



Care Quality Commission

# **The state of health care and adult social care in England**

2015/16

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Care Act 2008.

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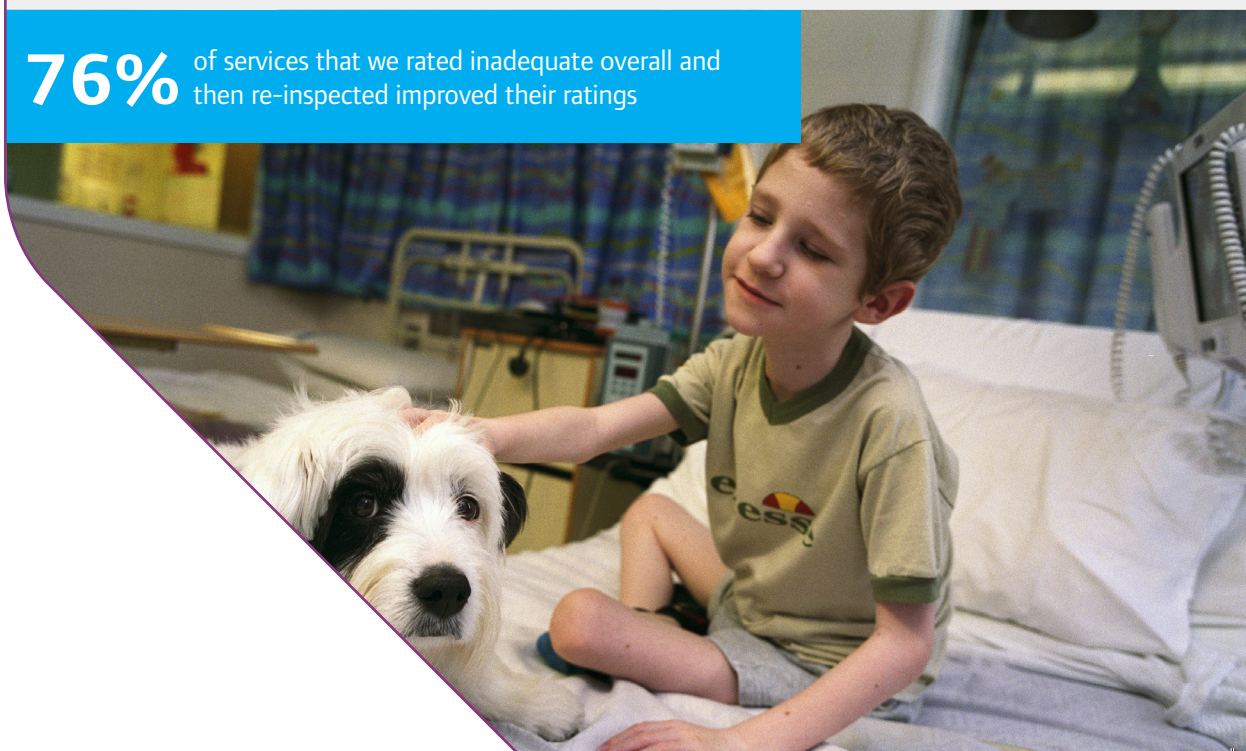
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**76%** of services that we rated inadequate overall and then re-inspected improved their ratings



# Foreword

This year's *State of Care* report shows that, despite increasingly challenging circumstances, much good care is being delivered and encouraging levels of improvement are taking place. However, the sustainability of this position is in doubt. We are also beginning to see some evidence of deterioration in quality, and some providers who are struggling to improve their rating beyond 'requires improvement'.

The fragility of the adult social care market and the pressure on primary care services are now beginning to impact both on the people who rely on these services and on the performance of secondary care. The evidence suggests we may be approaching a tipping point. The combination of a growing and ageing population, people with more long-term conditions and a challenging economic climate means greater demand on services and more problems for people in accessing care. This is translating to increased A&E attendances, emergency admissions and delays to people leaving hospital, which in turn is affecting the ability of a growing number of trusts to meet their performance and financial targets.

While large numbers of care homes and home care agencies are providing good quality care – and three-quarters of those that we had rated as inadequate, and then re-inspected, improved – this still left a quarter of services originally rated inadequate that did not improve enough to change their overall rating on re-inspection.

Through our market oversight function in adult social care, we also know that profit margins are reducing – both due to pressures on fees, and cost pressures that include the national living wage. Already we are seeing some providers starting to hand back home care contracts as undeliverable; local authorities predict more to come. Until recently, the growth in demand for care for people with greater care needs had been met by a rise in the number of nursing home beds, but this bed growth has stalled since April 2015.

The financial challenges in the NHS have been extensively documented. Despite this, we have found much good and outstanding care – particularly in children's and young people's services and critical care – which we highlight and celebrate. We have given outstanding ratings to five acute trusts and two mental health trusts, and five trusts have exited special measures since April 2015.

However, we have also found too much acute care that we rated inadequate – particularly urgent and emergency services and medical services. And it will be increasingly difficult for trusts to make improvements to these services unless they are able to work more closely with adequately funded adult social care and primary care providers.

The quality of care received in NHS mental health trusts is broadly similar to that in acute trusts, but with an even higher level of variability within providers as well as between them. Community services are more likely to be rated good and outstanding than inpatient services such as wards for working age adults and psychiatric intensive care units. In particular, we have concerns about the safety of acute mental health services. Problems with the physical environment frequently contributed to a rating of requires improvement or inadequate for inpatient services.

The quality of care provided by primary medical services remains high. Despite a context of increased demand, coupled with a shortage of GPs and increasing vacancy levels, 83% of the GP practices we have rated so far are good and 4% are outstanding.

The challenge for this sector, as for the rest of the system, is to consider what responses to increasingly difficult conditions will maintain quality, now and in the future. Some general practices have formed new models of care, including joining together in federations, and have involved people who use their services in their conversations from an early stage.





Last year we said that, to meet the challenges ahead, services needed to collaborate and leaders needed to think outside traditional organisational boundaries. We have since seen some cases where this is starting to happen, so we know it can be done. It now needs to happen more consistently, and faster.

Our evidence suggests that finance and quality are not necessarily opposing demands; many providers are delivering good quality care within the resources available, often by starting to transform the way they work through collaboration with other services and sectors. We cannot ignore the impact of tough financial conditions on providers – but our focus will always be on quality and we will always act in the interest of people who use services.

We will continue to highlight good and outstanding care, to support improvement and to take action to protect people where necessary. And we will continue to use the unique and detailed information we hold on quality to help those that lead, work in, and use health and care services to make the right decisions.

People have a right to expect good, safe care from their health and social care services. Working with our partners, we will offer the system whatever support we can to make the changes necessary to ensure high-quality care into the future.



**Peter Wyman**  
Chair



**David Behan**  
Chief Executive



# Summary

## **Many health and care services in England are providing good quality care, despite a challenging environment, but substantial variation remains**

Many people in England are receiving a good quality of care. As at 31 July 2016, 71% of the adult social care services that we had inspected were rated good and 1% were rated outstanding; 83% of the GP practices we inspected were rated as good and 4% as outstanding; and 51% of the core services provided by NHS acute hospital trusts that we inspected were rated as good and 5% as outstanding. There is much to be celebrated in the way that many staff, managers and leaders across the country deliver good, person-centred care.

But the quality of care across England still varies considerably, both within and between different services. Some people receive very poor care. We rated a minority of services as inadequate: 2% of adult social care services, 3% of GP practices and 5% of hospital core services as at 31 July 2016. Where we find unacceptable care, we take enforcement action to protect the people using these services and ensure that the care improves.

It is a time of unprecedented demand and financial challenge for health and social care, driven by the growing numbers of older people in need of care and support, and those with complex health and care needs. The NHS budget of £116.4 billion in 2015/16 had to cope with nearly 23 million A&E attendances (the highest number ever), 14 million GP referrals to acute hospitals, almost six million hospital admissions, 19 million first outpatient attendances, and more than nine million calls to ambulance switchboards. Local authorities spent £13.8 billion on adult social care services, covering short and long-term support for more than a million people.

By the end of 2015/16, NHS providers had overspent their budgets by £2.45 billion. Local authorities were reported to have spent £168 million

more than they budgeted for, often drawing on their reserves to do so. Delivering high-quality care while achieving good financial management is, therefore, more important and more challenging than ever.

## **Some health and care services are improving, but we are also starting to see some services that are failing to improve and some deterioration in quality**

Despite the difficult environment in which providers are operating, some have been able to improve the quality of care they provide. About three-quarters (76%) of those that we re-inspected following an initial rating of inadequate achieved an improved rating: 23% went from inadequate to good and 53% went from inadequate to requires improvement.

However, improvement is far from universal. Almost half (47%) of those services that we re-inspected following a rating of requires improvement did not change their rating. And in 8% of cases, the quality of care deteriorated so much that we rated it inadequate.

Our inspections supply care providers with detailed independent assessments of the quality and safety of their services. These inspection reports help to identify real issues for boards and leadership teams to consider how to resolve, alongside their own internal quality reporting and assurance.

Strong, visible leadership continues to be a major factor in delivering and sustaining high-quality services, and in making improvements. In services rated outstanding, the management team was aware of the organisation's strengths and areas for improvement, and engaged and involved staff, people who use services and local stakeholders in developing the organisation's vision and strategy. Effective engagement and understanding the point of view of the person receiving care and support were also important. Our inspectors noted that the best providers often had a stronger drive to improve, were focused on how to make services better for

people, and were committed to collaborating with others to achieve this.

### **People's views of services broadly remain positive, but this masks significant variation in experiences of care**

On the whole, public opinion of health and care is positive. When surveyed, around three-quarters (74%) of people agreed that local NHS services in general were good. Almost two-thirds (62%) of people receiving adult social care services paid for by their local authority said they were extremely or very satisfied with their care and support. But this is only a partial picture: it means that between a quarter and a third were not satisfied with their care, and there are no equivalent surveys to capture the views of people who pay for their own social care, or of those who have to rely on their families or informal care arrangements.

CQC hears directly from people who use services, and families and carers when they complete our online Share Your Experience form. In 2015/16, more than 16,000 people told us about their care in this way. The views they shared were mixed. Two-thirds of their comments were to report a problem, and a third were to compliment the care they received.

This variation in quality extends to the care received by different groups of people. People from different backgrounds and with different needs receive variable quality of care – for example people with mental ill-health and younger people, who say their experiences of using NHS acute hospitals are not as good as others.

### **The majority of GP practices are providing good quality care and leading the change in service design**

The majority of GP practices provide a good quality of care to their patients. We have rated 83% of practices as good and a further 4% as outstanding. Where we have re-inspected, three-quarters of

practices (153 out of 203) that needed to improve have done so. However, this means that a quarter of these practices did not improve.

Mounting pressures have been acknowledged in recent months with the publication of the *GP Forward View*. As this emphasised, the success of the health and care system relies on effective primary care to keep people well for as long as possible.

We have started to see substantial changes in GP practices, with informal and formal federations being created to achieve economies of scale in care provision and to transform the services they offer. We expect to see the first multi-specialty community provider being set up shortly – likely to be the first of many – that will seek to integrate provision of care more closely for population groups. We will continue to monitor their progress and support the sharing of best practice as it emerges.

### **Adult social care services have been able to maintain quality, but there are indications that the sustainability of adult social care is approaching a tipping point**

Many care homes, home care agencies and other adult social care services are providing good quality care (71% rated as good and 1% rated as outstanding). Where we identified services that were inadequate, some of these stopped operating before we were able to re-inspect. Of those that we did re-inspect, more than three-quarters (399 out of 520 initially rated inadequate) had improved enough to receive a higher rating.

However, this means that nearly a quarter of these re-inspected services did not improve. Also, far fewer services improved after being rated as requires improvement. Half of services rated as requires improvement that we re-inspected (904 out of 1,850) had no change to their rating. In 153 cases (8%), we found that the care had become inadequate.



Until now, the growth in demand for care for people with greater care needs has been met by a rise in the number of nursing home beds. However, this growth has come to a halt in the last 16 months. Through our market oversight team, we have access to detailed financial information about the largest adult social care providers. We have seen profit margins reducing – both due to pressures on fees that funders of care are able or willing to pay, and cost pressures that include the impact of the national living wage. Already we have seen examples of large providers starting to hand back home care contracts that they think are uneconomic and undeliverable.

While so far the sector has been more resilient than some anticipated, we are concerned about the fragility of adult social care and the sustainability of quality. This is concerning for the continuity and quality of care of people using those services, and for the knock-on effects across the whole health and care system: more emergency admissions in A&E, more delays for people ready to leave hospital, and more pressure on other services.

### **Hospitals are under increasing pressure**

While many hospital core services were rated good or outstanding, especially services for children and young people (63% rated good and 4% rated outstanding) and critical care (57% good and 8% outstanding), some need to improve, including urgent and emergency services (38% rated good and 5% rated outstanding) and medical care (39% good and 5% outstanding).

The difficulties in adult social care are already affecting hospitals. Bed occupancy rates exceeded 91% in January to March 2016, the highest quarterly rate for at least six years. And in 2015/16, we saw an increase in the number of people having to wait to be discharged from hospital, in part due to a lack of suitable care options.

At overall trust level, the majority of NHS acute trusts (61%) were rated as requires improvement

overall, because most have a few core services where the quality can be improved.

While we have seen improvement in several trusts rated inadequate with the help of special measures, we have also seen trusts that have failed to improve and a small number where there has been evidence of a deterioration in quality. Alongside our partners, we are exploring the reasons for this. However, we do have concerns about the implications, given that the pressures facing the hospitals sector are likely to increase.

More than eight out of 10 NHS acute trusts were in financial deficit at the end of 2015/16 and steps have been taken to address these. Our analysis shows that better ratings are associated with a better median year-end financial position (a smaller deficit or even a surplus). We have seen that good, stable leadership is a critical factor in maintaining quality and achieving financial control. If it is in place, there is a greater chance of success.

Overall, the quality of care received in NHS mental health trusts is broadly similar to that in acute trusts. There is a high level of variability within mental health providers as well as between them – community services are more likely to be rated good or outstanding than inpatient wards such as those for working age adults and psychiatric intensive care units. Where we had concerns about the safety of mental health services, problems with the physical environment frequently contributed to a rating of requires improvement or inadequate for inpatient services.

### **While we are seeing some improvement, we are concerned about the sustainability of quality**

Maintaining quality while demand increases and budgets are under pressure is going to be challenging, even for the best-led services.

Over the past few years, we have seen commissioners and providers aim to protect, as far as possible, the quality of care. It is important that the focus on







quality that we have seen over the past few years is maintained, and that people can continue to access high-quality care.

Some providers are navigating the demand and financial pressures by starting to shift towards new models of providing care. Some are engaging their own staff, other local care providers, local stakeholders such as Healthwatch, and the public to think differently about how they can deliver services together – such as moving services closer to people’s homes, exploring the relationship with local care partners to improve hospital discharge rates, and supporting more people to manage their own care through the use of technology. Some areas are having these conversations in the context of wider plans for devolution.

All local health and care leaders need to be having a conversation with their local populations about the hard choices that need to be made – about the right balance of investment and about which services to provide and invest in. The sustainability and transformation planning process, based on the NHS *Five Year Forward View*, is one important opportunity to do so.

These new care models may release efficiency savings in the medium term, but will take time to develop and embed. Sustained support will be needed for new models to become established and improve, and investment will be needed to support leadership and enable the desired transformation.

All parts of local health and care systems – commissioners, providers, regulators and local people – need to work together to help transform local areas. Working with our partners, CQC will offer the system whatever support we can to make the changes necessary to ensure high-quality care into the future.



**91%**

Hospital bed occupancy rates exceeded 91% in January to March 2016, the highest quarterly rate for at least six years.

The majority of GP practices provide good quality care – we rated

**83%**

of practices as good and

**4%** as outstanding





## Part 1 THE STATE OF CARE IN ENGLAND

The main cross-sector themes and picture of our findings across health and social care.

## Part 2 THE SECTORS WE REGULATE

A more detailed account of the quality of care we have observed in each of the sectors we regulate, and including reports on equality in health and social care and on the use of the Deprivation of Liberty Safeguards.

# Introduction

This report sets out the Care Quality Commission's (CQC) assessment of the state of care in England in 2015/16. We use our inspections and ratings data, along with other information, including that from people who use services and their families and carers, to inform our judgements of the quality of care.

## How we work

Our inspections and ratings allow us to highlight those services that are delivering high-quality care, and recognise and act when we find poor care. When we inspect we ask the same five key questions of every provider or service: Is it safe? Is it effective? Is it caring? Is it responsive? Is it well-led?

We then award one of four ratings: outstanding, good, requires improvement or inadequate.

## Our inspections and ratings programme so far

We are now close to establishing a full picture of the quality of health and social care in England. We have completed our first full programme of inspections with ratings for all NHS acute, mental health and community trusts. We will complete our inspection and ratings programme for adult social care, GP practices, out-of-hours GP services and independent acute hospitals by the end of 2016/17.

We now have a substantial baseline from which to draw conclusions about the quality and safety of care and what influences this.

There are some services that we inspect but do not rate, for example primary dental care. We assess these using our five key questions to check whether the fundamental standards are met, and publish the results in a transparent way. The Department of Health is currently consulting on proposals to extend CQC's rating powers to some sectors, including cosmetic surgery, independent community health services, independent ambulances, substance misuse centres and termination of pregnancy services.<sup>1</sup>





## Our data

To present as contemporary a picture of quality as possible, the data on inspections and ratings in this report is for CQC ratings published as at 31 July 2016. This covers:

- 16,764 adult social care services
- 133 NHS acute hospital trusts
- 35 independent acute hospitals
- 13 NHS community health trusts
- 47 NHS mental health trusts
- 161 independent mental health locations
- 3 NHS ambulance trusts
- 4,551 primary medical care services.

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

- Quantitative analysis of our inspection ratings of more than 21,000 services and providers (as set out above), 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 107 inspection reports that either showed evidence of improvement to a rating of good for our safe and well-led key questions, or evidence of outstanding practice in terms of our responsive key question. There were 63 reports from our Adult Social Care directorate, nine from our Hospitals directorate and 35 from our Primary Medical Services directorate, all published from September 2014 to March 2016.

- Analysis of 13 focus groups with more than 170 CQC inspectors, inspection managers and heads of inspection. Groups were held during April and May 2016 for every sector and across all regions to ensure diversity of inspectors' knowledge and experience.
- All the findings have been corroborated 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 and, unless otherwise stated, it relates to the year ended 31 March 2016.







# Part 1

## THE STATE OF CARE IN ENGLAND



# 1. Context

## Key points

- People are living longer, and many older people are living with multiple complex conditions.
- Adult social care faces rising demand and high levels of unmet need among older people.
- Last year, nearly two-thirds of all NHS providers recorded a deficit; the majority of these were acute hospital trusts.
- In primary medical services, there is a shortage of GPs combined with increasing vacancy levels.
- Some providers are starting to shift towards new models of delivering care to people, including using new technologies.

