, there are slight differences between the overall ratings of acute foundation and non-foundation trusts. Of those we inspected up to 31 May 2015, we rated 5% of foundation trusts as outstanding; none of the non-foundation trusts were outstanding. On the other hand, 13% of foundation trusts were rated inadequate overall, compared with 10% of non-foundation trusts.
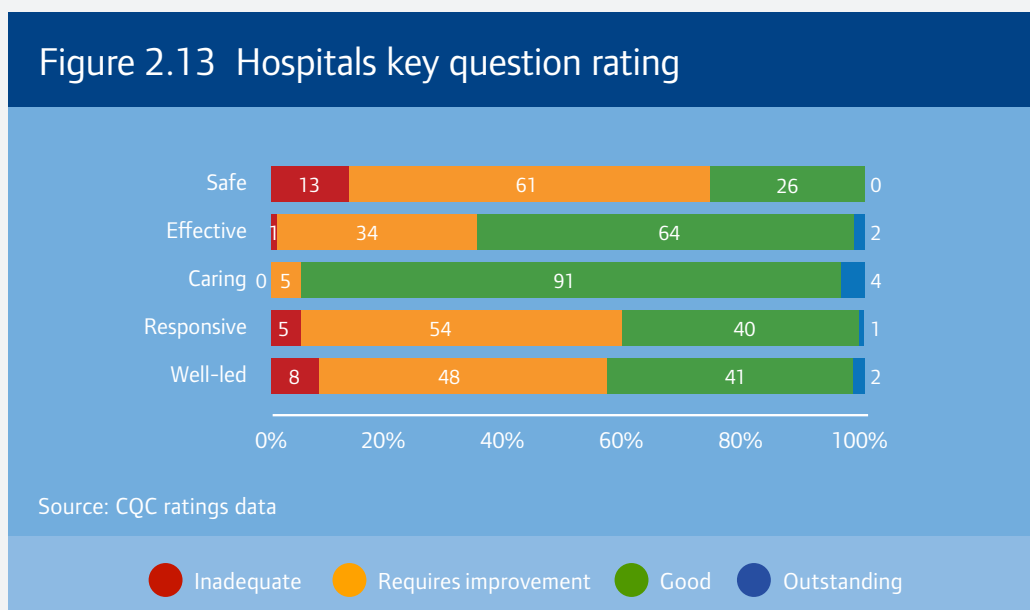
We have also found a relationship between our quality ratings, the level of confidence that patients report in their doctor (from the 2014 NHS inpatient survey), and whether staff would recommend their trust as a place to work or receive treatment (from the 2014 NHS Staff Survey). This shows that the views of staff and patients are good indicators of quality: providers should be taking this feedback very seriously.

Our ratings confirm the wide variation in the quality of care in NHS trusts. We see excellent care that is truly outstanding. But we have been surprised at how truly poor the care can be in those services that we rated inadequate.

Ratings for the five key questions

The safety of services remains our biggest concern. Only 26% of trusts were rated good for safety, and there were no trusts that were rated outstanding (figure 2.13). Sixty-one per cent were rated as requires improvement and 13% as inadequate for safety.

Figure 2.13 Hospitals key question rating

	Inadequate	Requires improvement	Good	Outstanding
Safe	13	61	26	0
Effective	1	34	64	2
Caring	0	5	91	4
Responsive	5	54	40	1
Well-led	8	48	41	2

Source: CQC ratings data

● Inadequate ● Requires improvement ● Good ● Outstanding

Trusts also need to improve in terms of their responsiveness and leadership. Most worrying is that 8% of trusts were inadequate in terms of being well-led.

Services received high ratings for being caring, with 91% rated as good and 4% outstanding. No trusts have yet been rated inadequate for caring.

Safe

By the very nature of hospital services, patients tend to be at a higher risk than in other sectors. Care is complex and varied, and hospital stays mean additional risk factors must be considered, such as falls, pressure ulcers and hospital-acquired infections.

Safety in this environment requires comprehensive processes involving multiple specialisms. However, our inspections have highlighted examples of poor safety cultures, a lack of processes and, in some cases, disregard for patients' safety. In particular we have seen:

- Incomplete safety checks and audits
- Staff not receiving essential training and not undertaking mandatory courses
- Inadequate management of medicines
- Ineffective record keeping.

- Poor management of patients at risk of health complications and ineffective use of the national early warning score (NEWS) system.
- Disregard for infection control practices.
- Unsafe patient streaming processes, for instance non-medically trained staff such as A&E receptionists triaging patients.

The acute sector reported 10% more serious incidents between 2013 and 2014 (figure 2.14). We believe this was primarily a result of the Francis inquiry into Mid Staffordshire NHS Foundation Trust, which made recommendations to include openness, transparency and candour throughout the healthcare system. The rise in reporting is evidence that some hospitals are responding to this need to have a more open, transparent safety culture.

We have found, however, significant inconsistencies in the reporting and investigation of incidents, as well as delays and poor escalation of issues. We have seen poor governance processes where risks were not reported and monitored effectively. In some cases the safety and risk system itself was not fit for purpose as it only looked at trust level and did not reveal local issues. This sometimes left the governing bodies unaware of incidents.

Figure 2.14 Acute hospitals serious incidents 2013 to 2014
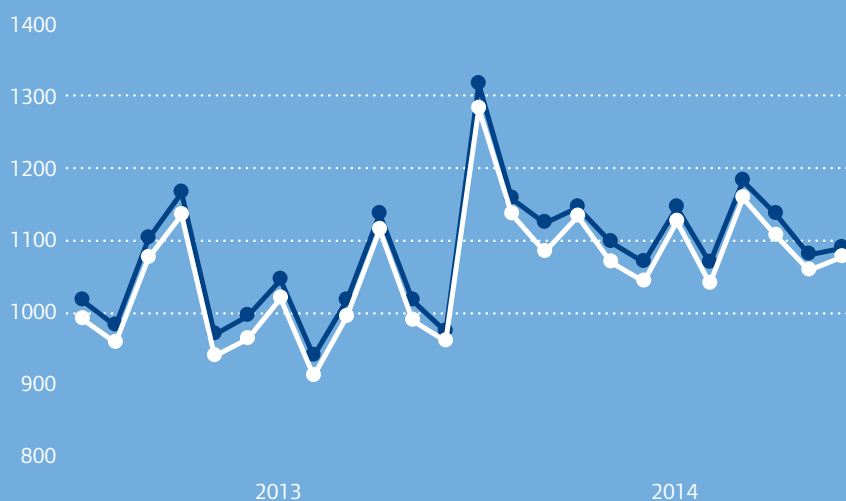
Source: STEIS data 2013-14

● All serious incidents including never events   ○ Serious incidents without never events

Across the sector, trusts have safety and risk management systems of varying quality, but what differentiates providers is their ability to share the learning, act on the issues and concerns that are identified and seek the input of multi-disciplinary colleagues.

In the outstanding trusts, staff actively participate in audits by monitoring patient outcomes and sharing the learning across the trust. Also, staff are confident in reporting incidents, and investigations are carried out impartially. Risks are identified early and detailed reporting dashboards allow monitoring and review of progress. The whole safety and risk management system is further bolstered by good 'board to ward' and 'ward to board' communication.

In trusts rated inadequate, or those that require improvement, there is limited cross-learning between and within departments, with low awareness of improvements that have taken place. After issues are identified there is often a lack of clear plans or proposals for how and when the issues will be addressed.

A major reason for failings in safety is insufficient numbers of staff and use of temporary staff. This is particularly prevalent in medical care departments, where key safety risks are not always recognised, patient assessments can be poorly carried out and deteriorating patients are not always recognised.

There has been some evidence that the special measures regime for trusts has led to improvement. In February 2015, Dr Foster reported that death rates had fallen across all English hospitals since July 2013 but that the downward trend was more pronounced at the group of 11 trusts that were put into special measures in 2013. The rates had decreased by 9.4% in the trusts in special measures, compared with a 3.3% decrease nationally.

Effective

Our inspections have shown that trusts have increased their participation in external benchmarking of outcomes, such as through national clinical audits. However, the results of these audits are not always reported at board level and there is sometimes not enough focus on addressing poor results. Clinical audit programmes and addressing locally-identified clinical risks are much less consistent and are frequently not monitored or managed effectively. Often there is little evidence that they are being used as part of a quality improvement programme.

Most of the core services we have inspected have good systems in place to ensure that evidence-based clinical guidelines are available for clinical staff. However, they are not always updated in a timely way and there are often no audits in place to make sure they are being implemented.

We have seen variable staff understanding of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). In a number of cases, staff did not understand how they should be applying the requirements of the MCA as a whole, or the DoLS in particular, in their roles. In some cases, there was a lack of adequate training for staff in these areas. There was varied understanding, for example, of when an assessment of capacity needed to be made and how a decision was to be made in a patient's best interests under the MCA, when they did not have capacity to consent to treatment. In some instances, staff could not describe when a DoLS application may be required.

There is a growing call for hospitals to move to a full seven-day working service, and we have seen some initiatives where trusts are adapting their business models. However, it is clear that in order to provide a consistent service over the complete week, considerable investment may be needed in support and diagnostic services and social care services, as well as basic medical or nursing care.

Caring

The one-to-one care in hospitals is almost always caring, with staff treating patients with respect, dignity and compassion. In particular, intensive care, services for children and young people, and outpatients achieve good or outstanding ratings for this key question.

In inspections so far, maternity, surgery and medical care have been the only services to show variation across providers of acute care. Two trusts received a rating of inadequate for being caring in one or more core service.

In August 2014, we carried out the first national survey of children and young people about their hospital experiences (figure 2.15). We received responses from 7,000 children and young people and from more than 12,000 parents and carers.

The results were largely very positive – nearly all of the young people said that staff were friendly, and eight out of 10 children said staff talked to them in a way they could understand. However, we did find that children with a learning or physical disability, or a mental health condition tended to have poorer experiences of care in hospital.

We also uncovered differences by ethnicity when we surveyed the experiences of adult inpatients in 2014. Our findings indicated that White people are significantly more likely to report being treated with dignity and respect than Asian and Asian British people. Similarly, the Cancer Patient Experience Survey 2014 told us that White people are more likely to rate their overall care as excellent or very good (figure 2.16). We explore these issues further in our 'Equality in health and social care services' section.

Figure 2.15 Children and young people's survey of their experiences in hospital, 2014
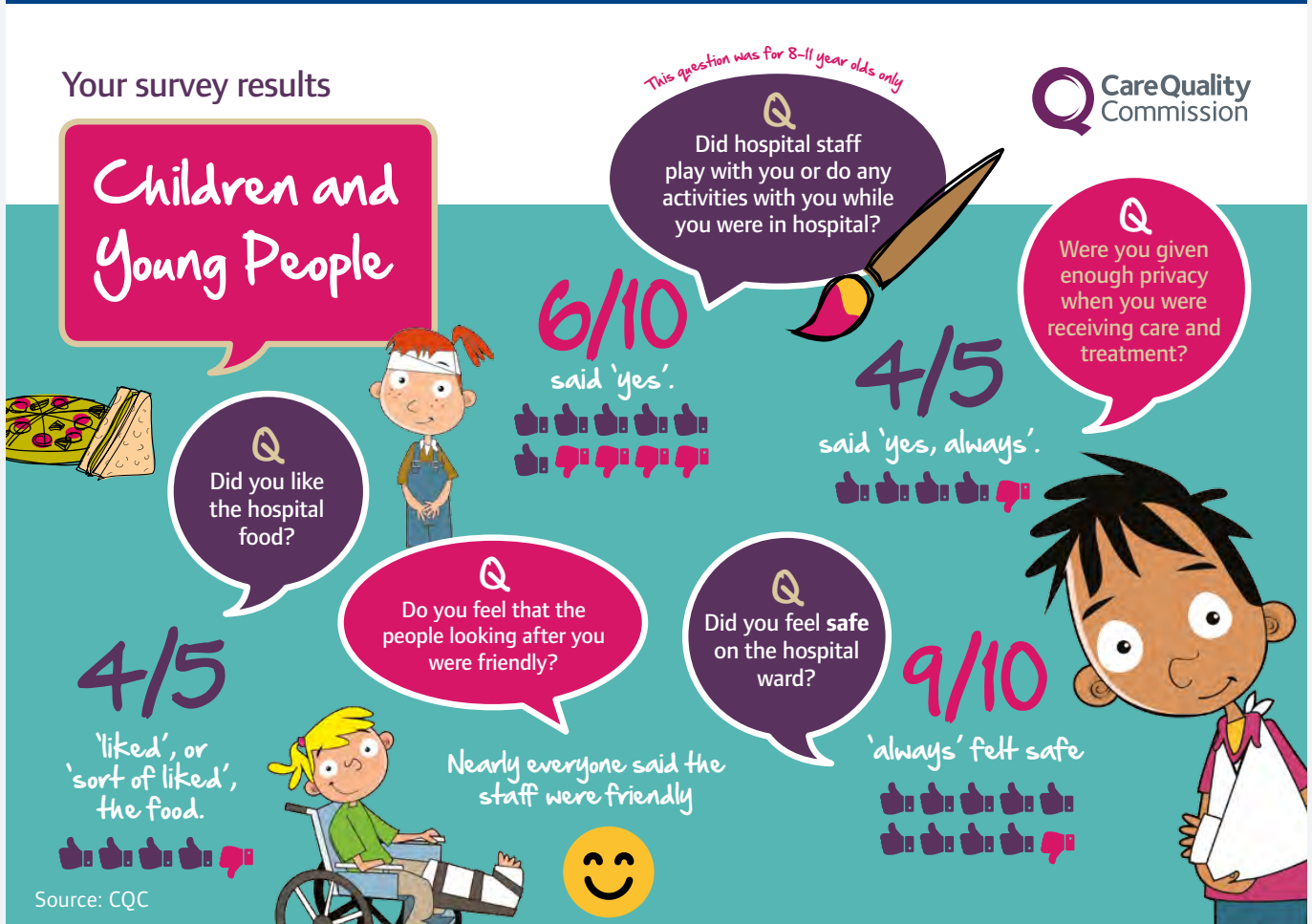
Responsive

Responsive services are those that are organised so that they meet the needs of their patients.

It has been widely documented that, across England, there is a growing increase in the number of A&E attendances and also hospital admissions (an average rise of 3,500 admissions a week in the last year), which has called for a review of patient flow and redesign of care pathways.

Despite the efforts of the majority of trusts, we have continued to see problems with patient admissions and discharges in some cases. High levels of delayed discharges and high bed occupancy rates (consistently above 85%) often lead to patients being cared for on the wrong ward in line with their condition. This, in turn, can lead to missed medical reviews and further delays in discharge.

We saw great variability in the extent to which trusts were actively managing the problem of delayed discharges. Too many regard it as unsolvable.

We also observed capacity issues resulting in long A&E waits and patients being left on trolleys for significant periods. In particular, during the winter of 2014/15, many A&E departments were working under considerable pressure because of an increase in attendances, admissions and acuity of the patients attending. There was, in a number of cases, little evidence that sufficient forward planning had taken place to meet this demand, despite the increase in attendances being generally predictable. Failure to plan ahead led to many hospitals resorting inappropriately to day-to-day crisis management. Some hospitals we inspected had been on the highest level of escalation for weeks. In some organisations we found that the senior management and board members did not put enough focus on the flow of patients through A&E and a degree of acceptance that waiting times would be affected by winter pressures.

Figure 2.16 Cancer patients' reporting of their quality of care by ethnicity
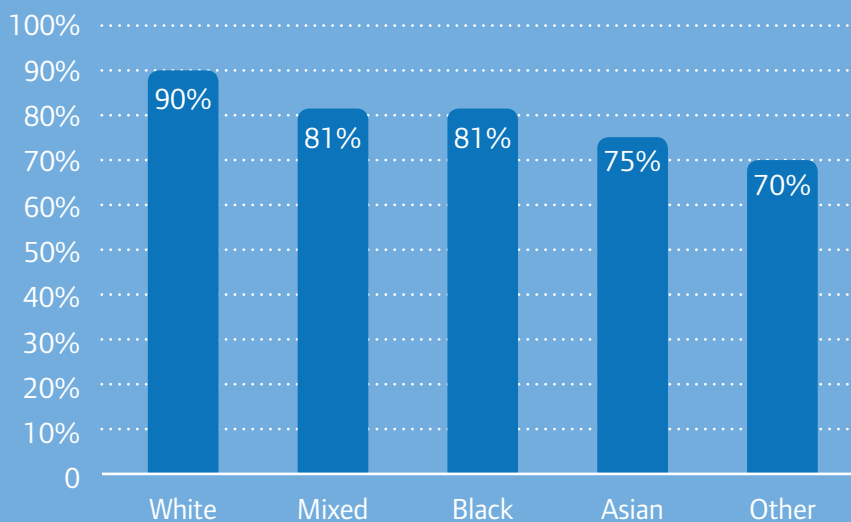
Source: Cancer patient experience survey 2014

Well-led

Good leadership at trust level and clinical team level is essential to provide safe and high-quality patient care. We have found problems at both these levels, often co-existing in the same trust. We find that leaders are frequently unaware of the problems that we find with regard to quality of care, or they are not taking the appropriate action. And there is also a lack of focus on creating the right culture, that emphasises evidence from embedding the values, encouraging transparency and openly apologising when things go wrong.

Where we see good leadership in hospitals, important factors are:

- Strong leadership with a culture of transparency where staff are valued for openly sharing concerns and reporting incidents or near misses.

- Clear lines of accountability and responsibility in all roles.

- Always putting patients first and working with other departments to maximise patient outcomes and experiences.

- Continuous learning, regular appraisals and support to develop specialist and advanced skills.

- Encouragement of all staff to participate in innovative improvements and embed the trust's values.

In our joint report with Monitor and the NHS Trust Development Authority published in August 2014, we reviewed progress in 11 of the first 14 hospital trusts that we put into special measures as a result of the Keogh review into high mortality rates.[49] Of the four factors identified as important in those that had improved, three of them related closely with being well-led: strength of leadership within the trust; acceptance of the scale of the challenges faced by the trust; and alignment or engagement between managers and clinicians.

An inspector's view

"You can often see there is a delay: the trust's very senior staff seven or eight months ahead of the ground staff, they actually think that's been embedded – implementation of policies. But actually when you get down to the ward it's not been implemented, staff don't really know about it. They're disconnected. But where it's good, the work that's gone on is properly translated, embedded and reviewed."

Outstanding multi-disciplinary teamwork
Frimley Park Hospital NHS Foundation Trust, Surrey

When we inspected Frimley Park Hospital NHS Foundation Trust in Surrey, the strength and depth of leadership at both board and ward level was outstanding. One of the most striking aspects was the way that teams worked together across the trust, and with other providers, to make sure that people were getting the best possible treatment and care.

Frimley Park was rated as outstanding in September 2014 – the first acute trust to receive the top rating.

A strong patient-centred culture was evident at all levels. Public engagement was seen as essential in developing services for the communities that the hospital serves. Gaining feedback from patients and their relatives was a priority and the trust used this to improve the care it delivered.

Inspectors saw multiple examples of how services had changed care delivery based on public feedback or working with the local community. The trust had worked hard to support patients whose situations made them vulnerable, such as those living with dementia or a learning disability.

The trust consistently demonstrated a strong safety culture, which was well embedded and a priority for staff at all levels. Learning from events was encouraged, and there were multiple examples where services had been improved as a result.

Staff and patient engagement at the trust were also outstanding. The leadership team were authentic, strong and effective, and at all levels staff reported feeling empowered to develop their own solutions to improve services. There was a strong sense of support and alignment between clinicians, managers and the executive team, who worked well together to deliver outstanding patient care.

Since our rating, the trust has acquired Heatherwood and Wexham Park Hospitals NHS Foundation Trust. They are focusing on clinical leadership to extend their culture of learning with an emphasis on values and support of frontline staff.

In contrast, evidence from trusts rated inadequate included:

- Staff that feel discouraged to report incidents due to a lack of follow-up action or feedback from incidents. Also, staff that are generally reluctant to speak out because they are afraid of repercussions, especially in trusts that are smaller in size.

- A culture of bullying in some cases.

- Low levels of annual appraisals and monitoring of staff needs.

- Frequent changes to management that lead to a lack of engagement and support, making it difficult for staff to develop plans for the future.

- A lack of understanding and following best practice guidelines.

- A lack of vision or long-term planning for the future of clinical services.

- Staff that feel well-supported by immediate line managers, but disconnected from the executive team.

- Inadequate challenge by non-executive directors and, for foundation trusts, governors.

Where we find good services in an otherwise poor trust, this is invariably down to excellent local leadership. What is disappointing is that trusts often do not recognise their own individual successes and share the learning from them among all staff. Leaders in NHS organisations need to demonstrate a commitment to developing a culture that delivers continually improving, high-quality patient care. They must:

- Identify clear objectives in collaboration with staff throughout the organisation.

- Develop multiple avenues for staff engagement and two-way communication.

- Support learning and innovation in all staff.

- Encourage teamworking.

An inspector's view

"There was lots of discussion with all staff involved, sharing learning and allowing staff to openly contribute."

Our challenge to the hospitals sector

- Move your focus from developing individual, short-term quality initiatives to creating the right culture in which staff are able work with autonomy and confidence. Adopt strong values and embed them into your decision-making processes.

- Focus on creating a culture of openness where staff feel empowered to raise issues and make suggestions for improvement, knowing they will be valued

- Patients must be able to complain with the confidence that they will be listened to, and you should actively reassure patients that raising a complaint will not negatively impact on the standard of care they receive.

- Use the findings from your staff surveys to improve morale and encourage continuous two-way communication.

Mental health

Key points

- Across the eight NHS mental health trusts that we rated by 31 May 2015, we rated the individual core services mostly as good (65%) or requires improvement (31%).

- There are some excellent examples of local leadership (for example ward managers), but we found that some boards were unaware of whether their decisions were having any impact on frontline services.

- Our biggest overall concern is the safety of care environments, particularly wards. These are not good enough and are creating risks to patients.

- Our report, *Right here, right now*, highlighted that the attitudes of staff can have a big impact, particularly for those in crisis. All staff, from receptionists to GPs and A&E staff, need to treat people with mental health problems with the kindness, dignity and respect they would provide to people with physical health needs.

- Access to beds, particularly in child and adolescent mental health services, continues to be a problem and leads to people being placed hundreds of miles away from their families.

Introduction and context

Mental illness is the single largest cause of disability in England. It accounts for 23% of the total burden of disease in this country – more than either cancer or heart disease.[50, 51] Despite this, recent estimates are that spending on mental health services forms just 11% of the NHS budget.[52]

As signalled in the NHS *Five Year Forward View*, the Mental Health Taskforce was launched in March 2015 to explore the availability of mental health services across England, look at the outcomes for people using these services, and identify key priorities for improvement. As part of their work, the Taskforce collected the views of 20,000 patients, carers, healthcare professionals and the public on the reshaping of mental health services. The top five calls for change by 2020 were: better access to high-quality services, a wider choice of treatments, more focus on prevention, more funding and less stigma.

The landscape of mental health care in England is complex. We register and inspect mental health NHS trusts, independent mental health hospitals and substance misuse services. These organisations care for people with a wide range of mental health needs in a variety of settings from community and residential care to crisis care services and detention under the Mental Health Act 1983 (MHA).

This landscape is also evolving. Organisations that were once traditionally just mental health services are now also managing, for example, dental surgeries, GP surgeries, community health services, care homes and healthcare services in prisons. In some instances, these are spread across the country, challenging organisations' capability and expertise to manage them.

Within this complex picture, we are continuing our work to better integrate our functions under the MHA and the Health and Social Care Act 2008. As part of this, every CQC comprehensive inspection of a service where there are detained patients includes a Mental Health Act Reviewer. The Reviewer looks at the way the provider discharges its duties under the MHA overall. We have seen pockets of good practice in the way that services use the MHA, but we have had to ask some providers to improve their governance systems and processes to make sure that the care and treatment they provide is in line with the Code of Practice and patients' rights.

In July 2015, with partners we published an update on how we are working together to make sure people with learning disabilities and/or autism, and those with challenging behaviours, get the best care possible in settings that are most appropriate to them.[53] This follows Sir Stephen Bubb's independent review into the future care of people with learning disabilities. We are further developing our work on registration, to make sure that inappropriate models of care do not continue after providers have applied to vary the type of service that they want to offer, and for new applications to only be approved if they reflect an agreed model of care.

Through our inspections we are forming a better picture of the state of mental health care in England. It is important to note, however, that due to the low volume of ratings published to date, we have limited data available so far under our new approach to inspection. As a result, the themes emerging in this report are based on our inspection report findings and evidence from our inspectors.

Overall ratings

Of all 57 NHS mental health trusts, we had inspected 18 (32%) and we had rated eight (14%) by 31 May 2015 (the remainder being part of our piloting phase). Of the eight NHS mental health trusts rated so far, four were good, three required improvement and one was rated inadequate.

We also inspected 14 independent mental health services by 31 May 2015, of which we rated seven. We were pleased in July 2015 to award the first outstanding rating to the North London Clinic.

Under our new approach, there are 11 core services that we will always inspect as part of our comprehensive inspections (figure 2.17).

We rate each of the core services on whether they are safe, effective, caring, responsive and well-led. We then use these ratings to determine how well the trust

is performing overall for each of these key questions.

The number of ratings for core services is too small at present to draw any particular conclusions about their relative performance. Of the 116 core services that we rated across both NHS and independent services, one (1%) was outstanding, 75 (65%) were good, 36 (31%) required improvement and four (3%) were inadequate (figure 2.18). We need to carry out more core service inspections before we are able to highlight any patterns of ratings.

Figure 2.17 Mental health core services inspected by CQC

Mental health wards	Community-based mental health and crisis response services
Acute wards for adults of working age and psychiatric intensive care units	Community-based mental health services for adults of working age
Long stay/rehabilitation mental health wards for working age adults	Mental health crisis services and health-based places of safety
Forensic inpatient/secure wards	Specialist community mental health services for children and young people
Child and adolescent mental health wards	Community-based mental health services for older people
Wards for older people with mental health problems	Community mental health services for people with a learning disability or autism
Wards for people with a learning disability or autism	

Improvement and learning is embedded
The North London Clinic, Edmonton

The North London Clinic in the Edmonton area of London is an independent hospital providing mental health services – forensic and long-stay rehabilitation care – for men. When we inspected we found a solid and committed leadership team driving change across the clinic.

We rated the clinic as outstanding, the first mental health provider to be rated outstanding under our new approach. This is particularly impressive given the challenges of this patient group.

The clinic was very patient-focused and patients were closely involved with the design and delivery of the service, with staff acting on their suggestions. For example 'living together' groups brought patients together to discuss how to improve their environment and clinic experience.

The multi-disciplinary team continuously sought creative ways to improve outcomes for the people in their care. For example, the clinic had introduced a work experience programme and patients received

dedicated support to prepare their CVs and apply for roles at the clinic, such as vehicle maintenance assistant or onsite shop manager. The clinic also offered English and maths tutorials to patients.