The health and social care system has continued to operate in a challenging context during 2015/16, with the demand for care services continuing to increase and the added pressure of tough financial conditions.

England's population continues to change and, with this, the nature and breadth of health and social care needs. People are living longer, and many of them are living with multiple complex conditions, creating a sharp rise in demand for health and social care. From mid-2005 to mid-2015, the number of people aged 65 and over in the UK increased by 21%; the number aged 85 and over increased by 31%.<sup>2</sup>

In primary medical services, a shortage of GPs combined with increasing vacancy levels means that practices may be understaffed. NHS England's *GP Forward View* describes a plan to create an extra 5,000 doctors in general practice by 2020.<sup>3</sup> The 2016 GP Patient Survey showed that, in the last four years, the proportion of people waiting a week or more to see a GP rose from 13% in June 2012 to 19% in July 2016.<sup>4</sup>

Hospitals are dealing with unprecedented demand for services. In 2015/16, emergency admissions, elective admissions and outpatient

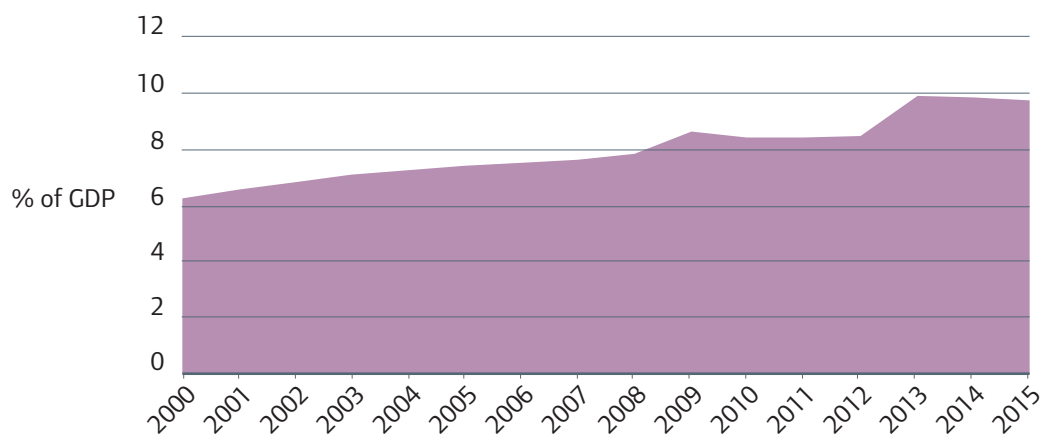
attendances each rose by 3% on the previous year.<sup>5</sup> Waiting lists also increased during the year – the proportion of patients on the waiting list for more than 18 weeks and still waiting to be seen increased to 8.5% in March 2016.<sup>6</sup>

Bed occupancy rates for general and acute settings were also high. In each quarter of 2015/16 they were above the recommended maximum of 85%.<sup>7</sup>

Hospitals are also being expected to make significant efficiency savings. The total provider deficit in 2015/16 (the amount spent by NHS trusts over and above their income) reached £2.45 billion. Last year nearly two-thirds of all NHS providers recorded a deficit; the majority of these were acute hospital trusts.<sup>8</sup>

In adult social care, authorities have reported that budgets have not kept pace with demand, and the introduction of the national living wage has increased cost pressures for providers. Many directors of adult social services have reported that providers are now facing financial difficulties and that some providers have decided to withdraw from local authority contracts due to low levels of funding.<sup>9</sup>

Figure 1.1 UK total health spending as a percentage of GDP, 2000 to 2015



Source: Organisation for Economic Co-operation and Development – Health expenditure and financing

At the same time, adult social care faces rising demand and high levels of unmet need among older people. In 2015, Age UK estimated that more than a million older people in England were living with unmet social care needs (such as not receiving assistance with bathing and dressing), a rise from 800,000 in 2010.<sup>10</sup>

The UK's spending on health as a proportion of GDP (9.8% in 2015 on public and private health) has started to decline after a number of years of growth (figure 1.1)<sup>11</sup>. We spend less on health when compared with some other western European countries, including France, Germany, the Netherlands, Sweden and Norway. Public spending on adult social care as a proportion of GDP declined from 1.05% in 2009/10 to 0.85% in 2014/15.<sup>12</sup>

The overall picture for the UK is that, although access to health care is broadly good, performance in key areas of health care is well below that of other OECD countries. In 2013, the UK had the second lowest rate of people waiting more than four weeks to see a specialist following GP referral (18 per 100 patients) of

16 OECD countries, but remained in the bottom third for five-year cancer survival rates.<sup>13, 14</sup>

This highlights the need for continued focus on driving up the quality of care and reducing inequalities in the experience of care for people living with different conditions and for different population groups.

Despite the pressures, public opinion of health and care continues to be generally positive. In the latest survey about people's perceptions of the NHS (July 2015), 61% of people thought it was offering a good service nationally; 74% agreed that local NHS services in general were good (although this was down from 78% the previous year).<sup>15</sup>

When considering adult social care in 2014/15, 62% of people who received services funded wholly or in part by local authorities reported



being extremely or very satisfied with the care and support they receive (broadly similar to previous years).<sup>16</sup> However, the number of people receiving local authority funded care has decreased and there is no equivalent data for satisfaction with privately funded care. The views of those no longer receiving care are also not captured.

Across the system, there is an innovation challenge to provide services in a different way, aligning with the ideas set out in the NHS *Five Year Forward View*. Some providers are navigating the demand and financial pressures by starting to introduce new care models and other developments in the way care is delivered, including using new technologies. For example, we are starting to see changes in primary care, such as online GP services and GP practices working together in federations. Some areas are having conversations about new care models in the context of wider plans for local devolution.

There are also examples of services working together more closely across local areas to deliver better person-centred care. Healthcare providers and commissioners are working within the Sustainability and Transformation Plan programme to develop new approaches to good quality, integrated care for their local populations. Some local adult social care stakeholders are involved in these conversations, but some are not. It is also important that wider engagement takes place across local government.





## 2. The quality of health and adult social care

### Key points

- The majority of people are receiving good quality care. Many services have achieved a good or outstanding rating, despite the difficult environment in which providers are operating.
- However, the quality of care varied considerably both within and between different services, and particular groups of people receive better care than others. Where we find poor care, we take action to protect people using the service.
- Some services were rated as requires improvement and have a number of specific areas to improve. More concerning are the minority of services rated inadequate – they are not providing care to the quality that people have a right to expect.
- Most services were rated consistently good or outstanding for being caring. However, we continue to find that safety is our biggest concern across all sectors and this is often influenced by the quality of leadership. Good leadership can reduce variation in the quality of care that people experience and is essential for sustaining high-quality care.

### 2.1 Most care that people are receiving is of a good quality

As at 31 July 2016, the majority of the services we have inspected were rated as good or outstanding, although this differs by sector. Given the rising demand and financial pressures under which services have been operating during 2015/16, this is something to be celebrated. The quality of care in the primary medical services sector was particularly good. Over four in five (83%) of GP practices were rated as good overall and 4% were rated as outstanding.

As we move towards completing our first full programme of inspections, we are seeing more providers rated good as our ratings coverage increases. This is partly because when we started our new approach, we first inspected services where we had most concerns; therefore as we expected, we are now seeing an improved overall picture. However, this improvement is also attributable to the hard work of providers –

when we went back to re-inspect we found that many services previously rated inadequate and requires improvement had made changes that improved their ratings (see section 3).

Other information also suggests that the majority of care delivered is of high quality: 85% of respondents to the most recent GP Patient Survey described their overall experience as very good or fairly good<sup>17</sup> and 85% of hospital inpatients surveyed rated their overall experience as seven or more out of 10.<sup>18</sup> Millions of people receive health or adult social care services every year that are safe and of high quality.

### 2.2 Services vary in quality

Despite the large number of services rated good or outstanding, variation in the quality of health and adult social care continues to be widespread, both within and between sectors.

Some services (around 23% of all those we have rated across all sectors) have received an overall



rating of requires improvement. Some aspects of care provided by these services may be good, but our inspection reports have highlighted specific areas that need to improve and that are significant enough to merit an overall rating of requires improvement.

We have also rated a minority of services as inadequate: 2% of adult social care services, 3% of GP practices and 5% of individual hospital services (we call the latter 'core' services). It is these services where we have the most concern.

Even within a single provider there can be large differences in the quality of care. There is also wide variation across our five key questions, with services consistently rated good or outstanding for caring across all sectors, but not necessarily for other areas of our inspections. Some groups of people say they experience lower quality care than others. For example, people with mental ill-health and younger people reported significantly poorer experiences when using NHS acute hospitals, while Black and minority ethnic groups and older people were less likely to be satisfied with adult social care services.<sup>19</sup> Our evidence continues to show that good leadership in a service can minimise the amount of variation that people experience.

There may also be some variation in the quality of care depending on where people live in the country. However, we cannot draw conclusions until next year, when we will have rated every service at least once.

Other information and research supports the view that variation in quality is a feature of health and care provision in England. People using adult social care services in London appear to be less satisfied than those in other regions (57% "very" or "extremely" satisfied compared with 65% in the south west).<sup>20</sup> There is a wide range in quality of provision by acute NHS trusts as shown in the performance against some high-profile targets. For example, in July 2016, the percentage of patients spending less than four hours in major A&E departments ranged from 64% to 99% (against a target of 95%).<sup>21</sup> Similarly in July 2016, the percentage of patients waiting less than 18 weeks for consultant-led treatment in NHS hospitals ranged from 75% to 100%.<sup>22</sup>

## 2.3 Quality of services

In this section we highlight what we have found in each of the main sectors (for more details, see part 2 of this report). We also give an overview of the quality of care as people experience it across services and sectors, based on our thematic reviews of the quality of care for people with specific care needs or for specific population groups.

### Adult social care

The adult social care sector continued to cope with a range of challenges during 2015/16, including reduced finances and problems with recruiting and retaining staff. However, despite some variation, overall quality remains good. Where we do find that the quality of care is lower than expected, we are taking action to make sure people are kept safe.

Up to 31 July 2016, we had inspected and rated more than 16,000 adult social care services (figure 1.2). Of these, 71% received a good rating overall and 1% were rated as outstanding (figure 1.3). A quarter (26%) of services were rated as requires improvement.

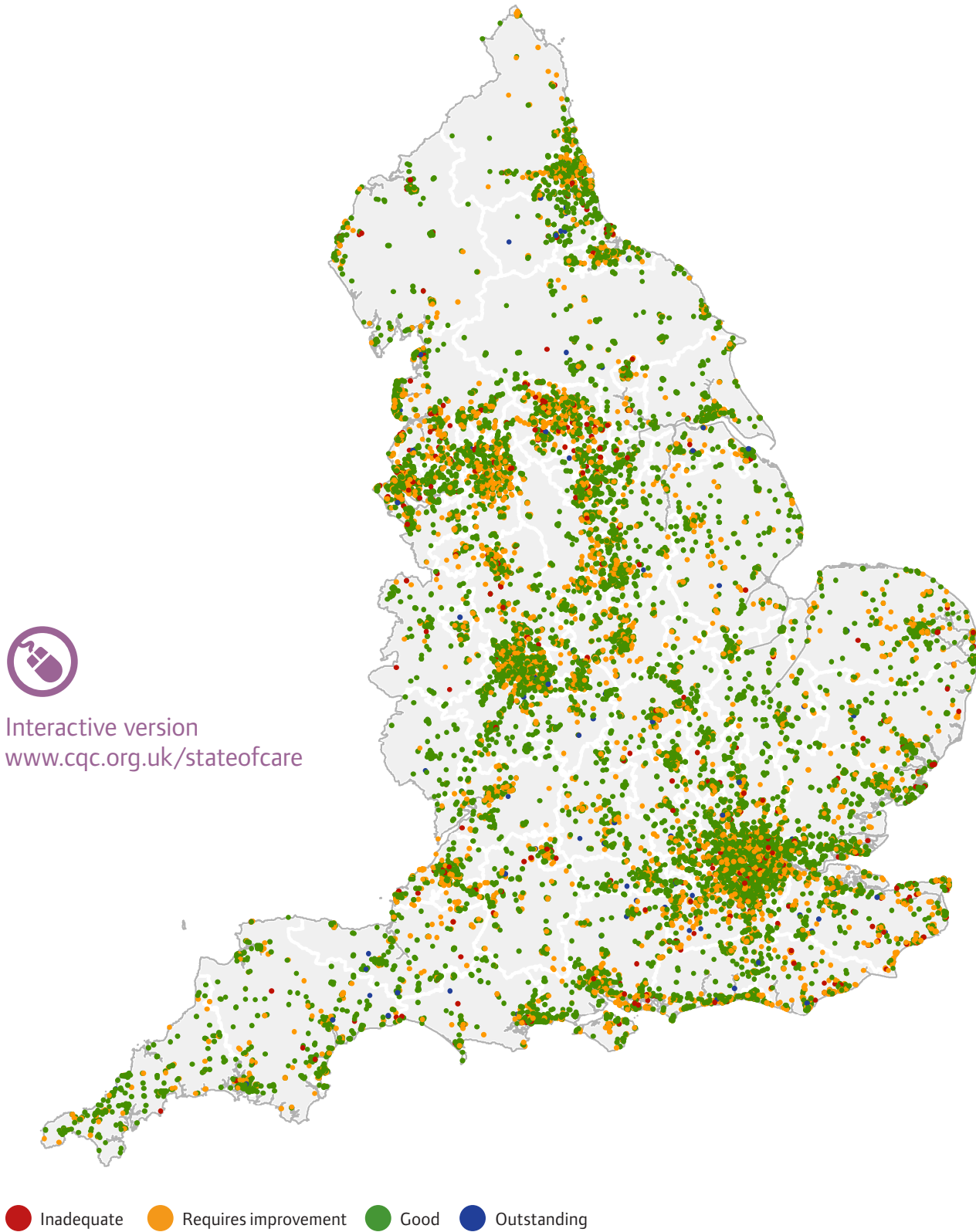
We are concerned about the 2% of services that were rated inadequate. Encouragingly, this figure was much lower than last year's figure of 7% of services rated inadequate.<sup>a</sup> This was due partly to the improvements made by many inadequate services that have resulted in better ratings, and partly to the targeted approach that we took when we began our new inspection programme to look first at services that were more at risk of providing poor quality care.

There is variation in different aspects of the quality of care. Services continue to perform best at being caring. In the majority of cases, our inspectors have seen that staff involve people in their care and treat them with compassion, kindness, dignity and respect. More than nine out of 10 services were rated as good (90%) or outstanding (2%) for caring.

Footnote:

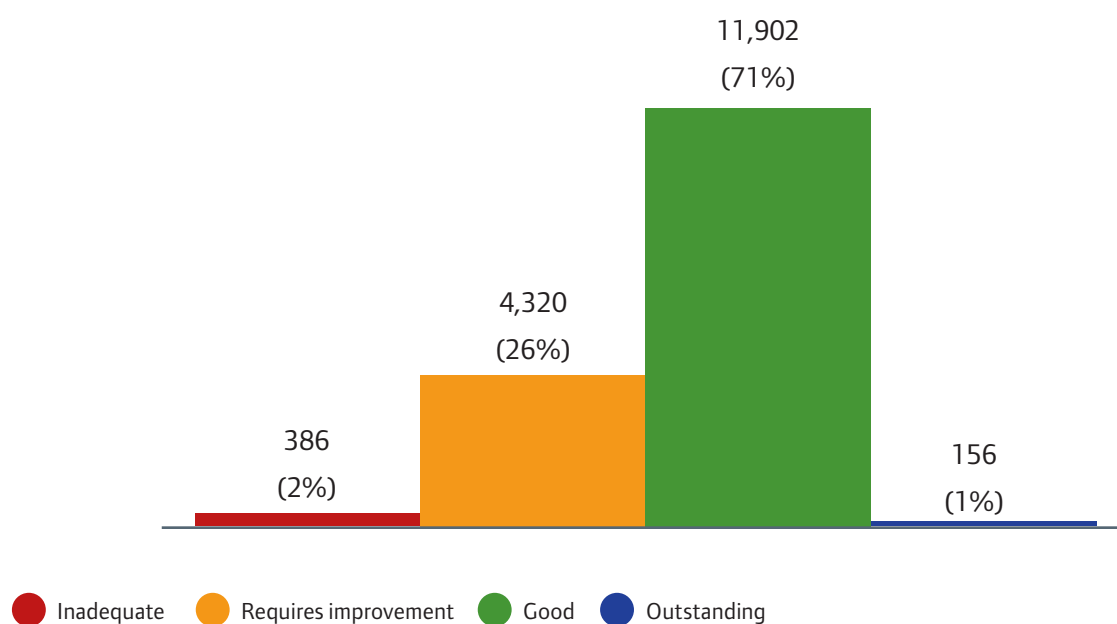
- a Note that the 2% of services rated inadequate relates to the latest position of all ratings as at 31 July 2016. As many of the services that were initially rated inadequate later improved, the picture throughout the year would have been somewhat higher than 2%.

Figure 1.2 Adult social care rated locations map, as at 31 July 2016



Source: CQC ratings data

Figure 1.3 Adult social care current overall ratings, as at 31 July 2016



Source: CQC ratings data, total of 16,764 services

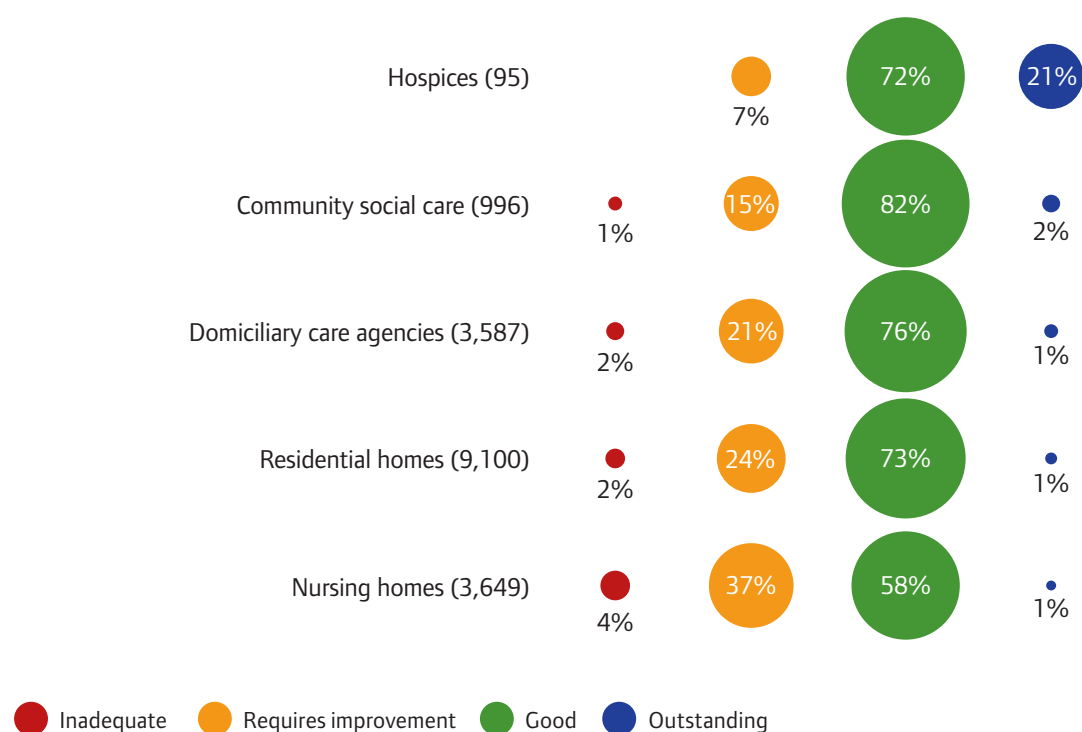
However, ratings for safety and leadership were comparatively lower, with 3% of services rated inadequate for safety and 3% of services rated inadequate for well-led. Low ratings for these key questions are concerning. Poor leadership can result in staff not being adequately supervised and people not being taken seriously if they raise a concern. Poor safety can mean systems and processes that are not adequate for managing medicines or serious incidents.