The service was also committed to reducing restrictions for patients. Additional staff were brought in to accompany patients during their leave (walks around the grounds, day trips) – allowing them freedom, but within safe boundaries.

There was a real sense across the service that continuous improvement and learning were embedded in the culture. The senior leadership team at board and ward level were open and transparent. They were committed to working together, learning from mistakes, and recognising, addressing and improving any shortfalls in the service.

* Note that the inspection report for this inspection was published on 28 July 2015, and is therefore not included in the analysis of inspections for this chapter (which had a cut off date for published reports of 31 May 2015).

Issues by key question

Looking at the rating for mental health services overall, services perform well in respect of caring. Our biggest concern is around the safety of the care being provided.

Mental Health Act

Each year, we publish a separate statutory report on the use of the MHA and the experiences of patients who receive care under the Act. In our 2013/14 report we expressed our concern that people across England are being detained under the MHA without their legal rights being discussed or explained to them, without being fully assessed for their willingness and ability to consent to their treatment, and without always having easy access to appropriate independent advice. Our findings from 2014/15 will be published in our MHA annual report later this year.

Safe

Our inspections show that safety is an area where trusts are frequently failing and need to make significant improvements.

It is not possible to eliminate all risks and sometimes a balance needs to be struck between creating a ward that allows staff to observe patients and one that gives people a degree of dignity and privacy. However, the safety of care environments, particularly wards, is not good enough. Often services have to manage the limitations of old buildings that do not meet modern requirements for design of a mental health facility. This can include managing increased risks for patients, for example the provision of separate accommodation for men and women and the removal of fittings and fixtures that people at risk of suicide might use to harm themselves.

In 2011, the Chief Nursing Officer and Deputy NHS Chief Executive required providers to declare that they would phase out all mixed sex accommodation by April that year. However, in our inspections we are still finding concerns about gender segregation. Many of these are directly linked to the physical design and maintenance of the buildings, with issues such as a lack of female-only lounges, or bathrooms designated for female use being accessible through mixed gender areas.

Figure 2.18 Mental health and community ratings at overall service level
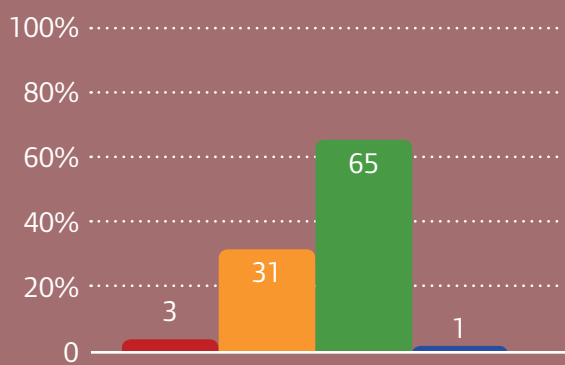
Source: CQC ratings data

● Inadequate   ● Requires improvement   ● Good   ● Outstanding

An inspector's view

"So the ligature risk assessment has probably been done, but nothing being done to mitigate the risk, that's a common thing – they've found the risks, they know they are there but they aren't doing anything to manage it safely."

Although the number of inpatients who commit suicide is reducing, in 2013, 67 people killed themselves while on a psychiatric ward.[54] Thirteen people killed themselves by hanging or self-strangulation using ligature points. Ligature points are anything that can be used to attach a cord, rope or other material for the purpose of hanging or strangulation. These include shower rails, coat hooks, pipes, radiators, window and door frames and hinges and closures. While we recognise that it is not always possible to get rid of ligature risks, how these risks are managed, prevented and reviewed is important. We have seen good examples where services had used ligature risk assessment tools to review risks and draw up action plans, but some services have not taken structured approaches to managing risk.

We are also concerned that our reports are highlighting problems with wards having the right number of staff. The Francis report in 2013 showed that inadequate staffing leads to poor quality care.[55] We are concerned that from September 2009 to March 2015 there was a 15% fall in the total number of inpatient psychiatric nurses – the equivalent of 4,000 nurses.[56] A report by the King's Fund on workforce planning in the NHS showed that, between 2009 and 2014, there had also been an increase in the use of bank and agency psychiatric nurses.[57] In addition, its analysis of NHS Professionals data found that the number of agency and bank staff hours requested by mental health trusts has increased by around two-thirds since the beginning of 2013/14.

While factors such as the transfer of nurses to voluntary and independent providers will influence these figures, the independent sector would need to be growing very rapidly in order to offset such consistent declines in the NHS workforce.

Effective

When we look at whether a trust is effective, we want to find out whether it is providing people with care, treatment and support that achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

One of the ways we do this is to check whether the organisation has staff with the right skills to deliver the right care, and provides appropriate training to keep these skills up to date. Our reports show that most staff in mental health organisations are appropriately trained and given the opportunity to develop their skills. This is supported by figures from the NHS staff survey, which show that 80% of staff said they received job-relevant training and were given the opportunity to learn and develop. However, of the 87% who said they had received an appraisal in the last 12 months, just under half (42%) felt that their appraisals were well structured (figure 2.19).

Caring

During each of our inspections, the inspection team members speak with hundreds of people who use services. Many of these interviews are conducted by Experts by Experience who themselves have experienced mental health care. On most inspections, the majority of people who use services talk positively about the caring nature of the individual staff members that they come into contact with.
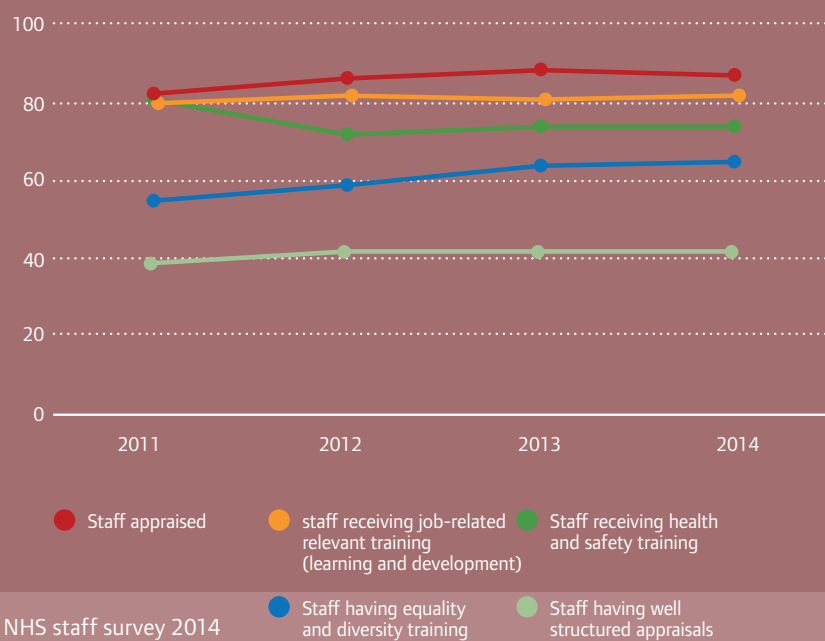
Challenging ward environments

A hospital had particular challenges on some of the ward environments due to the age, design and fabric of the building. However, overall the wards were clean and the provider had a maintenance programme in place to address these issues. For example, on one ward, which was located in the basement of the building, there was damp in one of the bedrooms. On another, there was an old fire escape door that allowed a draught and rain in through the base. The provider had taken action to address these issues by closing off the bedroom until further remedial work was completed and ordering a new fire door.

But we know that this will not be everyone's experience of mental health care. As part of our review of crisis care services for our *Right here, right now* report we held a call for evidence for six weeks in spring 2014. Forty-two per cent of respondents felt that the care they received failed to provide the right response and didn't help to resolve their crisis.

Outside of the voluntary sector, GPs were rated highest (70%) by respondents when asked whether a service made them feel respected when they tried to access it in a crisis. Only 52% of respondents felt that their community-based mental health teams treated them with warmth and compassion, and this dropped to 46% for crisis resolution home treatment teams (figure 2.20). In A&E only a third (34%) of respondents said they received warmth and compassion. Anecdotal stories we received suggested that there are some A&E staff who view people with mental ill-health as a burden that gets in the way of dealing with other patients.[58]

Figure 2.19 Mental health staff appraisals and training 2014

- Staff appraised
- staff receiving job-related relevant training (learning and development)
- Staff receiving health and safety training
- Staff having equality and diversity training
- Staff having well structured appraisals

Source: NHS staff survey 2014

Well trained staff

In a rehabilitation service at an NHS trust, the training records showed that staff had access to a range of training relevant to their role. Staff told us that they felt well supported by their local manager in relation to training.

Staff received regular clinical supervision and annual appraisals in line with trust policy. The ward had an established, 'Reflective Practice Group' that staff attended to discuss clinical issues. Staff told us they valued these sessions and found them very beneficial.

The Health and Social Care Act 2012 is clear that people who use mental health services should expect to receive the same quality of care as people who use physical health services. However, results from the NHS inpatient survey 2014 also show that people with long-term mental health conditions are less likely to report being treated with respect and dignity in hospital.

The attitudes of staff can have a big impact, particularly for those in crisis. All staff need to treat people with mental health problems with the kindness, dignity and respect they would provide to people with physical health needs.

It is clear that all services have work to do in improving how their staff respond to people in crisis. Every local area in the country has a local Crisis Care Concordat group and a multi-agency action plan in place that sets out how they intend to improve mental health crisis services. Local leaders need to deliver on their commitments.

We have made recommendations that local Crisis Care Concordat groups make sure that all ways into crisis care are focused on providing accessible and available help, care and support for all those who require it at the time they need it. They should also take responsibility for holding commissioners to account for commissioning crisis services that deliver a quality of care based on evidence-based good practice and that is in line with the Concordat's key principles.

LIGATURE POINTS
good practice example

In an NHS trust, staff knew and understood the ligature risks in the environment. For example, a bedroom was equipped for women with disabilities but which had known ligature risks. As a result, women were risk assessed before being allocated to the room. One-to-one observations of women were used when the level of risk was judged to be high.

LIGATURE POINTS
poor practice example

A long-stay unit at an NHS trust had carried out a ligature audit that had identified some ligature risks but not all. There were still a significant number of ligature risks within the ward environment, both high and low level, including in people's bedrooms and bathrooms. Risks we found included two balcony galleries on the first floor overlooking open communal areas below. People could jump or fall over these balconies. Both also had ligature points that people could access. These balconies exposed people to unnecessary and avoidable risk.

Impact of relying on temporary staffing

At a mental health trust, we saw that there were five staff on duty during the day and four at night. The ward manager told us that for various reasons a number of qualified nurses had left… This meant that there had been a high use of bank and agency staff over the last six months. One person who used the service said that at night there were often agency staff who did not know them, so they did not feel safe at all times.

Figure 2.20 CQC's call for evidence 2014: "I felt" statements

Service	I was treated with warmth and compassion	
	Yes	No
Volunteers or a charity	88%	8%
GP	65%	26%
Telephone helpline	63%	29%
NHS ambulance	63%	23%
Community-based mental health team	52%	39%
Crisis Resolution Home Treatment team	46%	43%
A&E department	34%	53%

Note: Excludes respondents who were "not sure". Table only includes services that were selected by at least 10% of respondents to our call for evidence. Source: CQC, *Right here right now,* 2015

Impact of staff attitudes

"I had not been taken seriously at triage. I explained how distressed I was feeling as I had been assaulted and how badly I was bleeding. I explained that if I lay down the bleeding was much less severe. The triage nurse was very dismissive and said there were no cubicles free and that I would have a long wait. She told me I would have to lie on the floor of the toilets if I needed to lie down that badly.

They accused me of self-harm while I was in the toilets, which was not the case. I was terrified, humiliated and upset, and could not calm myself down or trust anybody for the rest of my admission, leading to disturbance and distress for other patients.

I felt completely humiliated and was unable to trust the psychiatric staff and home treatment team that attempted to help me afterwards. I was unable to attend outpatient appointments as I felt so humiliated by my experiences and so ashamed."

CQC *Right here, right now,* 2015

Responsive

A responsive service is one that is organised so that it meets people's needs. Our ratings show that the majority (63%) of NHS mental health organisations are performing well in this area.

However, we are continuing to find issues, for example with access to beds. The NHS England Bed Availability and Occupancy Data for quarter 4 of 2014/15 shows that 89.6% of mental health beds were occupied overnight.[59] This is concerning as research in the acute sector has shown that bed occupancy levels above 85% can affect the quality of care that people receive.[60]

Accessing beds is a particular problem in child and adolescent mental health services (CAMHS), with children being placed in beds miles away from home or on adult mental health wards when there are no beds available elsewhere. This is inappropriate and unacceptable, and may indicate an issue with the commissioning of inpatient services.

This issue is highlighted in figure 2.21. It shows that, on average, people under 16 spent an average of 300 bed days in adult mental health inpatient settings each month during 2014/15. This equates to at least 10 children under 16 being placed in inappropriate settings every month. The figure is also probably higher than this and could be as many as 300 children, depending on how quickly they are moved off adult wards after they are admitted.

Accessing the right help at the right time is a problem that we are seeing across mental health services, particularly crisis care. Respondents to our call for evidence on crisis care services told us that people are turning to A&E because they do not feel they can access the help they need elsewhere, or because they have been told to go there by another service. For instance, one local group told us: "People are no longer receiving the level of support in the community that they used to. Out-of-hours people often have to resort to presenting at A&E." [61]

Figure 2.21 Number of bed days on adult wards for under 18s each month
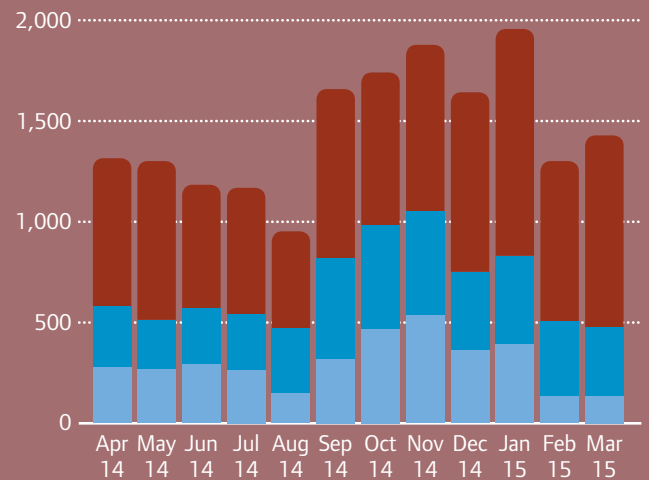
Source: MHLDDS/MHMDS by the Health and Social Care Information Centre

● 17 years old   ● 16 years old   ● Under 16

Impact of bed availability

In a mental health trust, all the wards we visited were full and the majority of patients on the wards were detained under the Mental Health Act 1983… as a result of the over-occupancy of wards, beds were not always available for patients on their return from leave. For the first two months of 2015 there were 68 occasions… when a bed was not available to patients… or there were delays to a patient receiving a bed.

Between November 2014 and January 2015 there were a total of 57 occasions where patients did not have a bed to sleep in and slept on the sofa or in the quiet room on a temporary bed. One person… spent 32 hours in the assessment area… when no bed was available… Between November 2014 and January 2015 there were 85 occasions across the acute wards where patients slept on a ward other than the one they were admitted onto… some patients were transferred during the night… Patients told us that when they refused to move they were accommodated on sofas on the wards.

Helping people before they reach crisis point, or preventing a crisis from escalating, helps to reduce delays to treatment, prevents relapses and reduces the long-term impact of the condition. Over the last four years demand for early intervention in psychosis centres has fluctuated, but the number of cases continues to surpass the annual target of 7,500 by 35-40% every year, illustrating the need for these types of services (figure 2.22).

Well-led

Mental health organisations are often very large, with a number of services spread across a big geographical area, making effective and integrated leadership and engaging with staff very challenging.

We have found issues with board assurance and governance processes, with some boards unaware of whether their decisions were having any impact on frontline services. We also found examples where there were significant gaps or inaccuracies in data that were provided to boards and no clarity on how decisions taken by the board would address performance issues.

Lack of beds for children

In a child and adolescent mental health service, parents told us about the impact of the closing of local inpatient beds. It meant that when children needed inpatient (or Tier 4) beds they were often sent out of the area. One parent told us that their child was "103 miles away, costing £100 to visit". Parents and staff told us of their distress when another child had to be admitted to a unit 126 miles away. We were told that the local children's units were invariably full and that children were being sent anywhere in the country and "being shoved into adult wards".

Figure 2.22 Number of new cases of psychosis served by early intervention teams by quarter
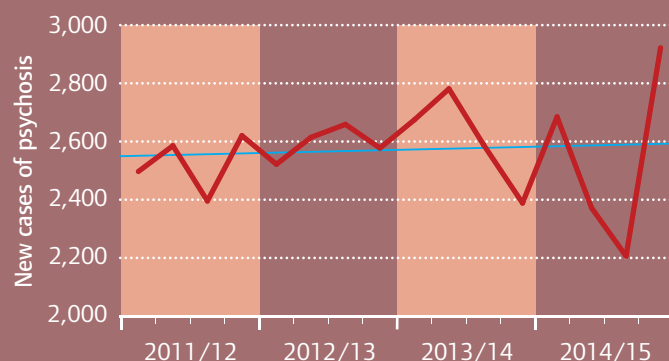
Source: NHS England, Mental Health Community Teams Activity, 2011 2015

What good local leadership looks like

In a forensic service, staff told us they felt confident raising any concerns or ideas to improve the service with their manager and were confident they would be listened to. Staff said they shared their views in a number of ways, including staff meetings, group supervision, away days and governance meetings. Staff told us the senior managers on the ward were visible, approachable and had an open door policy. They told us the managers and teams were open to trying new ways of working to improve the service.

USING FEEDBACK
good practice example

In a perinatal service, women, their partners and other professionals were asked to complete feedback questionnaires in order to develop an understanding of how they experienced the service. Analysis of responses helped to identify where improvements could be made to service delivery.

In addition, some staff did not feel engaged with the trust's visions and values, or involved with the development of the service. This can leave staff feeling demoralised and disconnected from senior management. Not having clear and effective governance structures in place, where staff can feed back to the board and get regular updates, can have a direct impact on the safe delivery of a service.

Good local leadership is equally important. We have seen some great examples, with visible, approachable and supportive managers creating an open culture where staff feel comfortable reporting incidents or putting ideas forward for improvements.

Making sure that local and senior leadership is integrated is very important for ensuring quality and safety. In well-led trusts, there are clear and effective governance structures in place that support the safe delivery of the service. In addition, there is good communication between local and senior management, and effective systems in place for both gathering and using feedback from people to improve their service.

An inspector's view

"There was a real commitment at all levels, from the chief executive to the ward managers, so you could see a kind of movement… they knew where their problems were and they had plans in place."

Our challenge to the mental health sector

- The layout and features of some old buildings that house mental health wards pose a risk to patients. We urge providers to undertake regular assessments of these risks and to take steps to mitigate against them. These steps should ensure that people at risk of suicide are kept safe.

- New build and refurbishment projects should be informed by the best practice standards suggested in building guidance, such as the Department of Health's Health Building Note on adult acute mental health units.[62] Services not covered directly by such guidance should consider and adapt its suggestions as appropriate.

- Staff in the emergency departments of general hospitals must show the same degree of kindness, dignity and respect to people with mental health problems that they would give to people with physical health needs.

- The senior managers of large mental health providers that deliver care from multiple locations must ensure that they have high-quality information about the performance of all of their services. They must also ensure that all of their staff share a common purpose and set of values.

- Local and national commissioners should work with providers to ensure that people who require inpatient care have access to a bed close to their home. This applies particularly to young people.

Primary medical services

Key points

- While most of the GP practices and GP out-of-hours services that we have rated up to 31 May 2015 are providing good care to their patients, we have been shocked at the very poor care provided by the 4% of practices that we have rated inadequate.

- Our inspections have highlighted a strong link between good leadership and good care. Likewise, the practices rated inadequate suffer from poor leadership and a failure to focus on what they need to do to improve.

- There is room for improvement in the safety culture in GP practices. We have seen examples of poor incident reporting and a lack of learning from significant events, as well as evidence of poor medicines management.

- GP practices deliver a better quality of care when sharing learning and providing joined-up care through multi-professional networks. Single handed practices are more likely to work in professional isolation, resulting in a lack of communication and engagement with staff and patients, and an environment that is not open and transparent.

- There is a need for GP practices to review access to medical advice and treatment to ensure they are in line with patients' needs.

Introduction and context

General practice and wider primary care services are under increasing strain. As well as tackling financial challenges, GPs are under pressure to effectively manage the rising demand on their services. An ageing population, more people with multiple health conditions and an increase in people living with long-term conditions (the number of people living with diabetes in the UK has soared by 60% in a decade[63]) are all placing a high demand on GPs across the country.

Pressure is also mounting from a rise in the number of patients registered with a GP and the number of unfilled GP posts. With fewer people entering the profession (in 2014, 12% of GP training posts went unfilled[64]) and 34% of GPs considering retirement in the next five years[65], the sector faces pressure to ensure that existing workforce numbers are sufficient to meet the current demand.

Through our Primary Medical Services and Integrated Care directorate we regulate and inspect a wide range of services:

Figure 2.23 Primary Medical Services and Integrated Care directorate – what we inspect and regulate

GP practices and GP out-of-hours services	By 31 May 2015 we had inspected and rated 976 GP practices and out-of-hours services* (11% of the total we have registered). We aim to have inspected and rated all services by Autumn 2016. Overall there are 8,405 GP service locations on our register. We have started to see new types of provider entering the market that are using Skype, email and web-based methods for consultation. We are also seeing an increasing number of multi-site practices – both through mergers and acquisitions between trusts and GP surgeries and consolidation and federation of GP practices.
Dental care services	There are 10,295 dental care locations on our register. We began our new approach to inspecting and regulating dental services on 1 April 2015 (we will inspect 10% of services a year and we will not rate them). In 2014/15, we continued to inspect services under our old approach.
Health and justice	We inspect, but do not rate, health and social care in prisons and young offender institutions. We also inspect, but do not rate, health care in immigration removal centres, police custody centres, secure training centres and youth offending teams in the community. We conduct this work with HMI Prisons, HMI Probation, HMI Constabulary and Ofsted.
Remote clinical advice	We have started to develop a methodology for regulating providers of remotely-delivered clinical advice.
Urgent care services	We inspect and rate a range of urgent care services such as NHS 111, walk-in centres, minor injury units and urgent care centres as part of our inspection of the primary care provider.
Children's health and children's safeguarding	We inspect, but do not rate, local health service arrangements for safeguarding children and improving the health of looked-after children. Some of this work is conducted with Ofsted, HMI Constabulary and HMI Probation.

* This figure includes two urgent care services and one independent consulting doctor service.

Overall ratings

Despite the challenges faced by the sector, the vast majority (85%) of the GP practices and GP out-of-hours services that we rated up to 31 May 2015 are providing good or outstanding care (figure 2.24). At a challenging time for primary care, there are many practices finding innovative ways of meeting the needs of their local population, and this is something that should be celebrated.
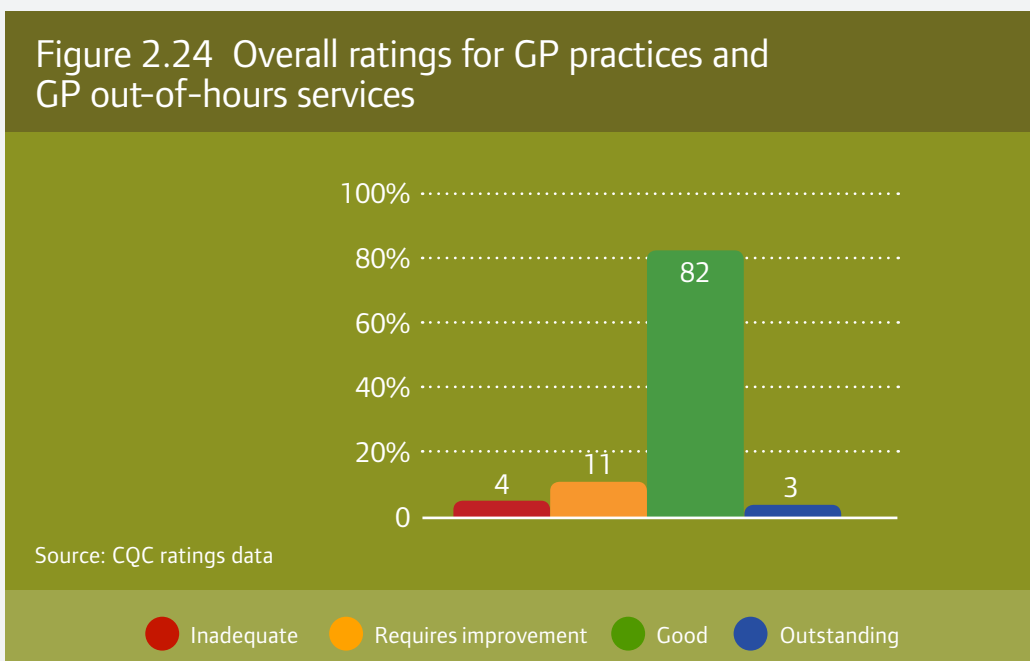
Almost one in nine (11%) of the GP practices we inspected required improvement.

Four per cent of those we inspected were rated inadequate. During 2014/15 we introduced a special measures programme for GP practices. Where we rate a practice as inadequate, the practice is given a defined amount of time to address the issues we have identified, normally six months. The practice is supported in this by NHS England and, in some cases, by the Royal College of General Practitioners. At the end of this period, we inspect again to check whether enough improvement has been made by the practice to bring it out of the regime. If the practice has not made sufficient progress they have another six months to improve before enforcement action is taken against the practice, normally resulting in the cancellation of its registration with CQC.

Up to the end of May 2015 we had placed 30 GP practices that were rated inadequate into special measures. As of 2 September 2015, we had re-inspected two of them, with one now being rated good.

We remain concerned by the very poor care we find in some practices through our inspections. Some of this care is shocking. We have recently cancelled the registration of some practices where we found very poor care, and where there was a real concern about the safety of patients. Where we cancel a registration, it means that the provider cannot legally continue to provide a service, and we work with NHS England to ensure alternative arrangements are made for patients.

For example, following an inspection in June 2015 we cancelled the registration of a GP practice because inspectors had serious concerns about the service and the risks to people using it. During the inspection we identified one locum staff member who had treated patients but could not provide evidence that they were medically qualified to do so. The management of medicines was found to be unsafe and placed patients at serious risk of harm.