The results of this, in some cases, can be that people are not getting the right medicine or staff are not having time to care for people properly. In September 2016, a care home owner and its former manager were fined over £50,000 in a prosecution brought by CQC after admitting they failed to provide safe care.<sup>23</sup> People living in the home had been put at risk of significant harm because of the home's poor management and recording of the medicines people received.

### Deprivation of Liberty Safeguards

CQC is responsible for monitoring the use of the Deprivation of Liberty Safeguards in care homes and hospitals. These are used to protect the rights of people who are deprived of their liberty, and CQC reports annually on how they are used. See page 136 of this report for details about the protection and empowerment of individuals who are unable to make some or all of their own decisions.

Figure 1.4 Adult social care current overall ratings by service type, as at 31 July 2016



Source: CQC ratings data

Note: Locations can provide more than one type of service, so some locations may be counted more than once.

Hospices and community social care services (for example supported living and Shared Lives) were rated consistently the best overall when compared with other services (figure 1.4). Domiciliary care services and residential homes were rated similarly to each other and better overall than nursing homes. It is nursing homes that remain the biggest concern – although 58% were rated good and 1% were rated outstanding, 4% were rated inadequate. It is important that the adult social care system, especially commissioners and funders, addresses this disparity to ensure that all people receive high-quality care.

Where we judge that the quality of care is too low and providers are failing to meet legal standards, we act quickly to ensure that people are protected and services improve. In the adult social care sector, the majority of the enforcement actions we took during the year were Warning Notices (711 of 901 enforcement actions).

A Warning Notice is issued when the quality of care falls below what is legally expected. We also took other action when we had to, such as cancelling the registration of some providers to ensure people were protected and safe.

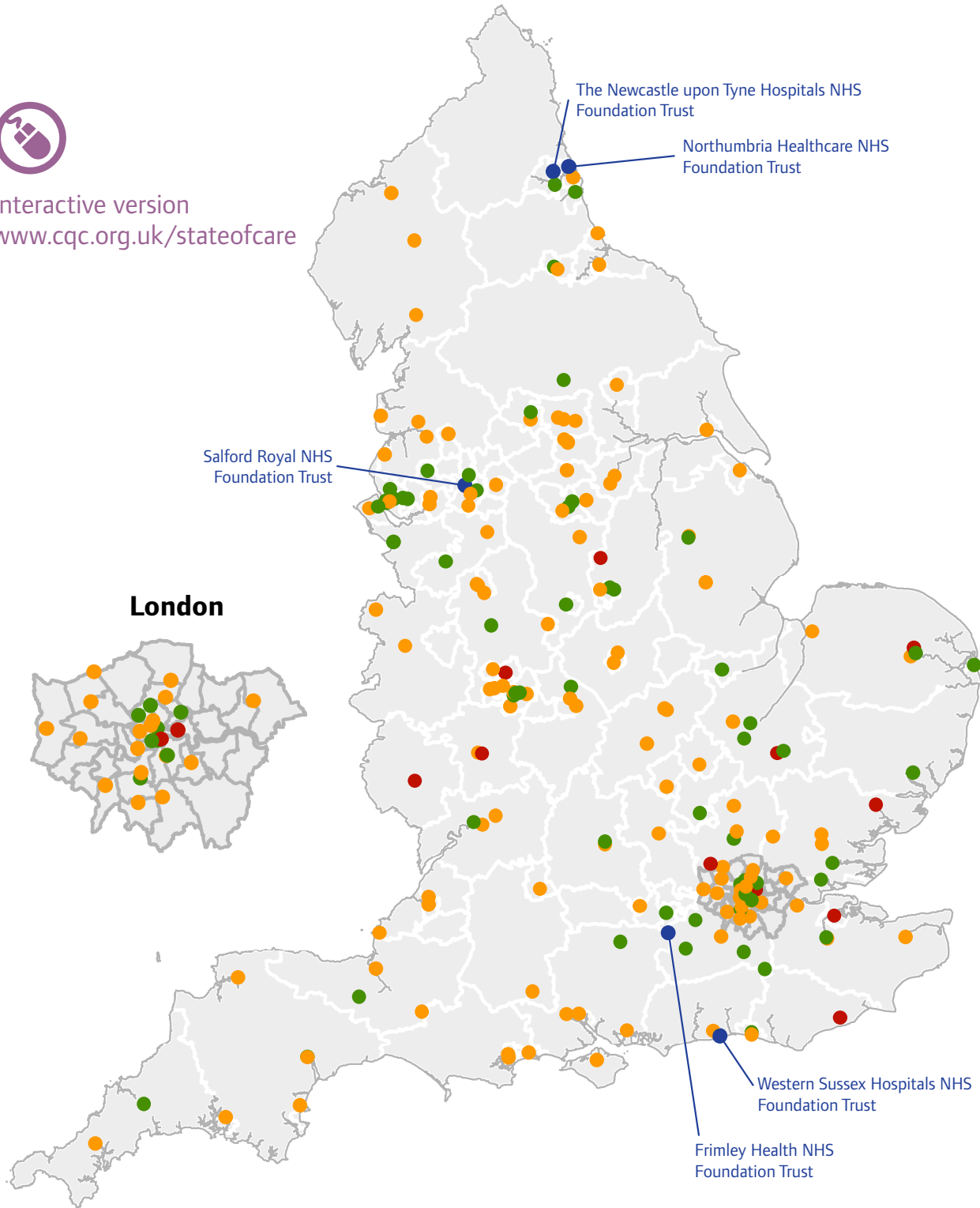
### Hospitals and NHS trusts, including community health and mental health

For this section, the definition of hospitals and trusts includes secondary and tertiary acute health care, mental health care, community health care and ambulance services. It covers independent healthcare settings as well as those provided by the NHS. As at 31 July 2016, we had rated 133 NHS acute hospital trusts, 35 independent acute hospitals, 13 NHS community health trusts, 47 NHS mental health trusts, 161 independent mental health locations and three NHS ambulance trusts.

Figure 1.5 NHS rated trusts map, as at 31 July 2016



Interactive version  
[www.cqc.org.uk/stateofcare](http://www.cqc.org.uk/stateofcare)



● Inadequate ● Requires improvement ● Good ● Outstanding

Source: CQC ratings data

Note: Map covers NHS acute, mental health, community health care and ambulance trusts

### Acute hospitals

Increased demand during 2015/16, such as for emergency and elective admissions, alongside difficult financial conditions, has put intense pressure on the hospitals sector. There is considerable variation in quality between and within hospital trusts and locations.

We inspect individual services such as urgent and emergency care, surgery and outpatients (we call these 'core services'). These core services are where most people directly experience care. Of the core services in NHS acute trusts, 51% were rated good and 5% were rated outstanding (figure 1.6).

A further 39% were rated as requires improvement. These services may provide good care in some areas, but they will have a number of specific areas that need attention. In these cases our inspection reports give detailed advice on how the services can improve. Five per cent of core services were rated inadequate and need urgent attention from management to address the problems.

We also provide ratings for a whole acute hospital, by aggregating the ratings across its core services. Looking at it this way, 37% of acute hospitals were rated good and 5% were rated outstanding. Performance is lower than for core services because it is much harder to be good across a wider spectrum. Hospitals offer a broad range of care, see high numbers of patients, and they have complicated pathways for patients with a wide range of needs. It is therefore possible that a few poorer core services will limit the hospital's overall rating. The example in figure 1.7 illustrates the range of ratings that a single hospital can have.

We also provide ratings for NHS acute trusts, which often manage more than one hospital and multiple different core services in a range of settings. These ratings are calculated by aggregating ratings across the hospitals within that trust. Again this means it is more likely that poorer ratings at core service or hospital level

will affect the trust rating. Overall, 28% of NHS acute trusts were rated good and 4% were rated outstanding.

Figure 1.8 shows the eight core services for acute hospitals. There was a marked difference between the proportion of services for children and young people rated as good (63%) and the proportion of urgent and emergency services rated as good (38%). This suggests that people may experience different levels of quality of care depending on the core services they need to use. Alongside the variation in quality that also exists between different hospitals and trusts, the quality spectrum can look very wide indeed.

As with other sectors, hospitals continue to receive the best ratings for the caring key question (77% of NHS acute trusts were rated as good and 17% were rated as outstanding for caring). We observe the majority of staff treating their patients with respect and dignity, for example making sure that they respect patients' privacy and that they explain to patients what their care involves. The safety of care is our biggest concern (10% of NHS acute trusts were rated inadequate for safety). Ensuring consistently safe care remains the single biggest challenge for hospital providers – for example, ensuring that patients always receive the correct medicine and at the right time.

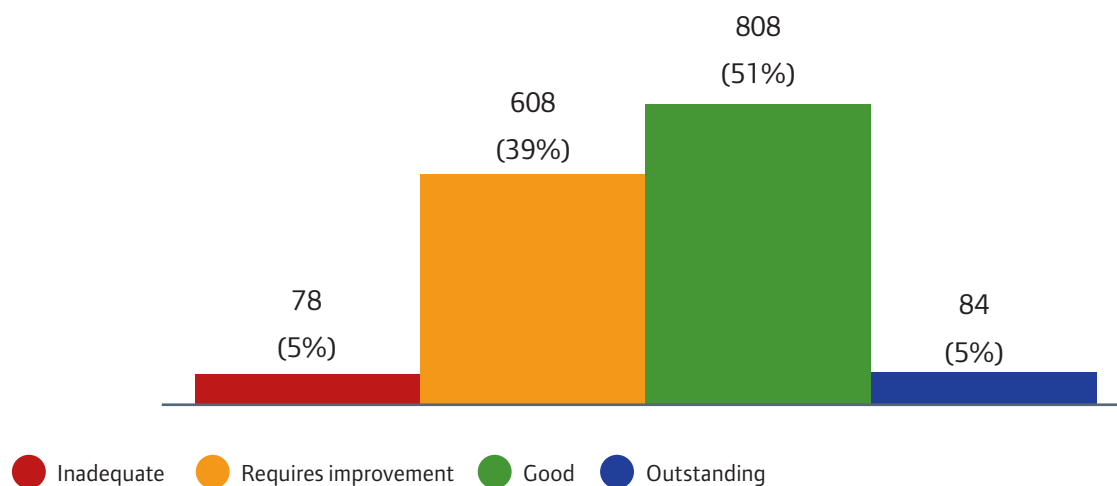
### Community health services

Community health care is provided by a range of different organisations. There are 18 NHS community health trusts that primarily provide community health services to their local populations. In some areas of the country, NHS community health services are provided by acute trusts or mental health trusts. In addition, there are more than 100 independent community health services – many of these are not-for-profit social enterprises and community interest companies.

Figure 1.9 shows the ratings given to the community core services, as at 31 July 2016, across the standalone community trusts, acute



Figure 1.6 NHS acute hospital current overall ratings for core services, as at 31 July 2016



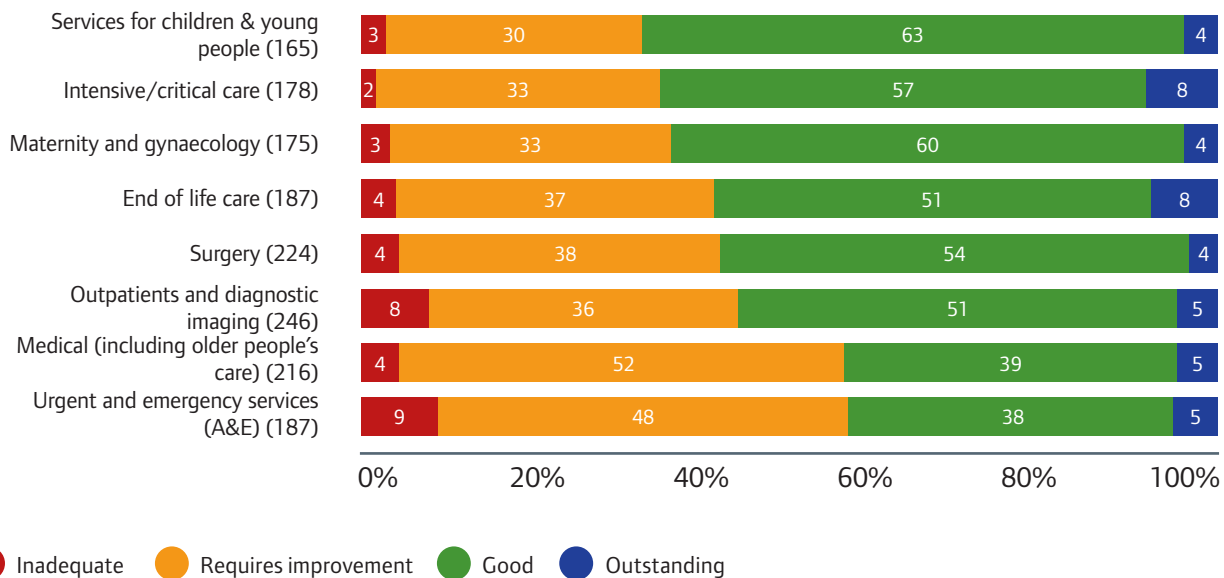
Source: CQC ratings data, total of 1,578 core services

Figure 1.7 Example of a ratings grid for an acute hospital

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

Source: CQC ratings grid for Weston General Hospital, August 2015

Figure 1.8 NHS acute hospital current overall ratings for each core service, as at 31 July 2016



Source: CQC ratings data

trusts and mental health trusts. Overall, the quality of care in community services was good. The quality of care was highest in community dental services, with five services out of 29 (17%) achieving an outstanding rating and 20 (69%) achieving a rating of good. The quality of care for the other three core community services was broadly the same, with around 70% of services being given a rating of good or outstanding.

### Mental health services

As at 31 July 2016, we had inspected all 57 NHS mental health trusts and published inspection reports and ratings for 47 trusts. Of the 47 rated, 16 were rated as good. In September 2016, we rated the first two outstanding mental health trusts – Northumberland, Tyne and Wear NHS Foundation Trust and East London NHS Foundation Trust.

However, care for people with a mental health condition needs to improve, with 30 trusts rated as requires improvement and one rated as inadequate.

In each mental health inspection we look at up to 11 core services and give each a rating, which is then aggregated to give an overall rating. As in acute trusts, there was considerable variation by core service. In some cases, community services were rated

better than their inpatient counterparts; in others the opposite was true (figure 1.10). A large majority of NHS community mental health services for people with a learning disability or autism were rated good (84%) or outstanding (3%). In these services, we tended to find that staff were skilled and appropriately trained, patients were involved in planning their care, and there were systems in place to deal with urgent referrals. At the other end of the scale, less than half (45%) of NHS acute wards for working age adults had a good or outstanding rating.

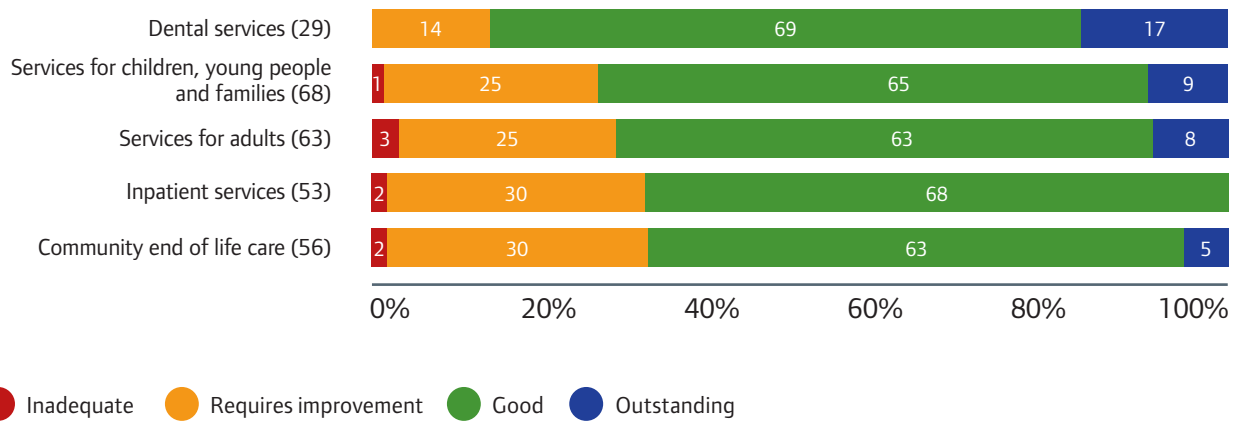
We also inspected 161 independent mental health locations. Of these, seven (4%) were rated as outstanding, 103 (64%) as good, 43 (27%) as requires improvement and eight (5%) as inadequate

Safety is our biggest concern for mental health services, with 9% of both NHS trusts and independent locations given a rating of inadequate for safety. Problems with the physical environment frequently contributed to a rating of inadequate or requires improvement for inpatient services.