Figure 2.24 Overall ratings for GP practices and GP out-of-hours services

Source: CQC ratings data

● Inadequate   ● Requires improvement   ● Good   ● Outstanding

Medicines were found to be out of date, which rendered them unsafe, and requests for prescriptions had not been processed in a timely manner to ensure patients had access to their medicines. Despite urgent appointments being available on the day they were requested, patients stated that they had to wait a long time for non-urgent appointments and found it very difficult to get through to the practice when phoning to make an appointment.

We also have the ability to temporarily suspend a provider's registration where we have serious concerns but we think that these concerns can be addressed. An example of where we have used this power is with a single-handed GP based in London. CQC had concerns about the performance at the practice since its first inspection in December 2013. Further inspections in 2014 identified serious concerns about risks to patient safety and an urgent notice to suspend the registration of the practice was issued in January 2015. Inspectors found a number of failings that led us to take enforcement action.

We have analysed GP practice ratings by locality and demographics and by organisational aspects such as staff, numbers of patients and financial data. The factors most strongly associated with a better rating included a higher percentage of patients who would recommend the practice (according to the GP Patient Survey), and a higher number of GPs in the practice (figure 2.25).

Ratings for population groups

Through our ratings, we are starting to look at the quality of services delivered to patient groups. Using six population groups, we want to make sure that our inspections include the quality of care delivered to different types of people, especially those who are particularly vulnerable.

Overall, our inspections show that GP practices typically provide good services to their population groups (figure 2.26). We have not yet carried out

Figure 2.25 GP practice ratings and number of GPs in each practice
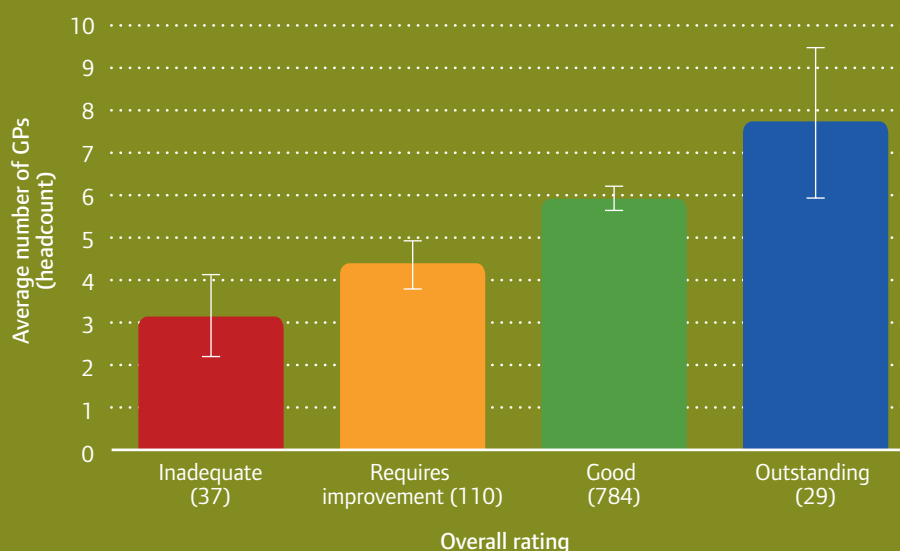
Source: CQC ratings; GP Patient Survey 2014

Note: We have so far rated only a minority of services. We have produced 95% confidence intervals for the average values by rating, as these values will fluctuate until all services have been inspected. The error bars in each chart show the width of these confidence intervals. If the confidence intervals do not overlap then the differences between the values are statistically significant.

● Inadequate   ● Requires improvement   ● Good   ● Outstanding

Findings from GP practices rated outstanding

The striking feature of outstanding practice is the breadth and diversity of the different examples we observe. We see a wide variety of initiatives that demonstrate:

- Effective leadership, manifested in a strong shared vision among practice staff, effective staff training and support, and a positive patient-centred culture.

- Effective working with multi-professional colleagues, including those from other organisations.

- Extra services that are empowering patients to self-manage long-term conditions and acute minor illnesses.

- Support for patients and carers with their emotional needs (for example, coordinating support groups) and close working with the community to raise awareness of health conditions and contribute to community wellbeing programmes – such as walking groups and social enterprise programmes.

In July 2015, we published our online examples of outstanding care in GP practices. These have been well received (all respondents to an online survey agreed the web tool is useful, with two-thirds reporting it is very useful). We encourage all primary care services to use the tool for learning and improvement opportunities.

Findings from GP practices rated inadequate

From our inspections we find that inadequate practice tends to reflect an absence of important systems or processes and poor outcomes for patients. Practices rated inadequate typically demonstrate:

- Weak leadership and a chaotic and disorganised environment.

- Isolated working – not working closely with other local services to share learning and provide a wider mix of services.

- A lack of vision for the organisation and clarity around individuals' roles and responsibilities.

- A poor culture of safety and learning (for example, a lack of significant event analysis or learning from complaints), poor systems for quality improvement, including quality audit, and limited examples of assurance of the quality of clinical care.

- Disregard for HR processes (for example, Disclosure and Barring Service checks).

- Unsafe medicines management.

- Limited access to advice and treatment.

- Lack of practice nurses or very low number of practice nurse sessions.

Figure 2.26 GP population group ratings

Source: CQC ratings data

Legend: Inadequate, Requires improvement, Good, Outstanding
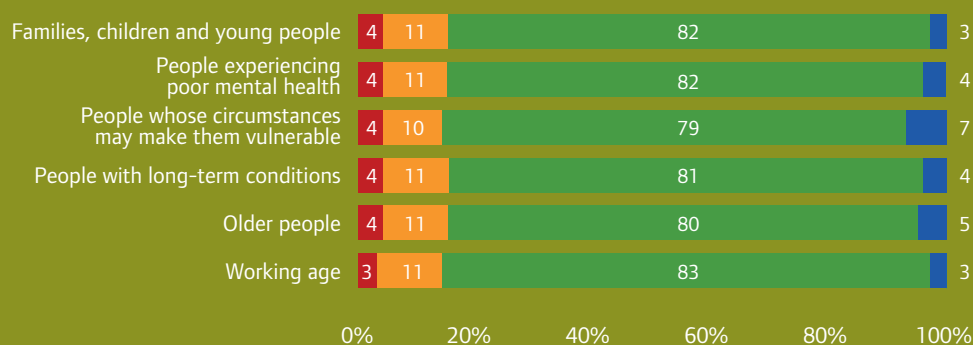
enough inspections to determine whether there is any particular variation of ratings between different groups. We did, however, find that in areas where there is a large number of people in one particular population group (for example, older people), some GP practices had done more to adapt their services to the specific needs of those patients.

Between May and July 2015 we surveyed 19 GP practices who have a high density of asylum seekers in their population. We captured the awareness of staff about the needs of asylum seekers, who often have significant physical and mental health needs. Around half of all staff surveyed showed a general lack of awareness of the healthcare needs and rules regarding the care of asylum seekers.

The main barrier to effective care was language differences and access to interpretation services. Clinicians often did not feel confident in the ability of interpreters to accurately convey patient histories and explain diagnoses. They also said they need more guidance and support in referring asylum seekers to specialist services, such as for survivors

Examples of GP services adapted to specific needs

Population group	Example
Working age people	Offering appointments before 8am, after 6.30pm and at weekends. One practice set up a sexual health clinic that ran on Wednesday evenings and Saturday mornings. The service was available to the whole community – not just patients of the practice.
People with long-term conditions	Educating patients to self-manage their long-term conditions more effectively and providing additional services that usually require a hospital visit. For example, managing intravenous lines used for prolonged treatments such as chemotherapy, long-term antibiotics and intravenous feeding.
People whose circumstances may make them vulnerable	Being flexible in their approach to vulnerable people by offering longer appointments, and allowing homeless patients to register at the practice using the practice address as their 'home' address.
Poor mental health	Working collaboratively with local mental health services and improving access to psychological therapies and substance misuse services. Also helping patients with mental illnesses to access high-quality, better coordinated care outside of hospital and therefore improving the number of patients being cared for in the community.
Older people	Managing beds in a care home that led to a reduction in hospital admissions and the number of days many older patients remained in hospital.
Families, children and young people	Offering information in age-appropriate formats for young people and ensuring staff are well-trained on local safeguarding processes. In one practice the nurse practitioner offered a texting service for young insulin-dependent diabetics. Teenagers were able to text their blood test results to the nurse practitioner if they had any concerns about managing their diabetes.

of sexual violence and torture. The complexity of managing this patient group raises concerns that clinicians are struggling to provide appropriate care under the confines of a standard 10-minute consultation.

Ratings for the five key questions

In the vast majority of cases, the services provided by GP practices are caring and responsive to people's needs. Ninety-six per cent of services were rated good or outstanding for caring, and 93% for responsiveness (figure 2.27). This latter figure reflects the fact that services are typically organised to meet the needs of their patients, and they commonly try innovative and effective ways to improve access to services and provide additional support for particular patient groups.

Where we do see inadequate care, this is often driven by poor safety or leadership ratings. Six per cent of the services we rated were inadequate for safety, and 4% were inadequate for well-led.
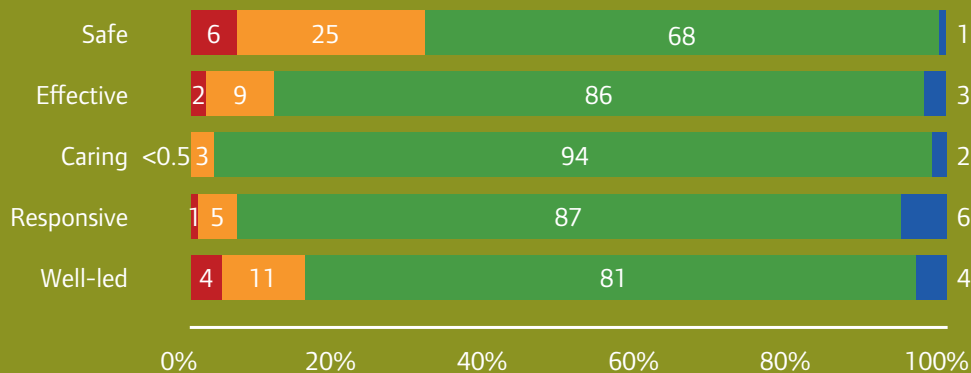
Safe

Of the services we rated up to the end of May 2015, 69% of GP practices and GP out-of-hours services were good or outstanding in terms of safe care. The most common theme underpinning safe practice is significant event analysis (SEA). We have seen evidence that most practices discuss and share their learning from SEAs with the multi-disciplinary team and external bodies such as the clinical commissioning group and other local GP practices.

However, we have concerns that incident reporting is not routinely carried out and often lacks the detail required.

In February 2015 a new GP e-form was launched as part of the National Reporting and Learning System. Approximately 100 practices are using it to report patient safety incidents for local and national learning. We encourage all practices to adopt it and we expect, in the near future, to see a significant improvement in the number of incidents being reported.

Although many practices are providing safe care, safety overall remains our main concern. Of the 976 services we rated, 25% required improvement and 6% were inadequate for this key question.

Figure 2.27 Primary medical services ratings by key question

	Inadequate	Requires improvement	Good	Outstanding
Safe	6	25	68	1
Effective	2	9	86	3
Caring	<0.5	3	94	2
Responsive	1	5	87	6
Well-led	4	11	81	4

Source: CQC ratings data

● Inadequate   ● Requires improvement   ● Good   ● Outstanding

We have found a range of safety issues that show a general lack of system and process, meaning risks are not properly monitored or assessed. For example:

- Insufficient evidence of risk management and learning from incidents, including as mentioned above, the completion of incident reports.

- Poor responses to patient complaint letters and a failure to act on the issues raised.

- Lack of effective and timely safeguarding training.

- Poor infection control procedures.

- Poor practice with the condition and storage of emergency equipment and the management of medicines is not satisfactory.

- Fridges at the wrong temperature, insufficient emergency drugs and expired medicines.

- Poor recruitment processes, where services may have had policies in place to ensure that staff were recruited in a safe manner but in reality some services were not properly implementing these. This meant that staff were being recruited without proper checks such as the Disclosure and Barring Service.

Effective

The range of activities provided in general practice is increasing. Eighty-nine per cent of practices and services were good or outstanding for the effectiveness of their care. Our inspections have highlighted multiple examples of good, effective clinical practice, expanded to account for the needs of local populations.

We see practices focusing on good outcomes for patients through quality improvement programmes, coordinated referral processes and joined-up care with other healthcare providers. We also see

Quality and safety are the priorities
Orchard Court Surgery, Darlington

Orchard Court Surgery is an outstanding GP practice that has excellent systems in place to keep people safe.

Inspectors could see that the arrangements for reporting, recording and monitoring significant events were consistently used to improve practice. This included identifying trends and themes and taking action on, for

example, medication, clinical assessment and consent, communication and confidentiality.

The whole team contributed to this approach. All safety concerns raised by staff and patients were taken seriously, used as learning and to improve the service provided to patients. Staffing requirements to meet patient needs were

clear and staff received the training and support they needed to deliver a good quality service.

Inspectors commented that the practice had a clear vision, which had quality and safety as its top priority. High standards were promoted and owned by all practice staff and there was evidence of team-working across all roles.

evidence of innovative services tailored to the individual needs of specific population groups.

Practices have worked hard over many years to build and maintain strong working relationships with organisations such as schools, universities, and local fire and benefits advisory services. The practices then use these relationships to deliver enhanced services.

Over the last 10 years the number of single-handed GP practices has fallen dramatically. We are now seeing the benefits of larger practices and joined-up models of working. These include offering appointments to patients outside normal working hours by taking shared responsibility for extended accessibility, and providing a wider range of services than most practices are able to deliver on their own.[66]

There are clear improvement opportunities for services rated below good and outstanding – in particular, for smaller isolated practices where collaborative working would be hugely beneficial.