### Primary medical services, including GP practices and dental practices

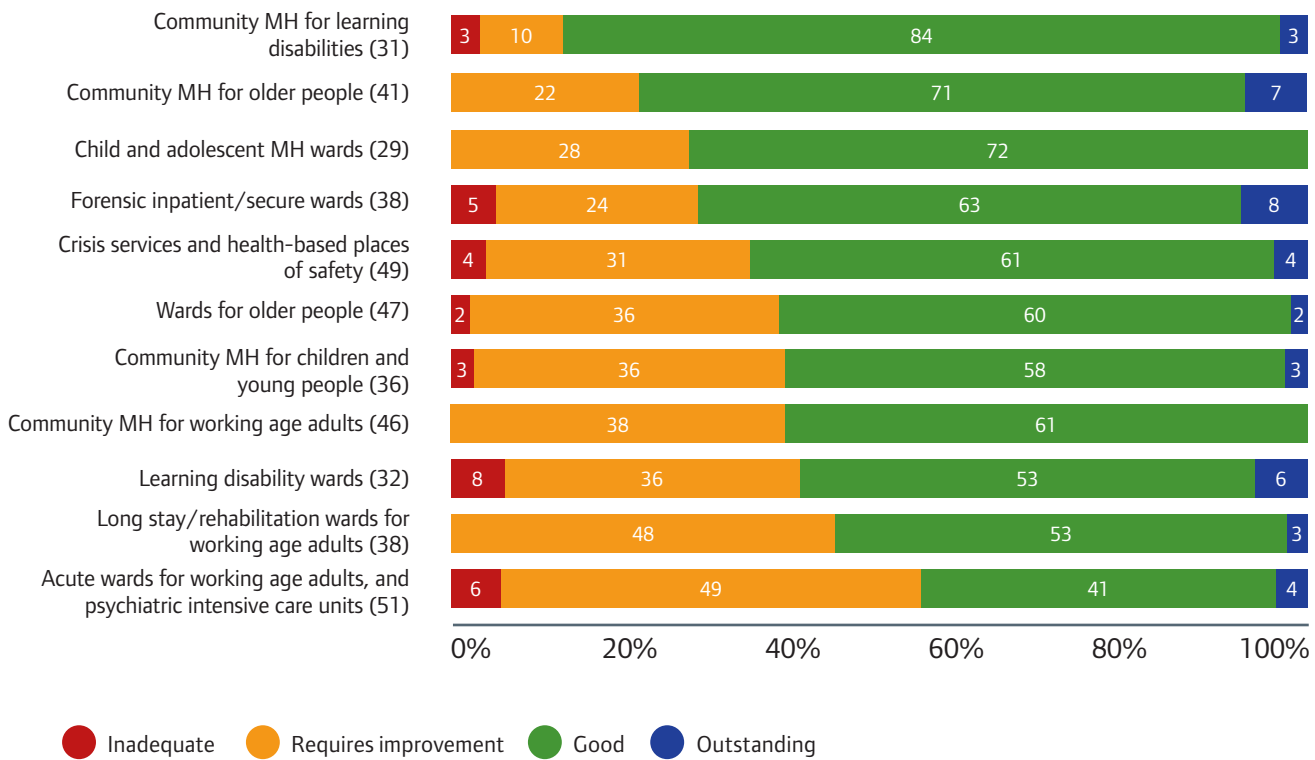
Like the other sectors, primary care is facing the challenge of increased demand, coupled with a

Figure 1.9 NHS community health current overall ratings for core services, as at 31 July 2016



Source: CQC ratings data

Figure 1.10 NHS mental health current overall ratings for core services, as at 31 July 2016



Source: CQC ratings data

shortage of GPs and increasing vacancy levels. Despite this, overall quality in the sector remains high.

The vast majority of the 4,511 GP practices rated so far (of more than 8,000 in total) had a good (83%) or outstanding (4%) rating. Ten per cent were rated as requires improvement (figure 1.11).

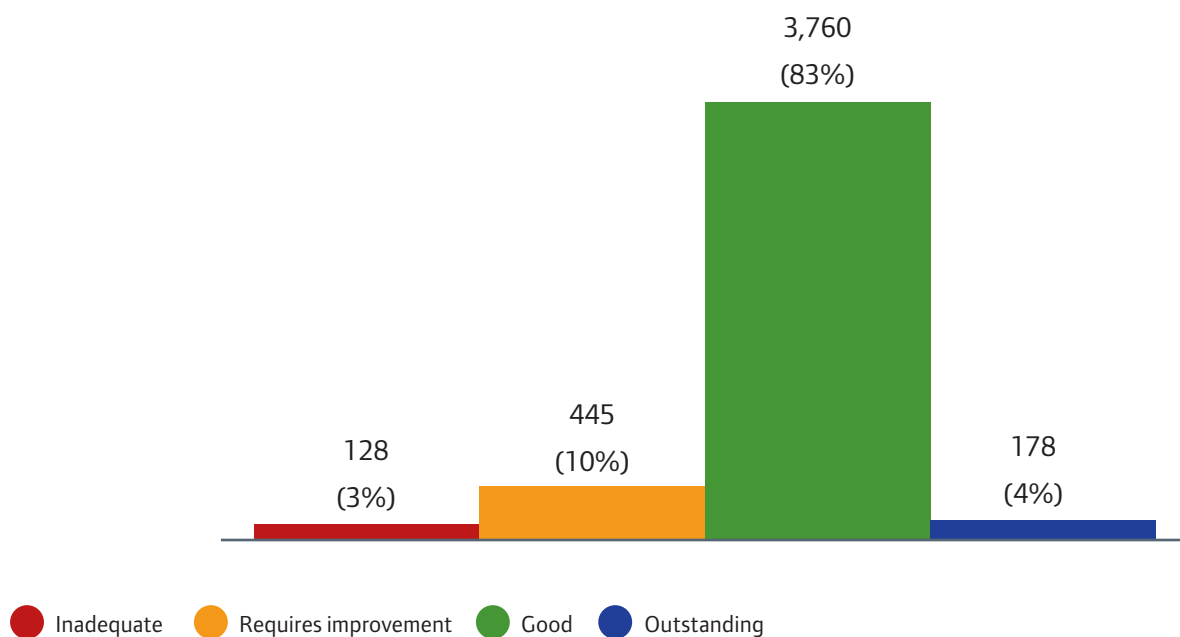
A small proportion of GP practices were rated inadequate (3%). We found that this is often underpinned, for example, by a poor safety or leadership rating. Even though the percentage is low, it means that more than 800,000 people were registered with practices rated inadequate for safety, which remains a concern. This can mean that buildings and equipment are not maintained properly, or that medicines are not stored correctly.

We inspect out-of-hours and urgent care centres, both of which are important routes for people who need rapid help and who otherwise would probably go to A&E departments. To date, 14 out of the 15 out-of-hours providers we have

inspected were rated good; 12 out of 17 urgent care services were rated good, and one service was outstanding. There were no services rated inadequate.

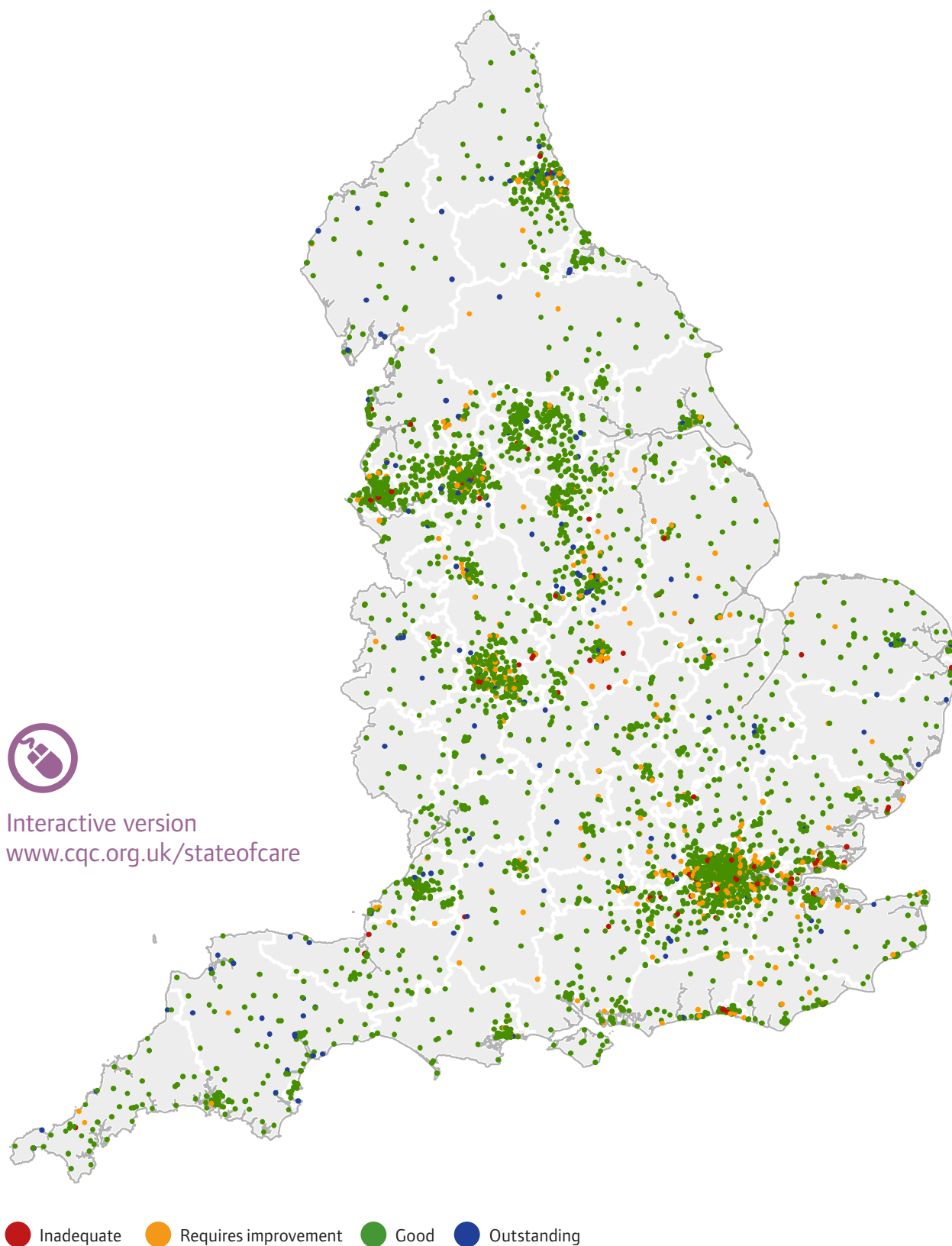
We also inspect dental care. Although we do not give dental practices a rating, we use our five key questions to assess practices and to make recommendations or take enforcement action where needed. Overall, people were receiving good quality dental care (figure 1.13). However, 10% of the dental practices that we inspected up to 30 June 2016 needed to make improvements, and we took enforcement action against 1% of the practices we inspected. As in other sectors, where there are concerns, they tend to be related to the well-led and safe key questions – for example not carrying out mandatory audits or having incomplete dental records. This can mean that dentists do not have the right information to hand when they are treating a patient.

Figure 1.11 GP practice current overall ratings, as at 31 July 2016



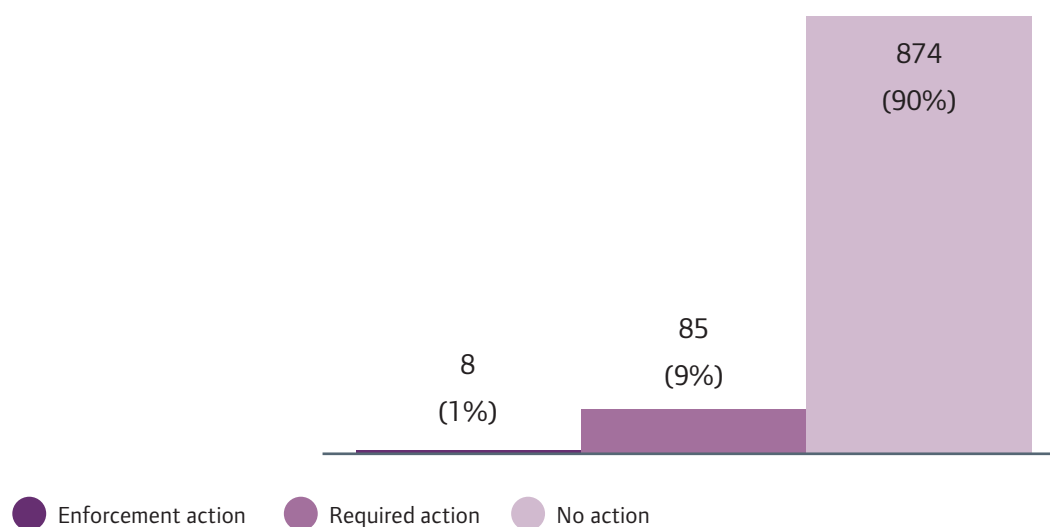
Source: CQC ratings data, total of 4,511 GP practices

Figure 1.12 GP practice rated locations map, as at 31 July 2016



Source: CQC ratings data

Figure 1.13 Outcome of dental care inspections, as at 30 June 2016



Source: CQC inspection and enforcement data, total of 967 inspections

## 2.4 The quality of care that people receive across services

Many people experience the care they receive as part of a number of different interactions with different services and staff – for example as part of a particular group (such as children) or in managing a particular long-term condition (such as diabetes). Our work includes looking at the quality of care for people as they experience it across services in this way, complementing what we know about individual services. We found much good care through this work, but also variations depending on where care is provided or who is receiving it.

### Integrated care for older people

We looked at how services worked together to meet the needs of older people:

- There was widespread commitment and drive from providers and commissioners to improve the way services work together to provide integrated care for older people.
- However, there was considerable variation in the quality of the care provided and in the experiences and outcomes for people using services.

- Where care was integrated, local leaders were working closely across health and social services to share information, reduce duplication and use resources more effectively.<sup>24</sup>

### End of life care

We looked at inequalities in care for people at the end of their lives:

- People from some groups, including equality groups and people whose circumstances may make them vulnerable, experienced poorer quality care at the end of their lives. Equality-led approaches by commissioners led to better experiences for people.
- A lack of understanding of people's individual needs was a significant barrier to people receiving good, personalised care. Health and care staff did not always have conversations about end of life care early enough to enable them to plan personalised care.
- Providers and commissioners did not always understand or fully consider the needs of everyone in their community.<sup>25</sup>



## Neonatal care

We looked at how risks for newborn babies are identified and managed, and at care for infants in the community who need respiratory support:

- There was limited national guidance on handling fetal anomalies and transition between specialist teams. There was inconsistency in how information about the fetus was communicated between specialist teams, and in how data was transferred from the mother's to the baby's notes.
- There were no national guidelines on how to identify hypertension in babies and children.
- There was variability across clinical commissioning groups in managing care for infants in the community who need long-term ventilation. This included training for care staff, the frequency of reviews of home care, and advice available to families.<sup>26</sup>

## Children's transition to adult services

There are more than 40,000 children and young people with complex physical health needs. We looked at their experiences of moving to adult services:

- Young people living with physical disabilities or illness were not always receiving the necessary care and support they need when they moved on to adult care services, with some children's services stopping the care they provide before the equivalent adult services had started.
- In some cases families were left feeling confused and distressed by the lack of information and support given to them.<sup>27</sup>

## Diabetes care in the community

Almost 3.5 million people are living with diabetes in England. We looked at how well care services work together to deliver diabetes care in community settings. The report made clear the importance of supporting people with long-term conditions to manage their own care:

- Some people needed more emotional support than they were receiving – at diagnosis and on an ongoing basis. This was not always recognised by services or health professionals, including for

people with Type 2 diabetes, where the need might be more than previously thought.

- Some people were not supported enough to fully understand their test results. Not enough people had a hand-held care plan that they could take with them as they moved between services.
- Knowledge of diabetes could be lacking within some staff groups, particularly in adult social care, and in some areas there was no diabetes training for care workers. This could result in a lack of support for people who rely on others to help manage their diabetes.<sup>28</sup>

## Mental health crisis care

In 2013/14, 1.8 million contacts were made with mental health crisis teams. We looked at the help, care and support people receive during a mental health crisis:

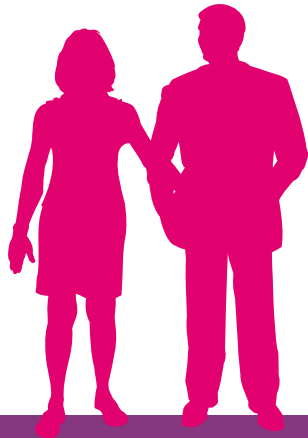
- The quality of care experienced by a person in crisis varied depending on where they live and when they seek help.
- Many people found that help was not available when they needed it, care was not centred around their needs and staff did not always treat them with respect or compassion when they were in crisis.
- Local services are developing innovative approaches to the challenge of providing a high-quality response to people in crisis.<sup>29</sup>

## Equality of care

Providers' focus on equality of access, experience and outcomes should be at the centre of their services. CQC has a statutory obligation to report on equalities and this runs through our work. In this report, we look at how providers are meeting the needs of their communities and we share examples of good practice. See page 122.

Figure 1.14 Improving the quality of care at different life stages





## Working age adults

### Mental health crisis care review

We looked at the help, care and support people receive during a mental health crisis.

### What is needed so people receive good quality care

- Services must be responsive to people's needs and enable people to have access to support and care when they need it, irrespective of where they live.
- People should be treated quickly and compassionately in line with evidence-based models of good practice.
- Innovative approaches to improving crisis care should be shared and services should be integrated around the needs of the person.



## Older people

### Integrated care for older people review

We looked at how services work together to meet the needs of older people.

### What is needed so people receive good quality care

- Care plans should be streamlined and information shared across services.
- Services should ensure that older people are fully involved in their care.
- Organisational barriers must be broken down so services can intervene early when people are at risk of unplanned hospital admissions.
- Leaders should develop a shared understanding of what integrated care means for people in their local area.
- Data and outcomes measures for integrated care should be developed and shared.



## End of life

### End of life care review

We looked at inequalities in care for people at the end of their lives.

### What is needed so people receive good quality care

- Responsiveness to people's needs to reduce inequalities and eliminate discrimination.
- Local system leaders, commissioners and providers need to work together to ensure staff have the right knowledge and skills to deliver good quality end of life care.
- GPs should initiate early conversations about people's conditions, options for treatment and their wishes.

Source: CQC thematic reports – Identifying and managing clinical risks in newborn babies and providing care for infants in the community who need respiratory support (July 2016); From the pond into the sea: Children's transition to adult health services (June 2014); My diabetes, my care: Community diabetes care review (September 2016); Right here, right now: Mental health crisis care review (June 2015); Building bridges, breaking barriers: Integrated care for older people (June 2016); and A different ending: End of life care review (May 2016).



## People's involvement in their own care

We looked at how well people are involved in their own care and what good involvement looks like:

- Enabling people to be more in control of their own care led to better and often more cost-effective outcomes, particularly for those with long-term conditions.
- Just over half of people said they felt involved in decisions about their health care and treatment, and women who use maternity services were particularly positive.
- There had been little change in people's perceptions of how well they are involved in their care over the last five to 10 years, despite the national drive for person-centred care.
- People with long-term health and care needs were least likely to report feeling involved, particularly adults and young people with long-term conditions, people with a learning disability, and people over 75 years old.<sup>30</sup>

Through these findings, we have started to develop an understanding of what needs to improve to make sure that people receive high-quality care at every stage of their lives and in different care settings (figure 1.14). We are also currently looking at how NHS acute, community healthcare and mental health trusts investigate deaths and learn from their investigations, and we plan to publish our findings later this year.

## 2.5 Quality of care in local areas

We are starting to look at quality of care across local areas and we have published ratings maps on our website to highlight the quality of care across England. We have identified some early themes around how care is coordinated and integrated, and how this affects people's experience of care. We will continue to refine our approach.

We also work closely with NHS England, NHS Improvement and other national partners to contribute to Sustainability and Transformation Plans, to ensure that maintaining and improving

the quality of care is built into local area planning. This includes a CQC ratings indicator in the NHS England CCG assessment framework.

### Salford and North Lincolnshire

In 2016, we published prototype reports that explored the quality of care in Greater Manchester (Salford and Tameside) and North Lincolnshire.<sup>31, 32</sup>

These were exploratory reports, focusing on two specific population groups – people aged over 75 and people needing mental health care. We found some examples of how integrated care was working well and positive outcomes for people.

In North Lincolnshire, there was good joint working and the needs of older people were being addressed across partners. Prevention services are helping people remain in the community: Sir John Mason House, a 30-bed unit providing integrated nursing, therapy and support with GP input, helps people to regain independence.

There is also a community support team helping about 1,400 people a year while they remain at home, showing a clear focus on helping older people to feel safer, stay at home for longer and feel more in control of their long-term conditions.

In Salford, there is evidence of integration and coordination that is helping the movement of patients from hospital into other care settings. And there is a city-wide initiative to improve the experience, health and care of people living with dementia, as a group over-represented in hospital admissions.

However, there are areas for improvement, and both Salford and North Lincolnshire are looking at developing their plans for integrated care. For example, partners in Salford are working on ambitious plans for whole system reconfiguration and integration of health and social care. They are developing an integrated care organisation for adults and older people, and better integrated care for children and young people, bringing together hospital, community health, adult social care and primary care.

# 3. Improvements in quality

## Key points

- We have seen improvements in the quality of care that people are receiving, with many providers being able to improve despite tight financial constraints and increased demand across the sectors.
- Good leadership is an important part of improvement – services that improve tend to have leaders who are visible and accountable to staff, promote an open and positive organisational culture, and engage effectively with partners.
- However, the improvement was not universal. Not all the providers rated inadequate or requires improvement that we re-inspected had improved.
- In around one in 12 cases where providers were rated requires improvement and were re-inspected, the quality of care had deteriorated.
- We are aware of the challenges of improving and sustaining high-quality care, and we encourage and support services to improve through all aspects of our work.

### 3.1 The improvement we see through our inspections

We have seen improvements in the quality of care in many services – particularly those with the poorest quality.

Since we started our new approach to inspection, we have re-inspected 3,317 services in total (comprising 2,849 adult social care services, 432 primary medical services, 26 NHS acute trusts, one acute independent health service, one NHS mental health trust, five independent mental health services and three community health services). Our re-inspections have mainly been of providers where we had substantial concerns and we wanted to check improvement. However, we also re-inspect when we receive new information of concern.

Some of the services that we rated inadequate have subsequently closed or are no longer operating. Of the 596 services and providers rated inadequate and then re-inspected, 455 (76%) improved their rating. Of these, 139 (23% of those we re-inspected) went from inadequate to good and 316 (53%) went from inadequate to requires improvement (figure 1.15).

However, improvements by services and providers rated as requires improvement were not so widespread. Of 2,006 services and providers, only 898 (45%) were able to achieve a rating of good. In 943 cases (47%) there was no change, and in 165 cases (8%) the quality of care had become inadequate.

We have seen providers achieving substantial improvements through the special measures programme. Where we find inadequate care, a provider is usually put into special measures. This works in different ways in each of the sectors, but generally there is a structured framework in which providers can be supported to improve, or signposted towards organisations that can help. There is a clear timeframe for providers to improve, and if that does not happen, we can take further action (and in cases where there is a serious risk of harm to people, we will take immediate enforcement action).

During 2015/16, four hospital trusts were able to come out of special measures, followed by a fifth in August 2016. Additionally, Heatherwood and Wexham Park Hospitals NHS Foundation Trust exited

special measures when it was acquired by Frimley Health NHS Foundation Trust (a process that started in 2014/15 and completed in 2015/16). One remarkable example of improvement at the trust was Wexham Park Hospital, which went from inadequate to good in just over a year. The hospital managed to reduce its deficit and its total number of staff while markedly improving its quality of care. A huge investment in changing the organisational culture and supporting leadership at all levels lay behind this impressive turnaround.

For some providers the inspection process can bring a fresh perspective, particularly when providers are rated inadequate or requires improvement. Staff had sometimes raised concerns with management that had not yet been addressed and so an inspection provided a chance to escalate concerns. For example, inspectors told us about staff on a hospital ward who thanked them for coming and told them they felt more confident and safer delivering care as a result of changes made following the inspection.

Providers who responded to our annual survey in November 2015 were positive about CQC's role in encouraging improvement. Almost two-thirds (64%) said that our inspection had helped to identify areas

of improvement and seven in 10 (70%) thought the inspection reports were useful for their service. Nearly two-thirds (63%) of providers said they thought that outcomes for people who use services were improved as a result of our inspection activity.

### 3.2 What services have done to improve

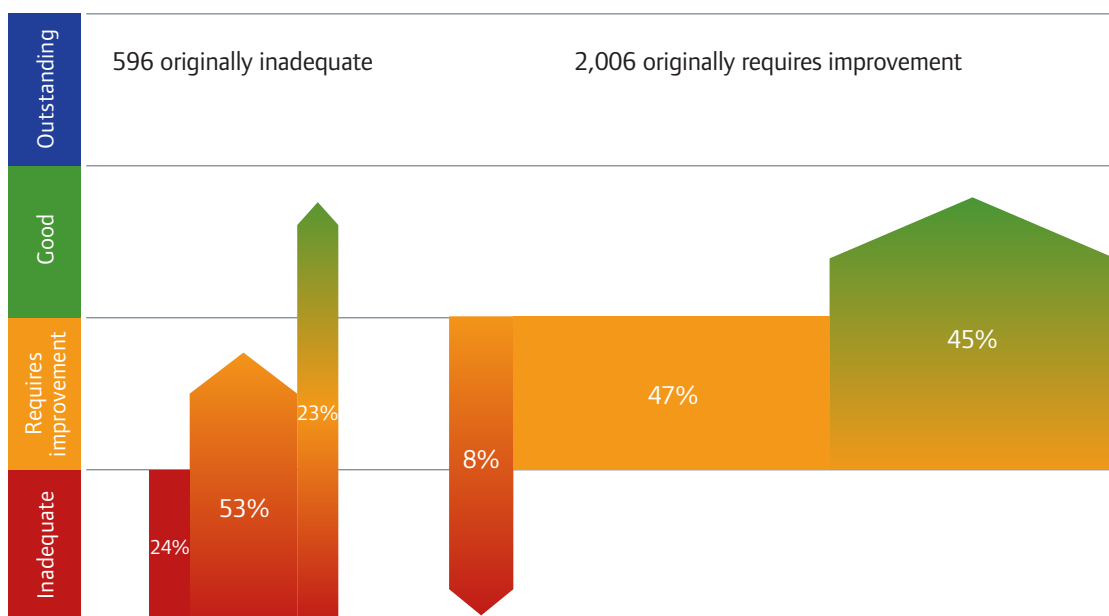
Good leadership continues to be an essential factor in improving and maintaining high-quality care. In services that have improved, there tends to be a positive organisational culture and leaders anticipate and respond to problems and concerns. Our ratings back this up, showing that the overwhelming majority of services rated good or outstanding overall have good or outstanding leadership.

Improvement is also more likely to happen when providers are open to receiving constructive feedback, and engage with CQC and collaborate with partners to improve care.

#### Strong, transparent leadership

Underpinning improvement is strong leadership: managers who have a good understanding of their service, are available to listen to their staff and to

Figure 1.15 Change in rating on re-inspection across all sectors, where initial rating was inadequate or requires improvement, as at 31 July 2016



Source: CQC ratings data. Note: The width of each cluster of arrows is relative to the number of re-inspections carried out.





people who use services, and are open to hearing the views of local stakeholders and representatives. They are clear and transparent about where there are concerns that need to be addressed.

### Good oversight of care

Where leaders are properly engaged, they are more likely to spot problems themselves and therefore changes can be made quickly. For example, the management team at Northumbria Healthcare NHS Foundation Trust (rated outstanding) were focused, aware of the trust's strengths and areas for improvement and had strong clinical and public engagement.

In services that improve, the leadership team have good oversight of what is going on and understand how services are delivered – improving quality assurance and audit processes to help monitor the quality of care. Some services benefited from strong regional oversight, as declines in the quality of care could be spotted quickly. Inspectors told us about a service improvement manager who had been appointed to focus on delays at one trust, and another appointed to reorganise the directorate structure.

### Driving change through effective systems and processes

Good leadership is supported by strong systems and processes that drive improvement, such as those that:

- help plan staffing and train staff effectively
- manage essential functions such as safeguarding, safety alerts and care plans
- strengthen governance and help to ensure transparency so that services can learn and improve when things go wrong.

For people who use services, improvements to staffing have a tangible effect on their experiences of care. For example, changes to rota arrangements, better monitoring of call bells and a reduced reliance on agency staff mean people are more likely to have their needs met and tailored to their individual situation.

Improved recruitment procedures, such as adult social care providers focusing more on the fit and proper person requirement, and on disclosure and barring service checks, create a safer environment for people who use services. We have also seen improvements in staff training that then improved

## From inadequate to good

### Hinchingbrooke Health Care NHS Trust, Cambridgeshire



Hinchingbrooke Health Care NHS Trust in Cambridgeshire was rated good overall in May 2016 after a period in special measures – a strong example of improvements in the quality of care being helped by special measures.

We rated the trust as inadequate in September 2014 due to a number of concerns, including a lack of vision for the trust at a senior level and a culture where staff did not feel able to report problems and workload issues – this was

affecting the safety of patients.

Our inspectors returned at regular intervals and, in May 2016, an inspection showed that real progress had been made. We saw a leadership team that was visible and accountable to staff at all levels. The trust had worked hard to address the reporting of incidents, embedding new systems and processes with an emphasis on learning. Staff were no longer reticent in raising issues, and the trust was able

to show where the issues had been raised and addressed.

We were also pleased to see strong collaborative working with other providers. For example, the trust was working with a local prison to review patients who were at the end of their lives, to ensure they were safely admitted to hospital or referred to the local hospice.

We will keep monitoring and working with the trust to make sure improvements continue and are sustained.



safety for people, for example mental health training for staff on acute children's wards.

In GP practices we saw examples of improvements to medicines management and infection control as a result of better accountability and governance systems. At one practice we noted the introduction of a new workflow system to track which documents had been reviewed by staff.

We have seen evidence that lessons learned from incident reports have been fed back to staff and discussed to prevent the same thing happening again, for example at County Hospital Louth.

### A positive organisational culture

Often the most important factor behind improvement is the culture of an organisation. Where the leadership team are visible and actively promote an open and positive culture at all levels, this can drive positive change. Staff feel supported and listened to, with the reasons for any changes to the service clearly communicated.

#### Clear vision

An important factor in driving improvement was

development of a clear vision and strategy with staff and people who use services. We found a link between a vision for improved service planning, and better engagement with people who use services. For example, at Alder Hey Children's Hospital, the trust had worked closely with young people and their families to be clear about the process for children moving to adult services, and the safeguards needed for young people with complex needs. In GP practices, we saw increased engagement with patients (through patient participation groups) as a factor in improvement. At Northfield Surgery, a full set of patient group meetings had been scheduled for the year ahead, and improvements had already been fed through to the practice management team.

#### Open to challenge and change

Poor culture is a significant barrier to change and improvement. If a service is not willing to change, it is unlikely that care will improve for people. However, where organisations are not afraid of criticism and have a desire to address issues in partnership, this helps improvement to take place. Inspectors told us about managers in adult social care who have an open door policy for staff, and for

## Still work to do, but an ethos of learning

### Constable Country Rural Medical Practice, Colchester



This GP practice provides primary medical services and was rated good following recent improvements.

At the heart of its improvements, inspectors pointed to changes in the way the service is led. Having been rated inadequate on CQC's first visit, the inspection manager described how the practice had been in special measures but decided to "tackle its problems head-on".

Dissatisfaction among patients was addressed at a public

meeting attended by more than 100 patients. Since then, an enthusiastic patient participation group expressed that, although there is still work to do, there is better cooperation between the group and the practice.

Inspectors said the management team was "quick to take on board" the concerns raised by CQC. Risks to patients are now assessed and managed, and staff understand and fulfil their responsibilities to raise concerns, and to report

incidents and near misses. This was evident in the high number of 'significant event' reporting, where staff highlighted areas to help improve performance.

Policies and procedures were in place to govern activity and there were systems in place to monitor and improve quality. There is also an emphasis on learning from stakeholders, including the local CCG, and an ethos of learning and improvement was found among all staff.

people using the service and their families.

CQC can act as a catalyst for positive change for organisations that are open and keen to learn. Some hospital trusts reported looking forward to CQC coming back to re-inspect so that the improvements they had made could be seen. Staff at these trusts were clearly engaged in the ethos of learning and improvement. In contrast, we have also found organisations that show a less open and more insular attitude – this can indicate a lack of a learning culture, and management being complacent or not willing to improve.

For services open to change, there are many examples of positive improvements to care, including mental health providers making improvements to health-based places of safety (such as better design of the care environment and the removal of ligature points) to help people with specific needs use the

service safely. Inspectors told us about an ambulance trust that turned around its long waiting times for a transport service. They also told us about adult social care providers who are working jointly with families and residents to manage medicines effectively.

#### Leaders that change organisational culture

We have seen existing leaders improving the services they provide when they are inspected. In one hospital, our inspectors described the management response to inspection as “incredible”. Within a week, the trust had changed the structures and strengthened the governance around end of life care.

However, where there are ongoing or entrenched problems, sometimes a change of leadership is needed to make the necessary improvements. A new leader can turn around the culture of an organisation, and motivate and engage staff

## An improved, open culture

### Acorn Care Home, Birmingham



Acorn Care Home in Birmingham provides nursing care for people living with dementia. The home has seen substantial and sustained improvements since a rating of inadequate prompted a change in management and culture.

CQC had serious concerns when inspections took place in February and March 2015. Procedures to keep people safe from harm were not being followed and people were not always asked for their consent to care.

There was ineffective leadership and the home did not have good monitoring procedures or robust systems to ensure that concerns and

complaints would be listened to and addressed quickly.

With a focus on improvement and turning round the culture of the home, rapid progress was made, resulting in a new rating of good in September 2015 following a re-inspection.

A major development immediately after inspection was the appointment of a new manager and changes to the management structure. This had a positive effect on the culture of the home. Staff said that they felt supported and there was an open door policy – they now felt able to be open and transparent about their concerns.

Staff had been trained in how to identify any possibility of abuse and take appropriate action. Procedures for monitoring important areas such as medicines and medical records had improved and were being properly followed.

Relatives noticed the improvements at the home and felt more involved in the care of their family member. One person said, “The staff pick up on health issues really quickly and act on it so my relative gets the treatment they need quickly. They always keep me informed of any medical issues or changes in their needs.”

and partner organisations. In one adult social care provider that was in special measures, the appointment of a new manager with clinical and leadership skills led people to describe to our inspectors how much happier and safer they felt. Our inspectors also reported staff at one ambulance trust as full of praise for their new chief executive, who had changed the culture and delivered improvement through leading by example.

### Effective collaboration with partners

When organisations collaborate effectively with partners and other providers in the local health and care system, this can support improvement.

In adult social care, joint working with local authorities and other stakeholder groups can play an important role in identifying improvements that need to be made. Support on specific areas, such as

from the local authority safeguarding team, are also influential in driving change. Our inspectors noted that one CCG had set up a team to help care homes in need of support to make changes. The team worked with managers at homes to help prevent unplanned hospital admissions.

Close collaboration between different services in a local area can support improvement. For example, inspectors told us about a hospital where staff developed a newsletter that went out to GP practices monthly to inform them of any changes to their unit. Acute trusts, such as Oxford University Hospitals NHS Foundation Trust, have set up closer partnership working with adult social care providers to enable them to help people's transition back into community care as quickly as possible.

In contrast, some providers found it more challenging to learn from others. Inspectors told us

## Successfully managing patient flow

### Northumberland, Tyne and Wear NHS Foundation Trust



Rated outstanding\*, Northumberland, Tyne and Wear NHS Foundation Trust is one of the largest mental health and disability trusts in England. It has designed some solutions to managing the challenge of patient flow by working collaboratively with other services, partners and agencies.

Senior managers have built relationships with commissioners to develop a community transitions team. Staff work with patients on wards before they are discharged and continue to support patients in

community placements for up to six months after discharge, including access to a consultant psychologist or psychiatrist. The team also organises risk management workshops for stakeholder groups, such as day service providers. The result of this has been sustainable community placements for patients, and a reduction in readmission rates to hospital.

Discharge planning starts from the moment a person is admitted and is monitored throughout with outcome measures to inform the assessment process and

measure the success of treatments. Flexible and adaptable, the process helps staff to meet the needs of people using the hospital, their relatives and carers.

The trust has a street triage service in which mental health nurses accompany police officers to incidents where police believe people need immediate mental health support. This has reduced the number of people assessed in health-based places of safety, and increased the number of people able to return safely to their own homes.

\* This trust was rated on 1 September 2016.

that engagement with the wider system (such as with CCGs) is essential to improvement in all sizes of GP practices. However, single-handed GP practices often found it harder than larger GP practices, or practices that are part of a provider structure, to make changes such as bringing in a manager from another practice to support improvement. Similarly, some hospital trusts that have taken over responsibility for community health services can have a disconnect between the acute and community aspects. However, it is possible for these different services to collaborate better. Northumbria Healthcare NHS Foundation Trust is a good example of this.

CQC can play a role in supporting such partnership working. Our inspectors helped one trust to organise a workshop to engage local stakeholders in improvement initiatives, an approach that has since been offered to another trust. We also encouraged some trusts to shadow high-performing peers in order to learn and improve.

### 3.3 How CQC is further supporting improvement

#### Improvement through our registration activity

In our post-inspection survey, providers told us that the standards and guidance we supply through the registration process helped them to recognise and address areas for improvement – most commonly around recruitment, training and supervision of staff.

Our registration activities aim to prevent unfit providers and managers from entering health and social care. They can also encourage improvement in providers before they register – when a provider applies but does not meet our requirements, this can help them understand what they need to do to improve.