Caring
We see significant examples where practices go the extra mile to involve and treat their patients with compassion, kindness, dignity and respect.

An inspector's view
"They were recording absolutely everything. A RAG (red, amber, green) rating system was in use, and 95% of incidents were green (no patient impact). The learning was clear and obvious."

The practices we rated as outstanding are able to demonstrate specific support for individual population groups, innovative programmes for certain health conditions and flexible access to services.

We rated two practices as inadequate for being caring – a very small number but wholly unacceptable. Our main concerns were based on feedback from patients who found staff to lack compassion and respect. We also observed poor concern for patients' privacy and dignity at the reception desk and waiting area in these surgeries.

Responsive
Typically, practices that are rated as outstanding consider the needs of their population and implement changes to improve the experience for their patients.

As demand for primary care grows, we have seen a sharp increase in the number of GP surgeries offering consultations over the phone and implementing telephone triage. In fact, 63% of GPs now believe that telephone consultations can be an effective replacement for face-to-face appointments.[67]

Innovation in how primary care is provided is developing rapidly. We are increasingly seeing new channels opening up, such as Skype, providing access to a medical consultation through an online video chat facility. Three social enterprises are leading the way in terms of new models of provision to improve the health of vulnerable and excluded groups. They work closely with services across their locality and are generally very responsive to the specific needs of their patients.

Well-led
GP practices are generally well-led, with 85% of practices rated good or outstanding. The typical examples of outstanding leadership we see relate to the culture that practice leaders create, which manifest in excellent staff development and support.

When practices are well-led, their patients are placed right at the centre of their developments. As a result, these practices often have effective patient participation groups that are involved in multiple aspects of the practice's business, including influencing practice development and coordinating services.

Innovative and proactive
St Thomas Medical Group, Devon

St Thomas Health Centre is one of four practices in a group and is rated outstanding overall.

The practice provides primary medical services to approximately 15,500 patients living in Exeter – it is well-led and responds to patient need and feedback, showing innovative and proactive ways to improve patient outcomes.

For example, some patients with leg ulcers no longer have to travel to the other side of the city for treatments, because practice nurses have worked with the dermatology department at the local hospital, and they can now perform more complex dressings. This is over and above what is expected.

Patients also have access to a headache clinic and a vasectomy clinic on Saturday mornings. Patient feedback is consistently positive.

The health centre has nine GP partners plus four additional salaried GPs, 10 registered nurses, four healthcare assistants, a practice manager, and additional administrative and reception staff. They show mutual respect and teamwork is evident – and there are systems in place to monitor and improve quality and identify risk.

Strongly performing healthcare organisations place high importance on staff development. Many of the outstanding practices we inspect demonstrate their effective leadership by implementing special programmes to develop or support staff in their role.

Practices that are rated poorly for well-led tend to lack clarity in the roles and responsibilities for the day-to-day running of the practice. There are also often poor relationships between groups of staff and a lack of visibility of senior staff.

The role and capability of the practice manager appears to play a role in a practice's overall rating. The level of training and support for practice managers is important, as is supervision and good line management. We see examples of poor working relationships between GPs and practice managers and isolated working when trying to make improvements.

In our ratings of GP practices, where well-led was rated inadequate or requires improvement, there was on average a lower proportion of patients who, when surveyed by the 2014 GP Patient Survey, said they would recommend the practice to others (figure 2.28).

Other primary care services

Dental care

We carried out 714 inspections of primary dental care services in 2014/15. Over several years, we have found that, compared with other sectors, dental services present a lower risk to patients' safety. Our stakeholders also agree that the majority of dental services are safe and that the quality of care is good. Therefore, from 1 April 2015 we are carrying out comprehensive inspections at 10% of all practices based on a model of risk and random inspection, as well as inspecting in response to concerns.

Unlike other sectors that we regulate, we will not be rating primary care dental services. It would be unfair and a disadvantage to other providers to rate only the 10% of providers that we inspect. We are working jointly with the General Dental Council, NHS England, NHS Business Services Authority and Healthwatch England on the future model from 2016 onwards.

Figure 2.28 GP practice ratings and whether patients would recommend the practice

Source: CQC ratings; GP Patient Survey 2014
Note: We have so far rated only a minority of services. We have produced 95% confidence intervals for the average values by rating, as these values will fluctuate until all services have been inspected. The error bars in each chart show the width of these confidence intervals. If the confidence intervals do not overlap then the differences between the values are statistically significant.

● Inadequate   ● Requires improvement   ● Good   ● Outstanding

Health and justice

People in the criminal justice system have a higher rate of ill health than the general population and are reliant on authorities for their safety, care and wellbeing. In secure settings there is no choice of service provider. This makes monitoring, inspecting and regulating even more important.

We have recently introduced a new approach to inspection alongside HMI Prisons. We published our new inspection handbook in July 2015 after a period of consultation and piloting. Our pilot inspections included three prisons, a youth offending institution and an immigration removal centre. The new approach is now used for all inspections in these settings.

In August 2015, we published new registration guidance for healthcare providers in police custody suites (PCS) and sexual assault referral centres. The guidance helps providers understand when registration is required. The current regulations allow an exemption for services that are commissioned by police authorities. It is expected that, from April 2016, commissioning for PCS will transfer to NHS England and providers will need to register with CQC. We will work with the sector, HMI Probation and HMI Constabulary to develop the approach to inspection for these services.

Pilot inspection of an immigration detention centre
Yarl's Wood Immigration Detention Centre, Bedford

In April 2015 we piloted our inspection method with Yarl's Wood Immigration Detention Centre during an unannounced inspection by HMI Prisons.

Of all the areas in the centre, health care had declined most severely. There were severe staff shortages and women were overwhelmingly negative about access, quality of care and delayed medication.

Our inspection indicated that care planning for women with complex needs was so poor it put patients at risk. Also, the available mental health care did not meet women's needs and this made it particularly unacceptable that a number of women with enduring mental health needs had been detained.

The small enhanced care unit was located in health care and used to isolate women. It was effectively used as an inpatient unit although it was not commissioned, resourced or registered to be so.

Pregnant women had prompt access to community midwives and reasonable antenatal care, but inspectors saw two instances where abdominal pain in early pregnancy was not managed appropriately.

Pharmacy services were chaotic. We issued three requirement notices immediately following this inspection and will be checking that improvements have been implemented.

Source: HMI Prisons and CQC

Children's services

We review how health services keep children safe and contribute to promoting the health and wellbeing of looked-after children and care leavers. In 2014/15 our children's inspection team has done this in three ways:

- Over a two-year period the team has inspected the health service provision in 41 local authority areas. Inspections have been based on the identified risk within the health services in those areas and we have visited at short notice. At the end of each inspection we publish a report that makes recommendation to individual providers of services and the clinical commissioning group. We are reviewing all the reports to draw out the national findings and learning for services.

- During 2015 we have developed joint targeted area inspections with other inspectorates that will examine how well local authorities, health, police and probation services work together in a particular area to safeguard children. The new inspections will include a more in-depth look at elements of practice, with the first six inspections to focus on children at risk of sexual exploitation and those missing from home, school or care.

- The team also works with other parts of CQC to provide advice and expertise in relation to safeguarding children and services to looked-after children. This has included contributing to hospital inspections, responding to concerns at GP inspections and conducting a local area inspection jointly with the hospital team. This year we are extending our work in this area under the banner of Think Child, an initiative to integrate the inspection of children's safeguarding into the wider inspection of health services provided to children.

In 2015/16 the children's team will also be starting a five-year inspection programme with Ofsted looking at how local areas are meeting the needs of children with special educational needs and disabilities.

Continuous improvement
Windsor Surgery, Lancashire

Windsor Surgery in Garstang, Lancashire was rated good overall by CQC and inspectors found evidence of outstanding work in the way the practice meets patients' needs and strives for continuous improvement.

Staff and patients were involved in local forums to drive up standards. Changes in national best practice were shared and agreed between staff and supporting community teams.

In particular, the practice held meetings every week to improve how it delivered services. Many meetings included external professionals – and where appropriate, patients were invited.

Inspectors saw audits on care delivery and outcomes for patients with long-term conditions – the aim is to improve services. The practice nurses worked with community teams to avoid hospital admissions.

For any GPs returning from long-term leave, mentoring is available. This involved a named GP mentor, who provided reviews and consultations around any issues or concerns, and regular meetings to discuss progress and any additional breaks that might be needed.

Our challenge to the primary healthcare sector

- We want primary healthcare services to become the safest, the most effective and the most compassionate in the world. We need clinicians, whether in their own practice or if they work in a leadership position, to speak out and not tolerate care that is unsafe, ineffective or lacking compassion.

- We encourage all healthcare professionals to avoid professional isolation and work with colleagues in and out of their practice.

- We encourage providers to work together across organisational boundaries to reduce variation and improve the quality of care and the provision of more joined-up health and care services. We demand investment in strong, credible leadership at all levels in primary healthcare services.

- At practice level, we need visible leaders, both clinical and managerial, to oversee the running of their practice and develop plans in response to the needs of their local patients. The vision and values of a GP or dental practice are important as they highlight the organisation's strategic objectives. These have a powerful influence on the behaviours of staff at all levels. Leaders within practices must ensure the vision and values are shared by all staff.

- Safety incidents, both within the GP practice and externally, should be reported using the e-form for the National Reporting and Learning System, and a culture of learning embedded among staff.

- Practices should become active learning organisations, encouraging all team members to be engaged in quality improvement activities.

- GP practices should improve patients' access to their services. They should encourage and facilitate self-care, and respond to the needs of their patients by improving appointment systems and looking at different ways to make contact with healthcare practitioners available for different patient groups.

An inspector's view

"One recent practice that was very well-led. One of the reasons for this was staff engagement by setting up task groups – one for patients' services, one for finance, and one for HR and training, each group had one GP, one admin person and one nurse or healthcare assistant. They talked about ideas for the future, feedback from the whole team, and how they could improve in those areas, and they showed how they implemented those ideas."

Equality in health and social care services

Key points

- While international evidence shows that the NHS is one of the most equitable health systems in the world[68], there is still significant variation in access, experience and outcomes for different groups of people using health and care services. This must be addressed, both to ensure good quality services for everyone and because these services need to be ready for changing demographics – for example the growth in the population of older people from Black and minority ethnic (BME) backgrounds.

- Although access issues differ by sector and by equality group, it is a challenge to ensure everyone has the right information in order to access services – we see this in both adult social care and acute hospitals. Also, changes in eligibility for funding in adult social care has had a variable impact on different equality groups.

- Whether people say they are treated with dignity and respect is closely linked to their overall experience of care. In acute hospitals, people in some equality groups are significantly less likely to report being treated with dignity and respect than their peers.

- It is important that providers also ensure equality for their staff. BME staff and women remain less likely to be in management roles than their counterparts, in both health and social care. Additionally, BME staff in NHS trusts report higher levels of discrimination and lower confidence in equality of opportunity. There is evidence that disabled staff and lesbian, gay, bisexual and transgender staff can also experience higher levels of discrimination at work.

- Information from adult social care providers shows that they are not consistently addressing equality. While almost all services say that they have equality policies in place, far fewer say that they have carried out work in the last year on equality – particularly in relation to sexual orientation and gender reassignment.

Introduction and context

This section forms part of our statutory equality information duties under the Equality Act 2010, in particular to report on what we know about equality for groups that are affected by our statutory functions – people using health and social care services and staff working in these services. This builds on our report *Equal measures* in which we concluded that there is still too much variation in access, experience and outcomes for people who use services – and staff working in services – on equality grounds.[69]

In relation to service provision, the Equality Act covers eight protected characteristics: age, disability, gender, gender reassignment, pregnancy and maternity, race, religion and belief, and sexual orientation. One of the challenges – for national reports and for service improvement – is that data is not systematically collected or analysed about the access, experience and outcomes for different equality groups using health and social care. We welcome the work of the NHS Equality and Diversity Council to improve this.[70]

Access to services

Patterns of access

In our *Equal measures* report, we analysed 14.5 million NHS hospital inpatient episodes and 83.5 million outpatient appointments where the age, sex and ethnicity of the patient was known.[71] This showed some differences in patterns of service use. More work is needed to understand if these variations reflect differences in need and behaviours, or in the accessibility or quality of services for these groups.

Equity of access

While the use of primary and secondary health services is increasing, the number of people able to access local authority funded or commissioned adult social care is decreasing, due to budget restrictions and tightening eligibility criteria. The latest figures available, published in December 2014, show a 4.1% overall reduction in the number of adults receiving a social care service, of any type, provided or commissioned by a local authority in 2013/14

compared with 2012/13. The previous year, the reduction was over 9%.[72] This is in the context of an ageing population and therefore potentially an increasing need for social care services. This reduction in access has had different impacts on various equality groups.

Two-thirds of the people receiving local authority funded or commissioned care – more than 850,000 people – are aged 65 and over. There has been a greater reduction in the percentage of older people receiving local authority funded or commissioned care, compared with 18-64 year olds. In turn, this is likely to explain the larger impact on women compared with men and on those with a physical impairment compared with those with a learning disability or mental health need.

People in Asian/Asian British, Black/Black British and mixed ethnic groups only make up 7% of people receiving local authority funded or commissioned care, despite being 13.5% of the population in England.[73] This may in part be a result of the demographic profile of these population groups (typically younger, although now the proportion of older people in these ethnic groups is increasing). The figures suggest an increase in the number of people from these ethnic backgrounds accessing local authority-funded adult social care between 2012/13 and 2013/14, although some of this increase may be explained by better recording of ethnicity. However there was a decrease in the number of people from other minority ethnic backgrounds, which includes for example Chinese and Arab people.