We completed almost 35,000 registration processes in the year to 31 March 2016. The overwhelming majority of applications for new registrations or applications by providers or managers to vary conditions were granted (99%), but a small minority were refused, for example where we were not satisfied about the provider's fitness or their

compliance with the requirements. In 2015/16, CQC proposed to refuse registration 343 times (1% of all variations or new registrations).

#### Improvement as a result of enforcement

Enforcement has an important link with improvement – it can help deter providers from breaching regulations. It also shows providers the areas where they need to improve to protect people from poor care.

In adult social care services, enforcement actions such as Warning Notices are often a powerful lever for change in services that are providing poor care. CQC's willingness to take enforcement action can also encourage improvement. The majority of the breaches of regulations in adult social care related to weak or absent governance and the safety of care.

Similarly in hospitals, mental health services and GP practices, enforcement often helps bring about improvement in specific aspects of the quality of care. For example, in response to Warning Notices to improve its learning disability service, a mental health hospital appointed an improvement board to lead the changes needed. Improvements included better engagement with patients, better quality of care and improved case load handling.

During the year to 31 March 2016, we took 1,090 enforcement actions and at the end of the year we were in the process of taking another 777 actions. The most common action was a Warning Notice (76% of our enforcement actions). We also took other more urgent actions, such as suspensions or cancellations of a provider's registration in order to protect people. In June 2016, we brought our first prosecution (since receiving new enforcement powers in April 2015) against a care provider where a man had sustained serious injuries and sadly died in circumstances that could have been avoided.<sup>33</sup>

We are aware that cancellations, and particularly urgent closures, can greatly affect people using those services. This is especially the case where the service is a person's home, such as a care home. However, it is our role to protect people from an unacceptable level of risk of harm. We work closely with commissioners and local authorities to make



sure that the interests of the people who use the service are considered first and that disruption to them is minimised. Recently we published a new good practice guide (jointly with the Department of Health, NHS England, the Association of Directors of Adult Social Services, the Local Government Association and the Care Provider Alliance), which sets out how local and national organisations should work together in the event of a care home closure to minimise the impact on the people living there and their families and carers.<sup>34</sup>

### Improvements in safeguarding

Safeguarding is about people and organisations working together collaboratively to prevent and stop the risks and experience of abuse or neglect, while promoting the person's wellbeing.

During the year we have seen some improvement in areas of safeguarding practice. For example, in adult social care services that had improved, we saw better safeguarding training for staff that had led to them being more confident in spotting and reporting abuse. In GP practices that had improved, we found better recruitment checks, good staff awareness and robust policies and procedures for safeguarding adults and children.

We also found examples of outstanding care that can inspire improvement, such as a GP practice with a very strong safety and risk management culture – the practice would follow up with the local authority if they felt a safeguarding incident concerning an adult or child was not being taken seriously. An example in our *Not seen, not heard* report showed where an assessment framework in Devon had integrated education, health and social care and has been effective in supporting families and reducing children's vulnerability.<sup>35</sup>

There is a high level of reporting of safeguarding incidents to CQC, but the picture is variable. We continue to monitor reporting over time and identify those providers that report high and low volumes of incidents for inspectors to follow up. Although we have seen improved reporting in adult social care, we still have concerns about the under-reporting of safeguarding in GP practices and hospitals,

particularly given the high volumes of activity in each sector.

We also continue to work collaboratively with other inspectorates – Ofsted, HMI Probation, HMI Constabulary and HMI Prisons – to review how services work in partnership to help and protect children and adults from harm, and we work with local partners to share information about safeguarding and improve guidance and processes.

# 4. The future resilience of health and social care

## Key points

- From 2001 to 2014, the number of people aged 85 and over rose by 33%.
- Since April 2015, the growth in nursing home beds at a national level has stopped.
- In 2015/16, the total number of days each month where patients have been delayed leaving acute hospitals rose to almost 170,000, the highest since at least 2013.
- Acute trusts that were rated good or outstanding were more likely to be better at balancing their budgets than those rated inadequate.
- The number of full-time equivalent GPs has declined since 2010, both in absolute terms and per head of population.

We show in this report how some services have improved the quality of care they provide and include examples of the different ways they have achieved this, particularly providers in special measures or with an inadequate rating.

These successes are set against a backdrop of significant financial challenges: as the demography of the country changes, demand increases across all sectors. Since 2001, the number of people in England and Wales aged 65 and over has increased consistently – a total rise up to 2014 of 22%.<sup>36</sup> There has been a sharper rise since around 2009 in the number of people between 65 and 74 (figure 1.16). From 2001 to 2014, the number of people aged 85 and over rose by 33%. Future projections show that these trends are set to continue in the coming decades, putting increasing demand on the health and care sector. For example, it has been estimated that there will be a 49% increase in demand for publicly-funded care home places for older people between 2015 and 2035.<sup>37</sup>

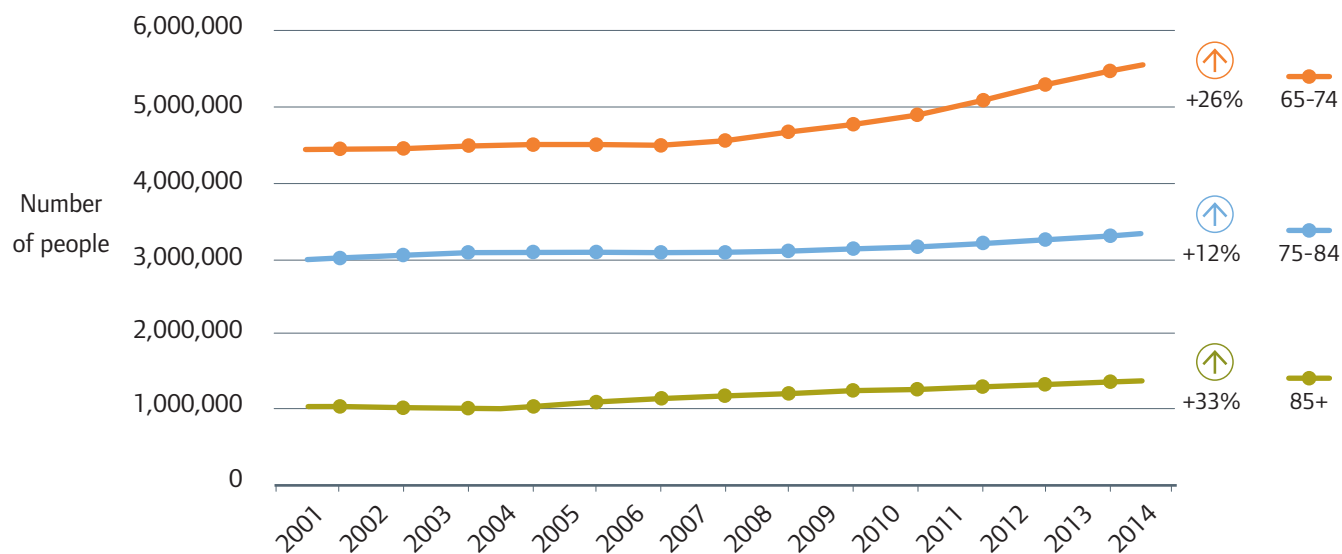
To meet this growing demand and people's changing needs, the *Five Year Forward View* showed that the funding gap would be £22 billion a year by 2020/21, if no further annual

efficiencies were made. Analysis from the Nuffield Trust suggests that, even if hospitals and other NHS providers made cost savings of 2% each year, the funding gap would still (after taking into account the £3.4 billion fund that has been set aside for investment in sustainability and service transformation) stand at around £2.5 billion by 2020/21.<sup>38</sup>

By the end of 2015/16, the deficit for all NHS providers had reached £2.45 billion. Deficits are no longer restricted to just a few trusts. By the end of 2015/16, two-thirds of all trusts were reporting a deficit (figure 1.17); the majority of these were acute trusts.<sup>39</sup> In contrast to the situation in acute trusts, community, mental health and specialist providers together delivered a combined surplus in 2015/16.

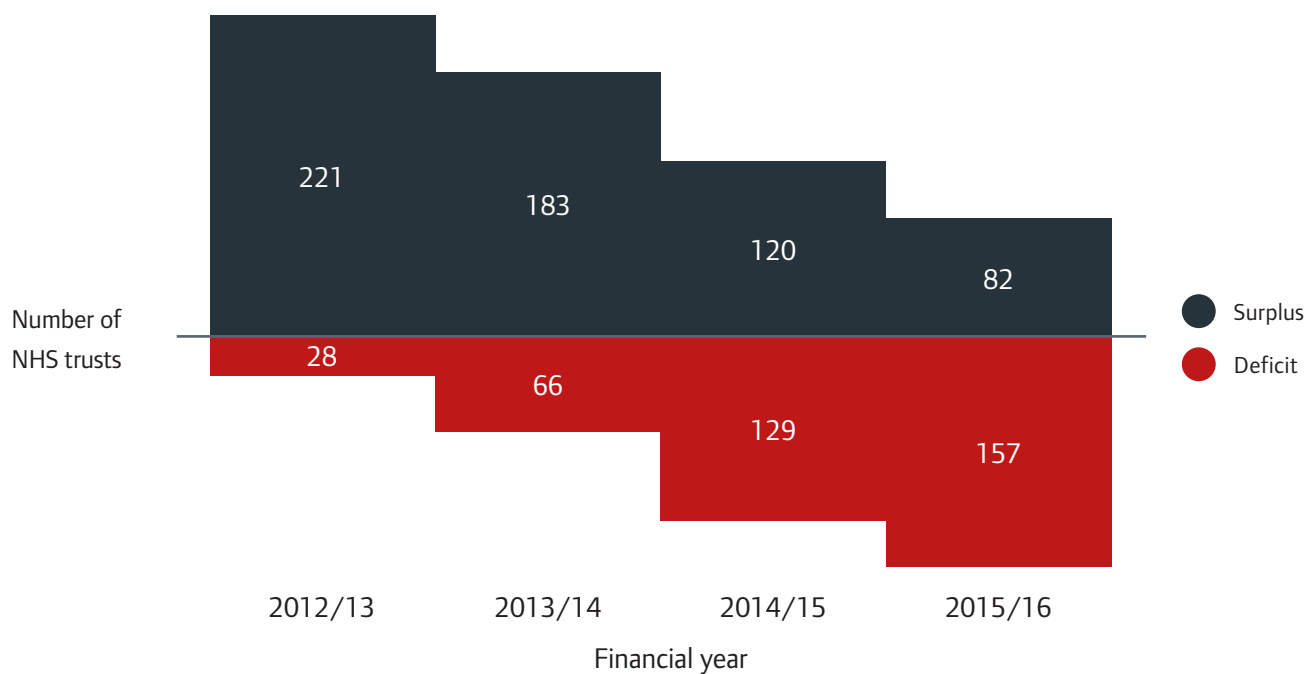
In adult social care, an overspend was reported by councils of £168 million (out of a budget of £13.65 billion).<sup>40</sup> It has been calculated that public funding for adult social care will rise by an average of 0.6% per year in real terms from 2015/16 to 2019/20 – a welcome increase, but lower than the projected increase in demand pressures of 4% per year.<sup>41</sup>

Figure 1.16 Population estimates for older people, 2001 to 2014



Source: Office for National Statistics mid-year population estimates

Figure 1.17 NHS trust year-end financial positions, 2012/13 to 2015/16



Source: Health Foundation: A Perfect Storm, NHS Improvement



Our evidence suggests that finance and quality are not necessarily opposing demands and, in spite of the constraints, some providers are managing to continue to deliver good quality care and manage within their budget. We are aware that the tough financial conditions will affect providers' ability to operate, but our focus will always be on quality and we will always act in the interest of people who use services.

## 4.1 Adult social care

The adult social care sector has for some time been managing reductions in public funding, with budgets not keeping up with increased demand. The number of older people receiving local authority funded social care fell 26% from more than 1.1 million in 2009 to around 850,000 in 2013/14 (the last year for which comparable data is available), and 81% of local authorities have reduced their real-term spending on social care for older people over the last five years.<sup>42</sup> Unmet need has also grown: a recent assessment for Age UK indicated that more than a million people who have difficulties with the basic activities of daily living – such as getting out of bed, washing and dressing – now receive no formal or informal help at all.<sup>43</sup>

The 2016 survey conducted by the Association of Directors of Adult Social Services (ADASS) noted that 94 councils exceeded their adult social care budgets in 2015/16 by a total of £168 million, in efforts to maintain adult social care spending wherever possible. This was financed mainly through the use of council reserves or from underspends on other council services. However, directors of adult social services said they were planning to make further savings of £941 million in 2016/17.<sup>44</sup>

The opportunities to make the same efficiency savings as in previous years have reduced. The ADASS 2016 survey suggests that the proportion of adult social care savings planned to be secured through efficiencies has fallen by 20 percentage points (from 75% to 55%) in the past year. At the same time planned savings from reducing services increased by 21 percentage points (18% to 39%) over the same period.

Also, in response to budgetary pressures, local authorities have been reducing the rates they pay both domiciliary and residential care providers for social care. From 2010/11 to 2013/14 the rate per week for residential and nursing care fell from £673 to £611 (at 2015/16 prices).<sup>45</sup>

### The impact on providers

Efficiency savings made so far by providers have been from non-staff costs. However, our market oversight data shows that staff costs on average make up a substantial proportion of total costs – about 60% of total cost in care homes and residential homes and about 80% in home care and non-residential care – and the cost challenge will also get harder to manage with the impact of the national living wage.

Providers may struggle to cut costs further without reducing staff numbers, and potentially compromising on the quality of care. Nurse vacancy and turnover levels are already increasing the fragility of the sector, and these will potentially impede the development of sustainable community-based plans.

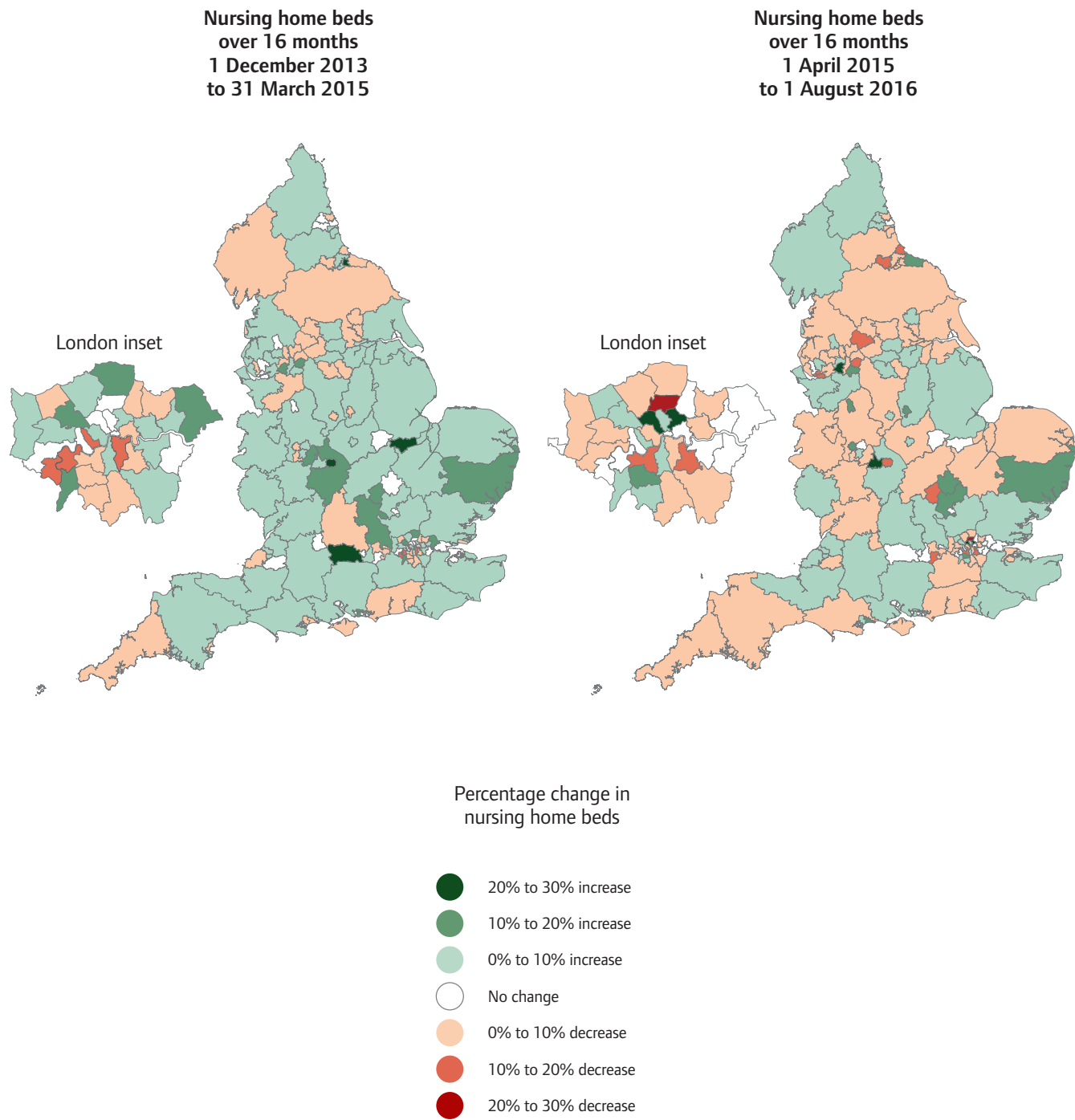
Emerging data from our market oversight work also suggests that the profitability of adult social care provision is falling. Since April 2015, CQC has been monitoring the financial stability of certain adult social care providers that are considered to be 'difficult to replace', either because they are large national operators (of both care homes and home care) or because they provide specialist services.

Our data shows the severe financial strain that local authority funded providers continue to be exposed to. Care home providers with more than half of their turnover funded by local authorities achieve, on average, 10% less fee income per bed and generate almost 28% less profit per bed, compared with all providers.

In domiciliary care, we continue to see profit margins being eroded. The primary drivers for this are pressure on fees and increased staff costs driven by higher use of agency staff. Falling profitability could make the sector less attractive to providers, thus reducing the amount of provision and increasing the demand on existing services.



Figure 1.18 Adult social care net change in nursing home beds, 1 December 2013 to 31 March 2015 compared with 1 April 2015 to 1 August 2016



Source: CQC registration data

Note: No change indicates where the number of beds has remained the same. This includes the Isles of Scilly and City of London where there were no nursing home beds.





Since 2010, there has been a long-term trend of fewer residential (non-nursing) care beds, balanced by a growth in numbers of domiciliary care agencies. This reflects the trend for people to be cared for in their own homes where possible, in line with recent health and social care policy.

From September 2010 to March 2015, the number of beds in nursing homes rose (from 205,375 beds to 224,754 – a 9% increase), in response to the greater care needs of people who are both living longer and with more complex health conditions.