Reductions in local authority funded or commissioned adult social care has had various impacts on different groups of disabled people. This needs to be seen in the context of changing needs, such as the increased number of people with dementia. However, there has been a particular impact on people with a primary need for services due to hearing impairment, with a greater than 10% reduction in the number of people receiving local authority funded adult social care in 2013/14 compared with the year before (figure 2.29).

	2012/13	2013/14	% change
Physical disability, frailty and/or temporary illness	750,705	704,305	-6.2% ↓
Hearing impairment	18,975	16,990	-10.5% ↓
Visual impairment	27,360	25,595	-6.5% ↓
Dual sensory loss	4,835	4,400	-9.0% ↓
Mental health (excluding dementia)	187,610	174,780	-6.8% ↓
Dementia	80,610	82,760	2.7% ↑
Learning disability	144,830	146,705	1.3% ↑

Source: Health and Social Care Information Centre Community Care Statistics 2013/14

Figure 2.30 NHS inpatient survey 2014: who to contact after hospital, by pre-existing health condition or disability
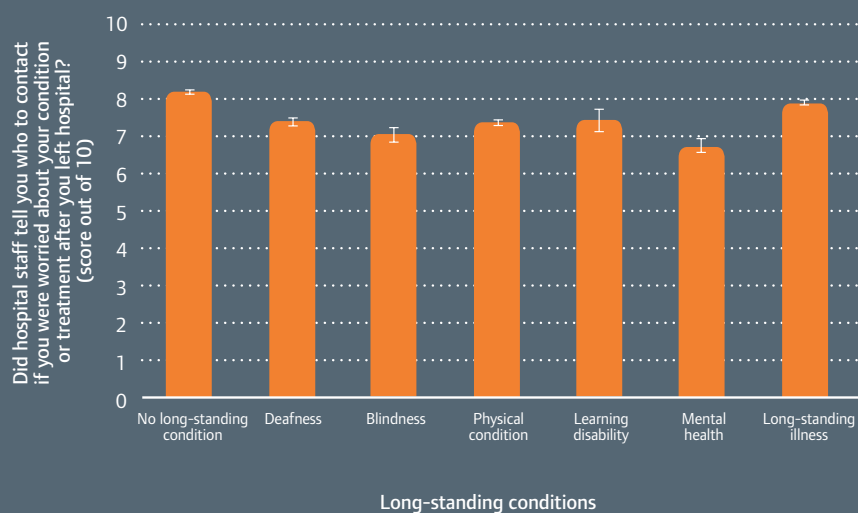
Source: NHS inpatient survey 2014
Note: The chart includes the 95% confidence intervals for the survey results. The sample size varies by demographic group, and the confidence intervals illustrate the level of precision we can attribute to each result.

Figure 2.31 NHS inpatient survey 2014: discussed further services after hospital, by ethnic group
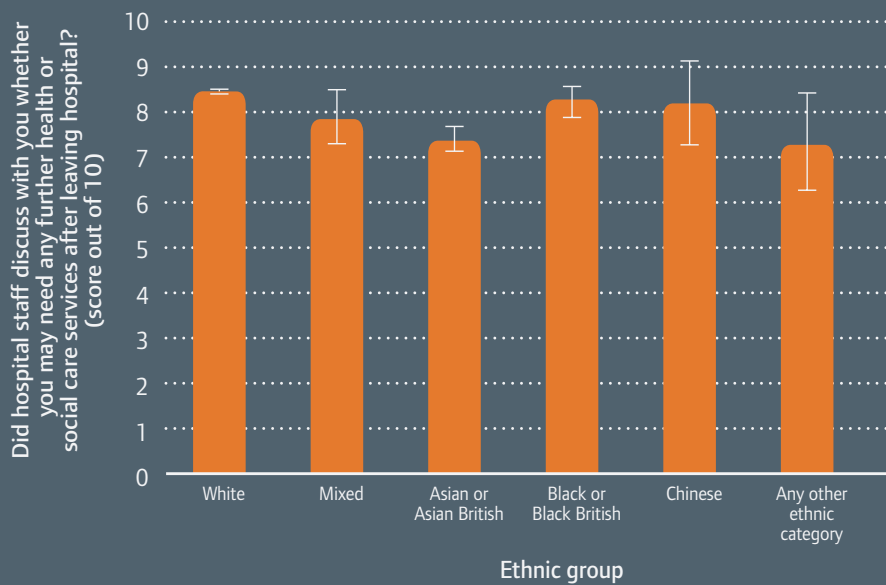
Y-axis: Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital? (score out of 10)

X-axis: Ethnic group — White, Mixed, Asian or Asian British, Black or Black British, Chinese, Any other ethnic category

Source: NHS inpatient survey 2014
Note: The chart includes the 95% confidence intervals for the survey results. The sample size varies by demographic group, and the confidence intervals illustrate the level of precision we can attribute to each result.

Specialist support
Dalefield Surgery, Bolton

We rated Dalefield Surgery good for their overall care of patients and outstanding for their treatment of people whose circumstances may make them vulnerable.

Approximately 9% of Dalefield Surgery patients do not speak English as their first language. The reception staff have translation prompts to greet all patients, establish the nature of their visit and help them to book appointments. They also display information and practice leaflets in different languages and offer a translation facility for their website content.

The practice employs support workers to work with non-English speaking families in their homes to help them understand the services available to them and access NHS and social care.

For all non-English speaking patients, extended appointments slots are booked and interpreters are available via a telephone service. For new patients, a referral is made to a support worker to ensure patients are supported to provide voluntary and informed consent to treatment.

Removing barriers

Lack of information can be a major barrier to access to services for some groups. We have analysed some questions in the 2014 NHS inpatient survey to see whether there were differences in how well people were signposted or referred to other services after a stay in hospital.

- People with no longstanding health condition were significantly more likely to say they were told who to contact after they left hospital if they were worried about their condition or treatment, compared with people who had a range of health conditions (figure 2.30). People with a mental health condition were least likely to say that they had been given the name of someone to contact. People with no longstanding health condition were also significantly more likely to report that hospital staff had discussed whether they need equipment or adaptations at home and whether they needed further health or social care services when leaving hospital.

- White people were significantly more likely to report that hospital staff had discussed whether they needed equipment or adaptations at home, compared with Asian, Asian British, Black, Black British or people who viewed themselves as being of mixed race. White people were also significantly more likely to report that hospital staff had discussed whether they needed further health or social care services when leaving hospital compared with Asian and Asian British people (figure 2.31).

There are two possible explanations for these differences. Either hospital staff are not discussing discharge arrangements with people on an equal basis – possibly because of language or communication barriers – or disabled people, people with mental health conditions and people from BME groups are not understanding or remembering the information given. Either way, the communication from hospital staff is less effective for some equality groups and needs to improve. The introduction of the NHS Accessible Information Standard may improve communication with disabled people, including those with a learning disability or mental health condition.[74]

Survey responses from people using adult social care also show a range of differences relating to whether people found it easy to find information about services.[75] In this survey a higher percentage of people with a learning disability found it easy to find information, compared with people with a physical or sensory impairment. A lower percentage of Asian/Asian British and Black/Black British people found it easy to find information, compared with White people, which is similar to the findings from the hospital inpatient survey.

Voluntary and community services can be important in helping people to navigate the health and social care system. There is some evidence that funding reductions have had an impact on voluntary sector advocacy provision for people with a learning disability[76], and on social care and support services for BME older people.[77] In both cases it is difficult to make quantitative assessments about the impact, as relevant data is not regularly collected.

There are other barriers to equality in service access, besides failure to communicate available services – for example physical access to premises and access to interpreting services in primary care.[78] We look in more detail at the issues for asylum seekers in our section above on primary medical services.

Our equality objectives

One of our equality objectives is to improve our regulatory insight and action about the safety and quality of mainstream health services – including acute hospitals – for people with a learning disability or dementia, and those experiencing mental ill-health. This will help us to shine a light on where communication between hospital staff and these patients needs to improve and where there is good practice.

Commissioning

Not all access issues are in the control of providers. Clinical commissioning groups (CCGs) are responsible for commissioning services to meet the needs of the local population. CCGs are required to make use of the NHS Equality Delivery System (EDS2). This is designed to help local NHS organisations, in discussion with local partners including local populations, review and improve their performance for people with characteristics protected by the Equality Act 2010.[79]

One of the 18 system outcomes reported is that services are commissioned, procured, designed and delivered to meet the health needs of local communities.

Figure 2.32 CCG gradings: How well services are commissioned, procured and designed to meet the needs of local communities

EDS2/EDS grading	Description	No of CCGs
Not available		56
Undeveloped	No evidence one way or another for any protected group of how people fare, or evidence shows that the majority of people in only two or less protected groups fare well.	2
Developing	Evidence that the majority of people in three to five protected groups fare well.	28
Achieving	Evidence that the majority of people in six to eight protected groups fare well.	11
Excelling	Evidence that the majority of people in all nine protected groups fare well.	3

Note: Sample was 100 CCGs.

We looked at a sample of 100 CCG websites to see the gradings for this outcome (or the equivalent predecessor outcome if EDS2 gradings were not available yet on the website). Only three CCGs felt they were excelling, and 11 of the 100 felt they were achieving the objective of commissioning, procuring and designing services to meet the needs of local communities (figure 2.32). There is no similar national system in place for adult social care to benchmark and develop commissioning of services to meet the needs of diverse communities.

Unequal experiences

Two of our key questions – whether services are caring and whether they are responsive – relate to people's experience of using health and social care. How people experience care is an aspect of service quality, alongside the outcomes from using care and ease of access. Analysis of the NHS 2014 inpatient survey shows that:

People with no longstanding condition reported a better overall experience than people with a mental health condition.

People aged 66-80 report a better overall experience than those aged 16-35 (figure 2.33). This may be due to younger people having higher expectations of health care.

Dignity and respect

There may be several causes of poorer overall experience, such as the communication issues highlighted above. Another factor that can have a bearing on people's overall experience of care is whether people feel that they are treated with dignity and respect during their hospital stay.

Several equality groups were significantly less likely to say that they were treated with dignity and respect. People aged 16-35 were less likely to say that they were treated with dignity and respect compared with people in older age groups (figure 2.34). People with a mental health condition were less likely to say they were treated with dignity and respect compared with people with no pre-existing health condition (figure 2.35). This supports findings in our mental health crisis care report *Right here, right now*.[80]
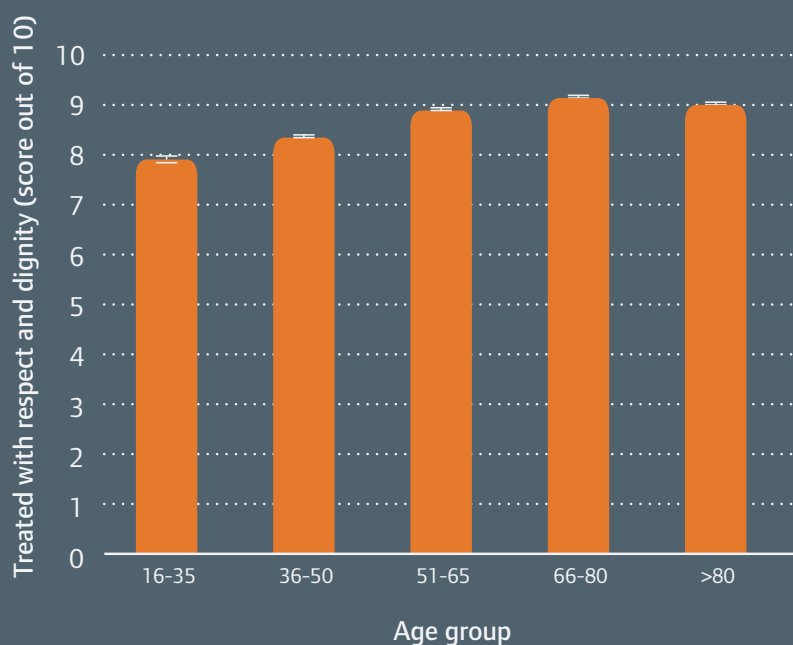
Figure 2.33 NHS inpatient survey 2014: overall experience by age
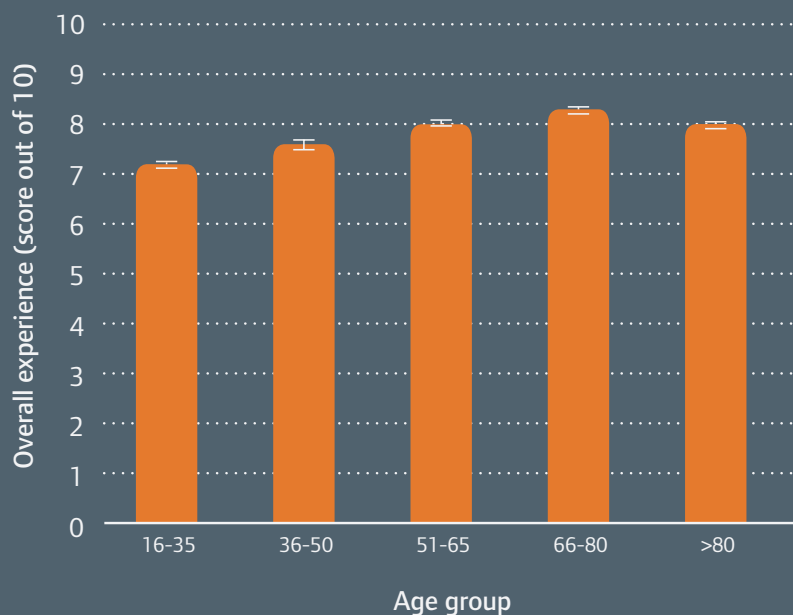
Source: NHS inpatient survey 2014
Note: The chart includes the 95% confidence intervals for the survey results. The sample size varies by demographic group, and the confidence intervals illustrate the level of precision we can attribute to each result.
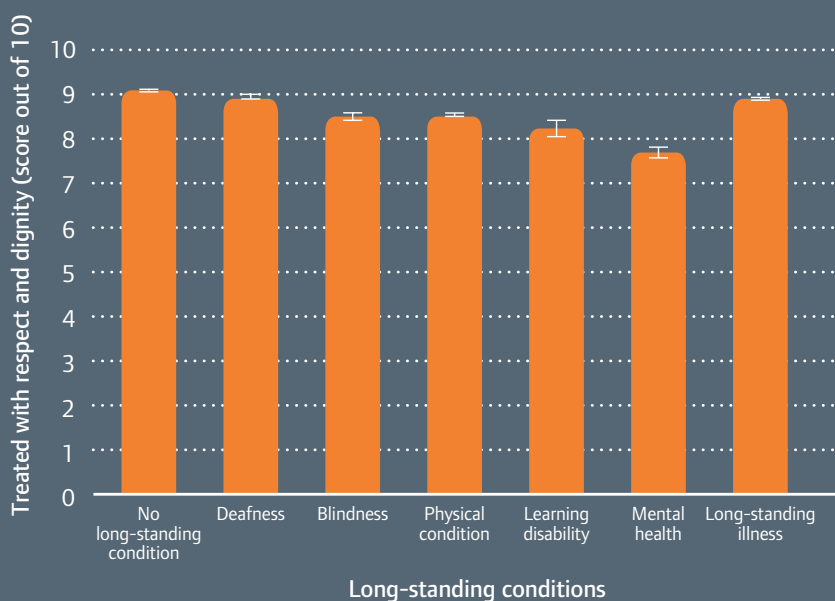
Figure 2.34 NHS inpatient survey 2014: being treated with dignity and respect, by age group

Source: NHS inpatient survey 2014
Note: The chart includes the 95% confidence intervals for the survey results. The sample size varies by demographic group, and the confidence intervals illustrate the level of precision we can attribute to each result.

Figure 2.35 NHS inpatient survey 2014: being treated with dignity and respect, by pre-existing condition

Treated with respect and dignity (score out of 10)

No long-standing condition	Deafness	Blindness	Physical condition	Learning disability	Mental health	Long-standing illness

Long-standing conditions

Source: NHS inpatient survey 2014
Note: The chart includes the 95% confidence intervals for the survey results. The sample size varies by demographic group, and the confidence intervals illustrate the level of precision we can attribute to each result.

Some other equality groups were also significantly less likely to say that they were treated with dignity and respect, although the differences in average scores were smaller than for the groups above. The groups where the average score was at least 0.5 lower than a comparison group included:

- Asian and Asian British people (compared with White people).

- People with a learning disability and blind people, (compared with people with no longstanding conditions).

- Bisexual people (compared with heterosexual people).

- Muslim, Sikh and people with 'other' religions, or those who prefer not to say (compared with Christians).

Other equality groups also had lower ratings, although the difference was less pronounced. These findings are similar to those that we reported in *State of Care 2013/14*, relating to the 2011 inpatient survey.

Meeting people's needs

Whether services meet people's needs can also affect your experience. In the inpatient survey, White people were significantly more likely to rate hospital food highly compared with all other groups. They were significantly more likely than all other groups to say that they had been offered a choice of food. This could be due to poor communication with people whose first language is not English, or a smaller range of choice available if people have specific dietary requirements related to religion or culture.

Information from adult social care inspections shows that adult social care services are not consistently addressing equality. Looking at information returned to CQC from more than 7,000 adult social care services between September 2014 and March 2015, 99% of those services have policies covering equality and diversity. However, the percentage of services that said that they had carried out work in the last

year to meet the needs of people with particular equality characteristics was much lower, between 13% and 78% depending on the type of service and the characteristic (figure 2.36).

Whether services meet the needs of people related to their equality characteristics is considered under the responsive key question. Residential services (which here include both residential care and nursing homes) have done the least work across all protected characteristics. Our ratings for the responsive key question mirror this data, with residential services having a higher proportion of inadequate and requires improvement ratings compared with other types of social care service.

Across all service types, except specialist colleges, the protected characteristics where least work has been done are gender reassignment and sexual orientation. This mirrors findings in comparable analyses published in 2008 and 2011.[81]

Figure 2.36 Percentage of services reporting that they have undertaken work on equality in the last 12 months – by service type and protected characteristic
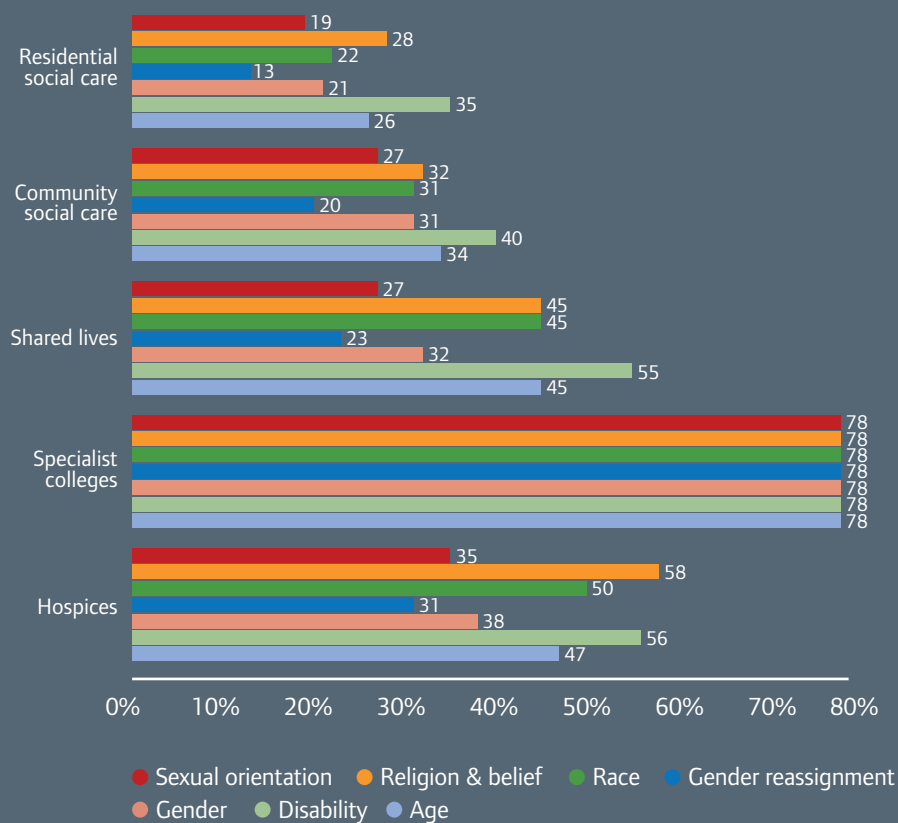
Source: CQC provider information returns, Q3/4 2014/15 and Q1/2 2015/16

Unequal outcomes

What do we mean by outcomes?
How we look at outcomes will depend on the type of service. For health services, it is possible to use clinical outcomes as a measure. Our key questions relating to safety and effectiveness are strongly linked with outcomes. There is some evidence of poorer health outcomes for equality groups – for example in relation to higher infant mortality rates among some minority ethnic groups – but the complex factors contributing to the inequality, including the interplay of deprivation, physiological, behavioural, cultural and service access factors are not well understood. There is also a wide body of evidence that some people with a learning disability are dying prematurely, yet there is no agreed data review process in place to see where improvement is needed (though one is proposed as part of the NHS *Five Year Forward View).*[82]

In adult social care, it is harder to define outcomes, as services have an impact on many aspects of a person's life. The Adult Social Care Outcomes Framework uses a range of indicators arranged into four domains covering quality of life, reducing need for care and support, positive experience of using services and safeguarding.[83] However, the findings from this only relate to people using local authority funded adult social care services. Looking at combined measures in a 'quality of life' outcome score in the latest data, there is little difference on the basis of age or gender. However, the score is higher for people with a learning disability compared with other groups – though this could be affected by expectations – and lower for Asian/Asian British and Black/Black British people compared with people in other ethnic groups.

Satisfaction levels with social care services are also higher for people with a learning disability compared with other groups and higher for White and Chinese people compared with other ethnic groups. Recent research suggests language barriers, knowledge of the "social care system", the need for culturally appropriate services and sometimes experiencing racism are the underlying drivers for the lower satisfaction levels of South Asian people using social care.[84]

Using our ratings
Our ratings of health and social care service providers against five key questions should form a proxy measure of likely outcomes from using a service. If a service is rated good or outstanding, the overall outcomes for people using the service should be higher than those in services rated requires improvement or inadequate.

An analysis of overall ratings for almost 1,000 GP practices rated to date showed no significant correlation between a practice's overall rating and the level of deprivation in the area it served.

Our equality objectives

One of our equality objectives is to help our inspectors to pursue key lines of enquiry and to make consistent and robust judgements about particular aspects of equality – including whether adult social care services meet the needs of lesbian, gay and bisexual people and people with a sensory impairment.

Workforce equality

The NHS workforce is very ethnically diverse: 38% of NHS medical staff are from BME groups, compared with 11% in the UK workforce in general. However, in both the NHS and adult social care, a higher percentage of White staff are in management roles than BME staff. In the NHS non-medical workforce, 7% of White staff are in management grades (Band 8a-9) compared with 5% of Asian/Asian British staff and only 3% of Black/Black British staff. In adult social care, BME people make up 20% of the direct care workforce but only 13% of managers or supervisors are from a BME background.[85]

A similar pattern appears by gender: 81% of non-medical staff and 82% of social care staff are women, compared with 46% in the UK workforce in general. However, only 5% of female non-medical staff in the NHS are in management roles, compared with 10% of male staff. Similarly, only 8% of women working in adult social care are in management or supervisory roles, compared with 10% of men.

Comparisons are difficult for other protected characteristics, because the monitoring information is poor due to a mixture of data not being gathered or staff choosing not to disclose.

In April 2015, the NHS Workforce Race Equality Standard (WRES) became mandatory for NHS trusts, following evidence that the number of BME staff at senior and board levels in the NHS is getting worse, that BME staff still experience high levels of discrimination[86] and that there is a link between the treatment of BME staff and patient experience.[87] For the first time, organisations employing almost all of the 1.4 million NHS workforce need to demonstrate progress against a number of indicators of workforce equality.

For acute trusts, we have analysed the four questions from the 2014 NHS staff survey that are included in WRES to look for differences between White staff and BME staff at national level and by trust.

BME staff report significantly more personal experience of discrimination at work than White staff. The highest percentage of White staff to report discrimination by a manager or other staff in any one trust was 12%; the highest percentage for BME staff was 33%. Nearly 60% of trusts showed a difference that is statistically significant between White and BME respondents, with BME groups always showing a higher percentage that say they experience discrimination.

Significantly fewer BME than White staff believe their trust offers equal opportunities for career progression or promotion. Sixty-one per cent of trusts show significant differences between BME and White respondents on this question with BME staff always showing a worse perception of equal opportunities.

An inspector's view

"It's a good sign when the manager actually knows people's names and gets down and does the work beside the staff and gets involved."

Our equality objectives

Another of our equality objectives is to include race equality for staff (through the NHS Workforce Race Equality Standard) as a factor in our judgements about whether hospitals are well-led.

Staff experience

In the analysis of the NHS staff survey for acute trusts:

- BME staff report slightly more harassment, bullying or abuse from patients, relatives or the public than White staff. The highest percentage of White staff to report this in any trust was 40%, whereas the highest percentage for BME staff was 50%.

- BME staff also experienced significantly more harassment, bullying or abuse from other staff than White staff in 13% of trusts. The highest percentage of White staff to report this in any trust was 42%, whereas the highest percentage for BME staff was 55%.

Recent research by the NHS Equality and Diversity Council[88] and Stonewall[89] considers the experience of disabled staff and lesbian, gay, bisexual and transgender staff working in health and social care. These two reports show that staff in these groups can also face discrimination and a poorer workplace experience.

Our challenge to the care sectors on equality

- Everyone has a right to be treated with dignity and respect when using services. Acute hospitals need to engage with local communities to understand why some groups such as Asian and Asian British people and people with mental health conditions are less likely to feel treated with dignity and respect and put plans in place to address the causes.

- Adult social care services need to look at a range of equality issues for people using their service – including giving due to consideration to whether work is required to ensure equality for potentially less 'visible' groups such as lesbian, gay, bisexual and transgender people.

- Providers need to do more to improve communication with all the people that they serve, to ensure that everyone has access to the full range of services that they might need.

- Sectors need to plan services to meet changing demographics – for example the increase in older BME people.

- Sectors need to develop better national and local data on access, experience and outcomes for different equality and inclusion health groups – and make better use of existing data to understand and address service inequalities, including where there is evidence of serious inequalities in outcomes such as higher mortality rates.

- The NHS Workforce Race Equality Standard is a good start to improving workforce race equality and time will tell if it makes an impact. Ways of improving equality for staff on the grounds of other protected characteristics also need development.

STATE OF CARE

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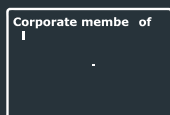
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