However, since April 2015, at a national level the growth in nursing home beds has stopped, with the total number of registered beds only going up by 89 in a 16-month period. Furthermore, in that time, the number of nursing homes has fallen by 1.6%, from 4,698 to 4,623. The maps in figure 1.18 show how these changes in nursing home provision have played out across the country. Some parts of the country continue to show increases in provision, while many others are decreasing.

Data from ADASS suggests that 32 councils had residential or nursing care contracts handed back to them in the six months up to May 2016, affecting around 700 residents. Also, 59 councils had home care contracts handed back, which affected more than 3,700 people.<sup>46</sup>

The number of contracts that providers are terminating early is concerning as this gives an indication of the fragility of the social care sector. Providers tell us that increasingly they are making the decision to hand back contracts where they feel they cannot meet the fundamental standards of care while maintaining profitability.

One large provider of home care, Mears, publicly stated recently, “The contracts we have exited are those where simple mathematics shows that the charge rate a council wants to pay will result in a provider either not meeting the requirements of the national living wage for care staff, or not delivering the service needed by the

user.”<sup>47</sup> Another large provider, Mitie, recently announced a long-term review of its health and care provision in the face of “reduced local authority social care budgets and further evidence of unsustainable pricing”.<sup>48</sup>

### **The sustainability of quality**

To date, the sector has worked hard to protect quality in the face of its significant financial challenges. But the sustainability of adult social care is now at risk – with the combined pressures of fewer nursing homes, reducing profitability in both residential provision and domiciliary care, and increasing demands put on staff – where the quality of care may not be maintained.

People may experience difficulties in finding the best type of bed for their needs or one that is in line with their preferences. Our data also shows that the services closing are more likely to be smaller services, which have to date achieved better CQC ratings. The risk, therefore, is that as options for people reduce, the potential to find a bed in a good quality service may also become more limited.

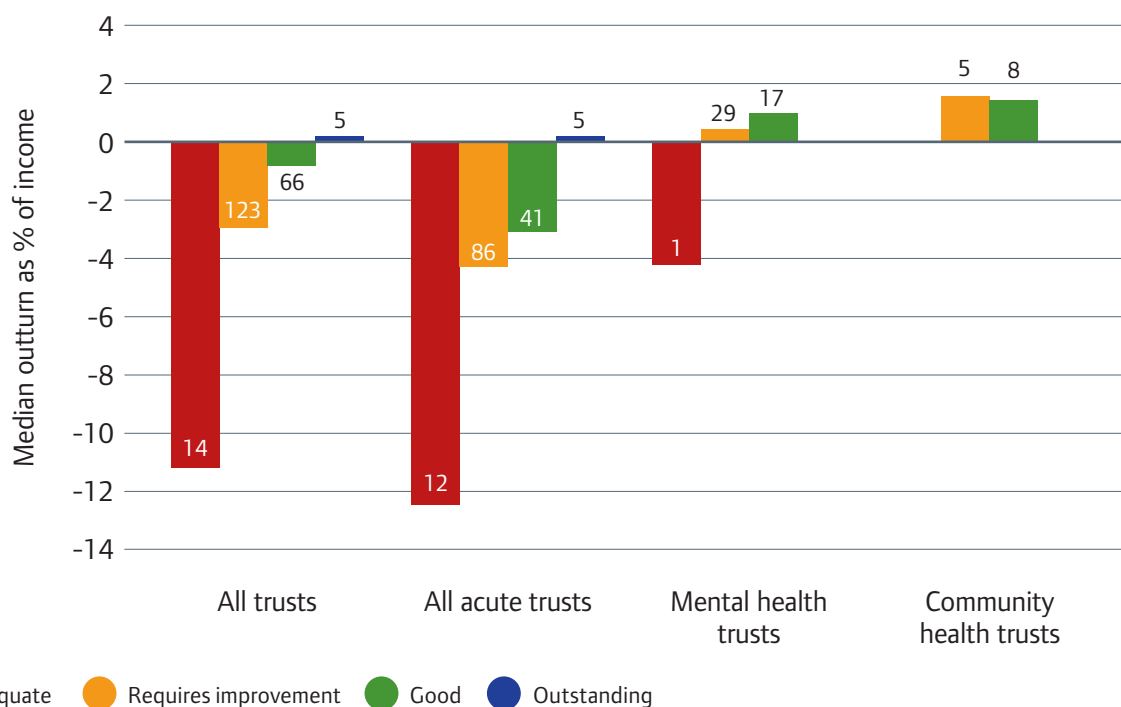
For those people who are not eligible for public funding, and who cannot rely on private funding, we are concerned about an increased reliance on unpaid care and greater levels of unmet need. Estimates have been made of the value of unpaid or informal care provided to adults by friends or family. Although these estimates vary, there is an agreement that the use of informal care has been increasing substantially. An annual survey by Carers UK highlights the difficulties experienced by those in need of support and their carers. One in five carers who provided 50 hours or more of care each week said they were receiving no support with their caring role.<sup>49</sup>

Finally, this affects the wider health and care system. People who are unable to access the care and support they need, or who receive poor care, will increasingly need costly, and often unplanned, hospital care and treatment. For those people leaving hospital who need





Figure 1.20 NHS trust 2015/16 median financial outturn as a percentage of operating income, by overall rating



Source: CQC ratings data up to 31 August 2016, NHS Improvement.

Note: Numbers on columns are number of NHS trusts. 'All trusts' includes ambulance trusts, which are not shown separately here.

to March 2016. The number of total days delayed each month rose to almost 170,000, the highest number since at least 2013, and it has continued rising in 2016/17. In 2015/16, the total delayed days reported was up by 11% on the previous year. The two main reasons cited for the delays were that patients were waiting for a care package in their own home or waiting for a nursing home placement or availability. Both saw a large increase over the previous 12 months (figure 1.19).<sup>52</sup>

The effect of these delays on the NHS is significant. The National Audit Office estimates that the gross annual cost to the NHS of older patients (representing just one patient group albeit the heaviest users of acute services) in hospital beds who are no longer in need of acute treatment is £820 million per year.<sup>53</sup> This figure requires resilience to be built across the whole health and social care system. It requires a strong and robust adult social care system. It requires system partners and providers to be supported in becoming increasingly

effective at discharging people from hospital and receiving people into community care.

Patient flow has been one of our main concerns in our inspections of acute hospitals. The ability of a hospital to manage it well is a major factor in that hospital delivering high-quality care for its patients. It is not in people's best interests to remain in hospital when they are fit for discharge or find that there is no appropriate hospital bed for them when they need to be admitted. With both trust finance directors and CCG finance leads citing the flow of people through acute services as one of their top two causes for concern,<sup>54</sup> there is an urgent need to prioritise measures to reduce admissions and improve discharge practice; for example, by making it best practice to start the discharge planning process with community services from the moment patients are admitted to hospital.

Our evidence also shows that there is an association between the quality ratings of acute trusts and their financial health. Those trusts that have been

rated good or outstanding are more likely to be better at balancing their budgets (or have smaller deficits) than those rated inadequate (figure 1.20). Additionally, trusts rated good or outstanding for their leadership were more likely to be able to accurately predict and sometimes improve their end of year deficit at the mid-year point. Since we know that, in all sectors, providers with better overall ratings tend to score better in terms of being well-led, this suggests a link between good leadership, good financial management and higher quality ratings.

### 4.3 Primary care services

There is evidence that primary care is facing increasing pressure. Patients are getting older, with multiple complex conditions. The workload for GP practices has increased, with rising numbers of patients on GP practice lists. Analysis from NHS Digital population data shows that the average list size in England grew by 2.8%, the equivalent of 197 patients, from April 2014 to April 2015, because of an increase in total patients and a fall in the number of practices.

As in other sectors, there are problems with recruitment and retention of staff in primary care, particularly for services that are more geographically isolated.

In addition, while the overall number of GPs is increasing, the number of full-time equivalent GPs has declined since 2010, both in absolute terms (figure 1.21) and per head of population.<sup>55</sup> This may suggest that more GPs are choosing to work part-time to achieve a better work/life balance, and may also reflect the number of GPs choosing to retire and then return to work on a part-time basis.

Looking at healthcare support in the community, which helps to keep people out of hospital, there has also been a 28% reduction in the total number of full-time equivalent district nurses from 2009 to 2014 (figure 1.22).<sup>56</sup> Having the right community workforce is critical for the transformation of core services out of hospitals.

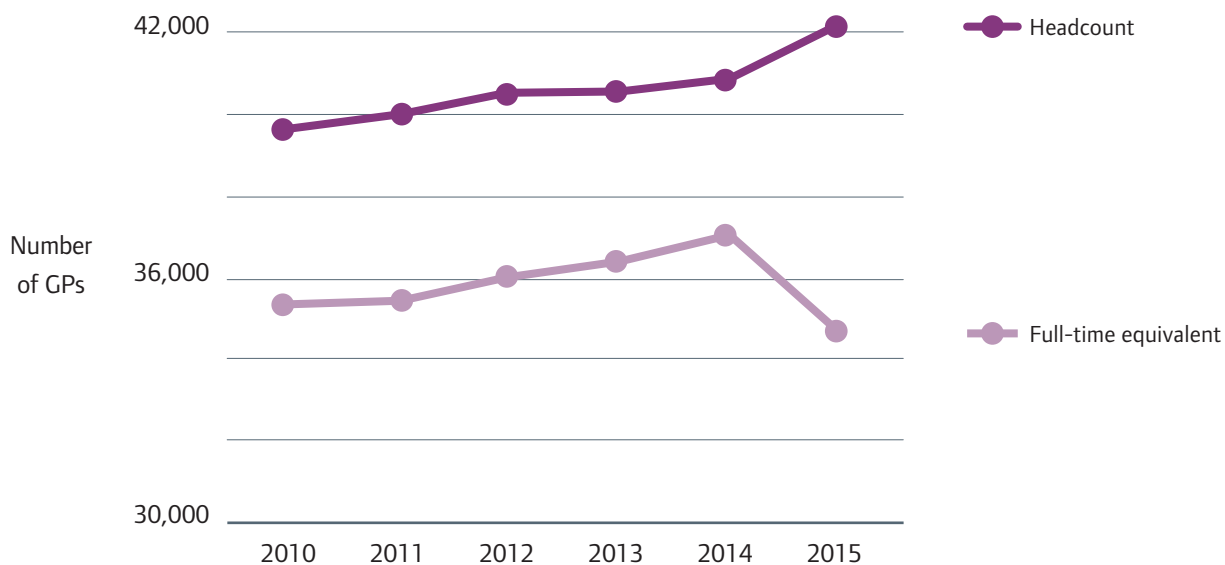
Recruitment issues in primary care are being addressed in different ways. We saw evidence that some GP practices are upskilling staff and creating more effective multidisciplinary teams that include pharmacists, nurse practitioners and physician associates. Some have introduced allied health professionals, including physiotherapists, providing open access for their patients, and reducing the burden on GPs and freeing up appointments. Others are funding community matrons to meet the needs of older patients in the community, or employing mental health nurses or other specialised nurses to address gaps in the provision of GP services.

These mounting demands and financial pressures culminated in April 2016 with the publication of the *GP Forward View*, which set out the changes needed by the sector.<sup>57</sup> Primary care is leading the way in service design – it is changing rapidly, with GP practices coming together in federations and with acute trusts starting to employ their own GPs. There is also a rise in digital services that offer remote consultations and advice using online technology.

To support the changes, the *GP Forward View* announced further investment into GP services of £2.4 billion a year by 2020/21, increasing funding from £9.6 billion a year to £12 billion a year. Investment is also likely to grow further as CCGs build community services and new care models in line with the *Five Year Forward View*.

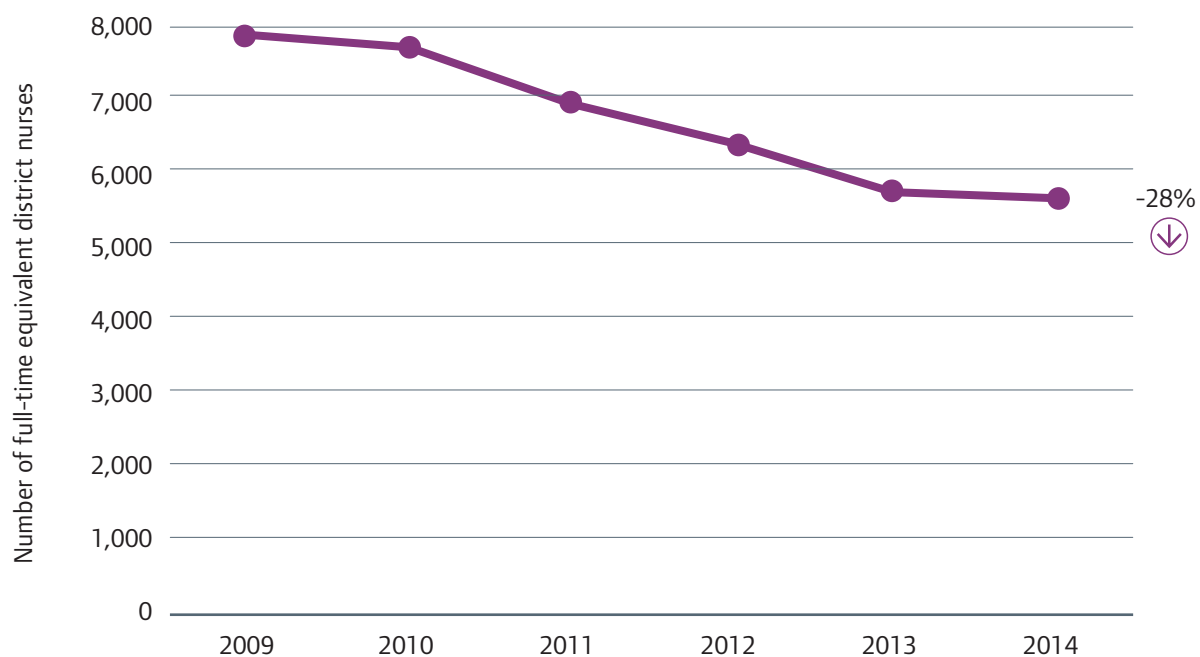
It is important to have a strong and healthy primary care sector, as it is at the forefront of helping people to stay healthy, to keep out of hospital and to receive the care and support they need. Sustained support is needed to ensure that primary care can be an enabler of the service changes needed.

Figure 1.21 Changes in GP headcount and full-time equivalent, 2010 to 2015



Source: NHS Digital

Figure 1.22 Number of full-time equivalent district nurses, 2009 to 2014



Source: NHS Digital



# 5. The future outlook

## Key points

- The *Five Year Forward View* sets out plans to develop new care models that aim to improve the quality of care and efficiency through the integration of services.
- The challenge for local health and care economies is to unlock the money needed to invest in future changes while continuing to deliver current services that meet increasing demand.
- Sustained support will be needed for new care models to become established and improve. Investment will be needed to support leadership and enable the desired transformation.
- All parts of local health and care systems – commissioners, providers, regulators and local people – need to work together to help transform local areas.

In this report we have highlighted the backdrop against which the health and social care sector needs to continue to reduce variation in the quality of care that people experience.

Health and social care provision is undergoing a period of transformation and the momentum to deliver integrated, person-centred care is increasing. Initiatives set out in the *Five Year Forward View* such as the new care model vanguards and the Better Care Fund, and the later development of Sustainability and Transformation Plans (STPs), are all important factors in taking health and social care forward.

It will be critical that change is properly supported to maintain quality and ensure sustainability. Some providers have shown that they can improve, even with tight finances, and they have told us that we are helping them do this. Supporting good leaders will be important in the way these changes are successfully implemented.

## 5.1 Providers and commissioners are responding to the challenge

The *Five Year Forward View* sets out plans to develop new care models that aim to improve the quality of care and efficiency through the integration of services.

The vanguards are one of the first steps towards delivering this vision. New ways of working are being piloted through five models: multi-specialty community providers (MCPs), primary and acute care systems (PACs), acute care collaborations, enhanced health in care homes, and urgent and emergency care systems. Examples include adult social care and health working more closely together to make sure people get care in the most appropriate setting, local commissioners and providers working across traditional boundaries and sectors to build joined-up services, and focusing proactive interventions for people with a high risk to their health and wellbeing.



Other new models are also emerging – for example, using technology to support the delivery of high-quality care and using online communication to provide advice remotely where it is safe to do so.

The NHS mandate is for at least half the population to be covered by new care models by 2020. CQC is committed to supporting the development of all new care models, and we are working with the vanguards and other services to support their progress. We intend to learn alongside these new models as they develop. Registrations for new model services are still relatively low in number, but we expect this to change in the months ahead. We will support innovation by removing barriers where we can. We are committed to working more closely with system partners and leaders to align what we do and reduce duplication.

## 5.2 Balancing investment and delivery

The *Five Year Forward View* outlines why substantial change to the way health and care is designed and delivered is necessary.

Plans to transform the health and care system depend on having the resources to achieve real change. The challenge for local health and care economies is to unlock the money needed to invest in future changes while continuing to deliver current services that meet increasing demand. Being able to bridge this gap is paramount.

In adult social care, the planned increase in funding available through the Better Care Fund and Social Care Precept is designed to address some of the shortfall identified in recent years. However, the Better Care Fund is back-loaded so the impact is unlikely to be seen until 2018/19, and the introduction of the national living wage

is already pushing up providers' costs. Also there is an assumption that the majority of councils will continue to add the full 2% from the precept to council tax bills, as they have in 2016, but this will not be easy to achieve and local authority elections in 2017 and beyond may influence the way that budgets are set.

STP areas have been agreed locally, bringing together providers and commissioners across health and social care to develop five-year plans for collective action. Some of these areas are just starting to build their relationships, but the STP plans are an important opportunity to determine the right balance between health and social care funding, to enable new ways of providing care.

This means making hard choices about the right balance of investment and about which services to provide and invest in. Some are beginning to engage their own staff, other local care providers and the public to think differently about how they can deliver services together, such as moving certain services closer to people's homes, exploring the relationship with local care partners to improve hospital discharge rates, and supporting more people to manage their own care through the use of technology.

All local health and care leaders need to be having a conversation with their local populations about these choices and what they mean – conversations that need to happen now and that need to happen quickly.

## 5.3 Working together to ensure sustainable change

While most of the commitments for change constitute relatively substantial investment, the challenge will be ensuring that they can be carried forward sustainably in the long term and that the quality of care is not affected during this period of change. Maintaining quality while demand increases and budgets are under pressure is going to be challenging, even for the best-led services.

Over the past few years, we have seen commissioners and providers aim to protect, as far as possible, the quality of care. It is important that the focus on quality that we have seen over the past few years is maintained, and that people can continue to access high-quality care.

Sustained support will be needed for new care models to become established and improve, and investment will be needed to support leadership and enable the desired transformation.

All parts of local health and care systems – commissioners, providers, regulators and local people – need to work together to help transform local areas. Working with our partners, CQC will offer the system whatever support we can to make the changes necessary to ensure high-quality care into the future.







It will be critical that change is properly supported to maintain quality and ensure sustainability. Some providers have shown that they can improve, even with tight finances, and they have told us that we are helping them do this. Supporting good leaders will be important in the way these changes are successfully implemented.

 STATE OF CARE







## Part 2

# THE SECTORS WE REGULATE





# 21,000+

Care service ratings analysed

**71%** of adult social care services inspected were rated good

**83%** of GP practices inspected were rated good

**51%** of NHS acute hospital trusts' core services inspected were rated good



**Adult social care**



**Acute hospitals, community health services and ambulance services**



**Mental health**



**Primary medical services**



**Equality in health and social care**



**The Deprivation of Liberty Safeguards**







# Adult social care

## Key points

- Services that were rated good and outstanding engaged well with people who use services, their families and carers, and the community to design care plans, facilities and activities that meet people's diverse needs and preferences.
- The quality of care continued to vary. Particularly striking was the difference between the key question about caring, which performed best, and the comparatively lower performance of safe and well-led. Good systems and management are important drivers that support caring staff to deliver better services.
- The adult social care sector continues to experience financial strain. Further efficiencies are difficult to achieve, due to staffing being a high proportion of costs, and profitability is reducing, leading to some services exiting from the market. The potential impact of these exits are people having less choice or experiencing a lack of continuity of service, and delays in securing them a package of good quality care that meets their needs and preferences. It is also likely to lead to greater use of unpaid care.
- Some of the services we rated inadequate have subsequently closed and are no longer operating. Of the inadequate services we re-inspected, more than three-quarters (77%) were able to show us that they had improved the quality of their care. This improvement is closely linked to good leadership that helps shape a more positive culture within a service.
- Of services that we re-inspected after initially rating them as requires improvement, 43% were able to improve, while 8% had deteriorated to inadequate.

# Introduction and context

The regulated adult social care sector in England is large, with services being delivered in more than 25,000 locations. We regulate:

- accommodation and personal care provided in residential care homes, nursing homes and specialist colleges
- services provided in people's homes through domiciliary care services
- services provided in the community through extra care housing, Shared Lives schemes and supported living services
- inpatient hospices, day hospices and community-based hospice services.

As described in part 1 of this report, the sector continues to be under pressure from increased demand, coupled with financial strain and difficulties in recruiting and retaining staff. This puts many adult social care services in a fragile position. The reports of our inspections monitor the quality of care delivered and the experiences of people who use services.

We have a number of concerns about the current state of adult social care in England:

## **Recruitment is a problem for many providers, both in terms of attracting and retaining staff**

- Recruiting nurses remains a significant concern. Some providers have considered providing residential but not nursing care, because they could not recruit enough staff. Others have responded by training and developing other care staff to expand their roles and making links with universities to encourage nurse recruitment as well as offering apprenticeship schemes.
- It is estimated that non-British EU workers made up 7% of the adult social care workforce in 2015/16 – equating to around 90,000 jobs – and it is uncertain as to the extent to which they will be affected by the vote to leave the European Union.<sup>58</sup>

## **Many providers are under considerable financial pressure**

- Many directors of adult social services (84%) reported that providers are facing financial difficulties now.<sup>59</sup>
- The introduction of the national living wage is increasing financial pressures. In adult social care, staff costs are a high proportion of total costs. Our analysis of some of the largest providers suggests that staff costs are around 60% of total costs in residential care homes, and around 80% in domiciliary care.
- The funding and staffing pressures are leading to reduced profitability – especially for providers more reliant on local authority funding. Analysis of some of the largest providers shows that care home providers where over half their turnover is funded by local authorities, on average, achieve 10% less fee income per bed and 28% less profit per bed compared with all providers. This data has also shown that the profit margin for domiciliary care providers has continued to fall.

## **These pressures have led to services exiting the market**

- Some providers, particularly in domiciliary care, have withdrawn from local authority contracts where they felt there was too little funding to enable them to be responsive to people's needs. For example, Mears Group has served notice to both Liverpool City and Wirral councils for offering hourly rates of £13.10 and £12.92 respectively, compared with the minimum £16.70 recommended by the United Kingdom Homecare Association.<sup>60</sup> They said this would “lead to unworkable pay and conditions for care workers” and “the people who will suffer the most are those receiving care”.<sup>61</sup>
- Smaller providers are particularly susceptible to closures, and we are concerned that reduced capacity limits people's choices in an area and may force local authorities to use poorly-performing providers.

## Adult social care providers were often frustrated at the lack of integration with other providers

- A lack of joint working on admission and discharge from hospitals was a key issue. When not done well over a period of time, this could result in an entrenched reluctance between different providers to develop and maintain closer working relations.
- However, innovation in this field exists – for example, there is an initiative in a domiciliary care

## Overview of quality

We now have a much stronger baseline of information that tells us about the quality of adult social care across the country. From October 2014 to the end of July 2016, we inspected and published ratings for more than 16,000 adult social care services.

At the end of July 2016, 72% of all services were rated good or outstanding (figure 2.1), compared with 60% when we published our findings for last year's *State of Care* report. Correspondingly, 2% of services were inadequate at the end of July 2016, compared with 7% when we published our last report.

These figures give a more positive picture of performance this year. They can partly be explained through our inspection programme being aimed at visiting those services where we had greater concerns first. But they also reflect the improvements that we have seen when we have gone back to re-inspect services that were first rated inadequate or requires improvement – we returned to 2,370 such locations rated up to the end of July 2016. However, overall 28% of services still need to improve, putting people at risk of poor care.

We saw variation in the quality of care across our key questions, and in the type of services, the size of services and the type of care needs.

In terms of our key questions, services remained stronger in some areas of care than others. The key question about caring performed best – 92% of

service where GPs or community professionals can make referrals to the service to try and prevent people having to be admitted to hospital.

Despite the pressures on services, people should still expect and receive safe, effective, compassionate, high-quality care that responds to their needs. Our findings show that some types of service are more resilient than others – both in terms of their quality and their ability to remain in the market. We have also found that certain characteristics help a service to improve, which can lead to it becoming good or outstanding.

services we rated were good (90%) or outstanding (2%) at being caring, meaning that staff are involving and treating people with compassion, kindness, dignity and respect. However, we think that the difference between this high performance and the performance of safe and well-led, with only 68% and 71% being good or outstanding respectively, is striking. In too many services, good staff are not supported by good systems that can protect people from abuse and avoidable harm, or by leaders who promote high quality and an open and fair culture. For example, a culture of failing to notice problems and of “doing just enough to get by” was seen by our inspectors as being a significant barrier to improvement.

Some types of services performed consistently better than others. Services that specialise in community social care and hospices performed highest: 84% of community social care locations (92% for Shared Lives services) and 93% of hospices were rated as good or outstanding overall. Domiciliary care services and residential homes performed similarly to each other. Nursing homes remained the biggest concern, with 41% being rated inadequate (4%) or requires improvement (37%). They were particularly poor in our assessments of being safe and being well-led, due to failings in areas like medicines management and staffing.

There was also variation in performance depending on the size of services. Figure 2.2 shows that,



generally, small care homes performed better than medium or large ones. This pattern may be partly, though not wholly, attributable to smaller services being dominated by provision for people of all ages with a learning disability. The pattern could be emerging for domiciliary care agencies as well, but we need to gather more information and explore this further.

Our registration data shows that there has been a 12% drop in the number of small residential homes (1 to 10 beds) and a 27% rise in large homes (50 beds or more) since 2010, although large homes still only make up 6% of locations. Since smaller homes perform better overall, we are monitoring these trends further to understand their effect.

Our analysis also shows services that care for smaller numbers of people often found it easier to demonstrate a good level of responsiveness, for example through a more tailored approach to their support for activities. This was linked to smaller services finding it easier to coordinate staff to deliver person-centred care.

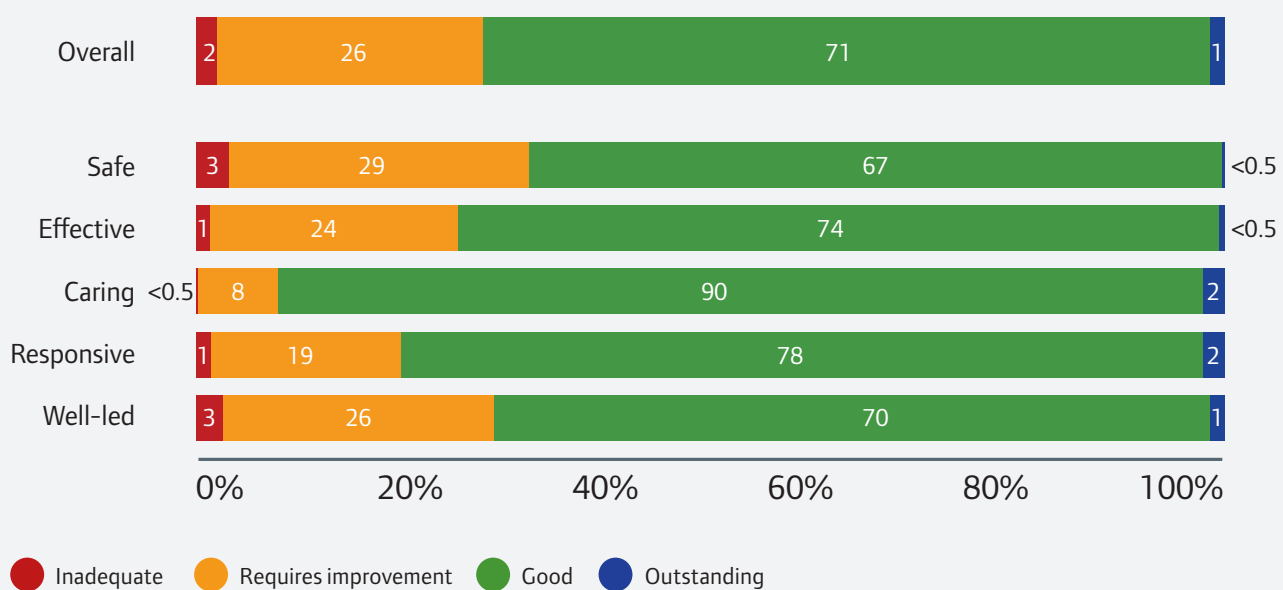
In contrast, larger providers that were performing well had effective internal quality assurance

processes, for example electronic systems to simplify management reporting and reduce the administrative workload. These systems could then be used effectively to spot early warning signs of problems.

People may also experience a different level of care, depending on their care needs. Figure 2.3 shows the much smaller proportions of inadequate and requires improvement ratings for services that are registered to care for people with a learning disability, compared with those that are not, in domiciliary care and residential care homes. This positive performance is encouraging and supports the work that national partners, including CQC, have set out through the Transforming Care programme to improve services for people with a learning disability.

The costs of services for people with a learning disability are considerably higher compared with care for older people: for example, in 2014/15 the average cost for nursing care was £552 per week for adults aged 65 and over with physical support needs, compared with £1,119 per week to support adults aged 18 to 64 who have a learning disability.<sup>62</sup>

**Figure 2.1 Adult social care current ratings, as at 31 July 2016**



Source: CQC ratings data, total of 16,764 services

# “A home from home”

## Vida Hall, Harrogate



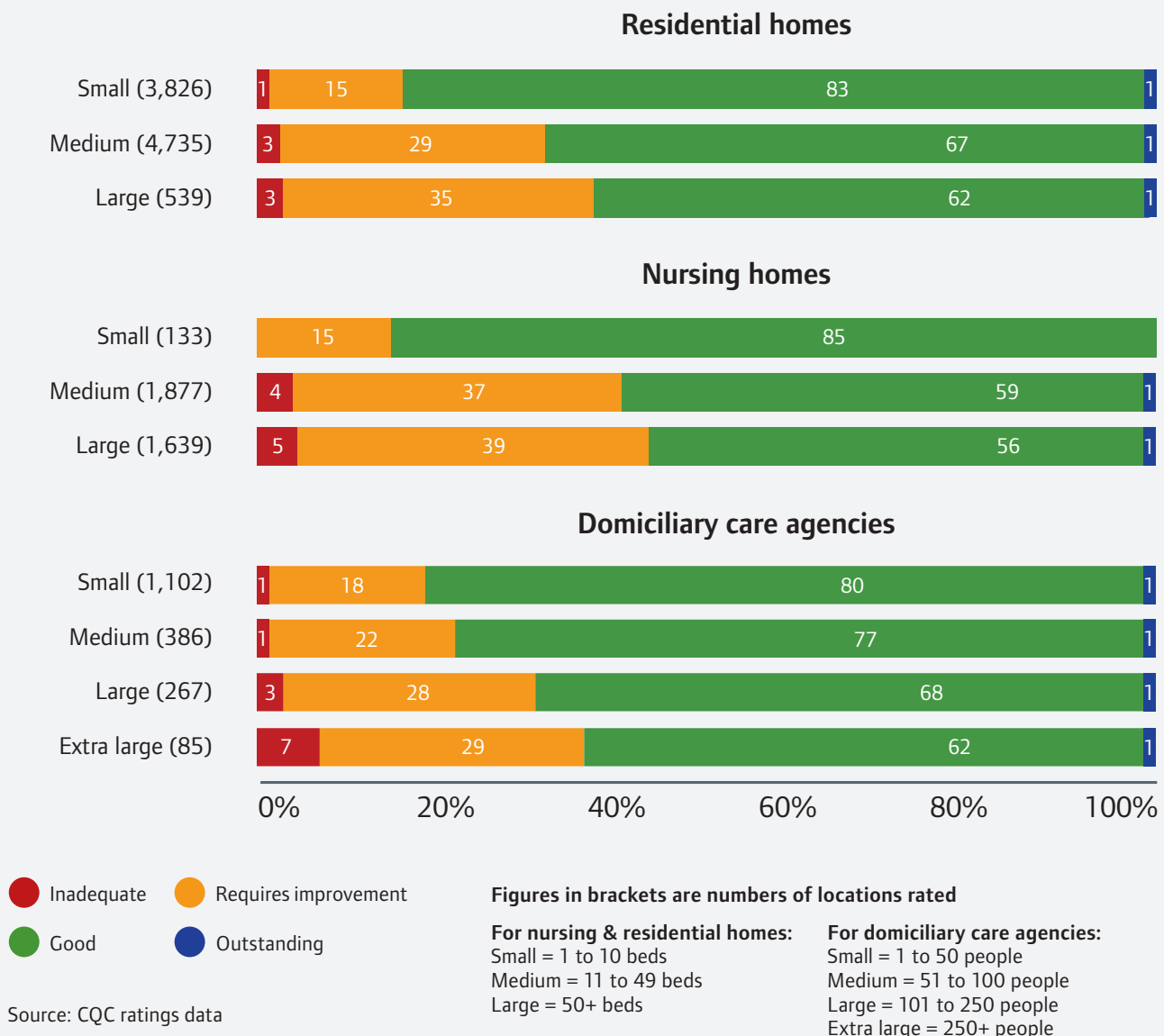
Vida Hall in Harrogate, rated as outstanding, is a large nursing home that provides accommodation for up to 70 people who live with dementia. It is purpose built and consists of a main reception area with four ‘houses’: Woodlands, Orchard View, The Glades and Meadow View. Despite its size, its design helps it to be, in the

words of a relative, “a home from home” with “a homely atmosphere”.

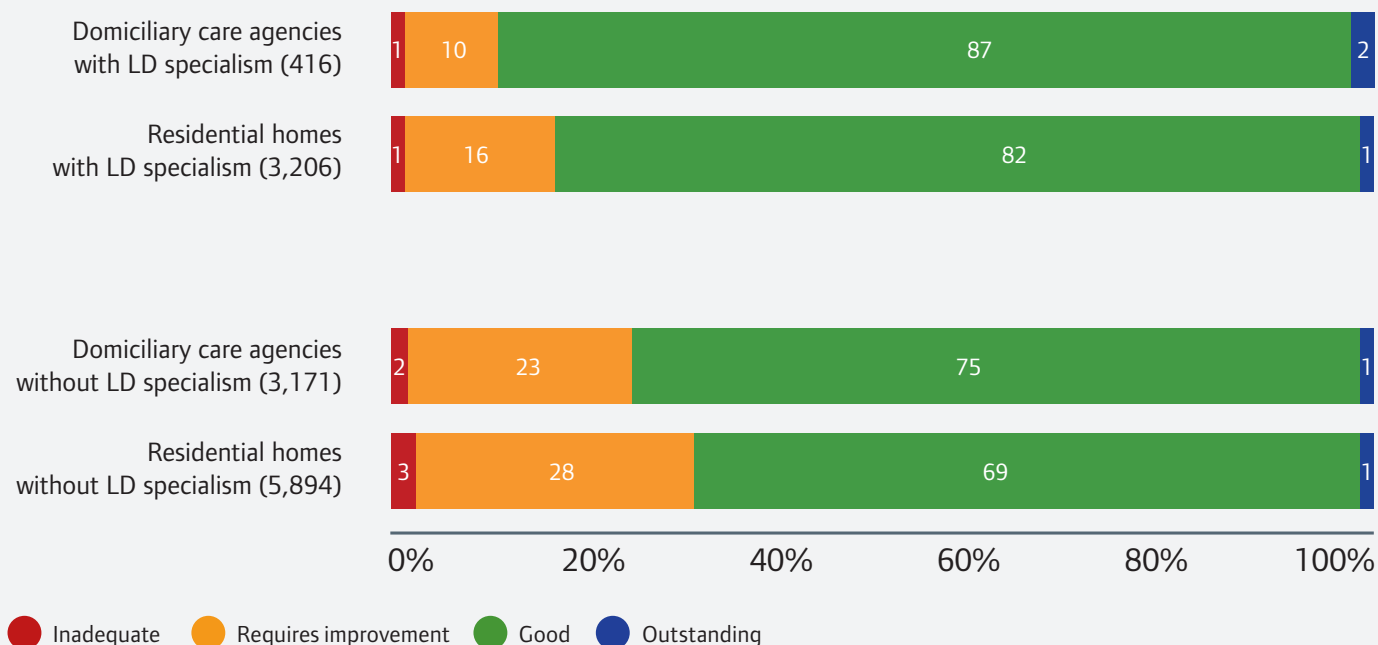
During our inspection, relatives told us how the manager led the team by example. We saw them speak with people on friendly, first-name terms. Relatives said, “The manager makes all the difference” and

“For the rest of my life I will be grateful that my Mum lived here and enjoyed her life.” A healthcare professional told us, “Four or five staff have told me that the manager is the most amazing mentor”, leading one member of staff to say, “I love it here, it is the best job I have ever had.”

Figure 2.2 Current overall ratings by size and type of service, as at 31 July 2016



**Figure 2.3 Overall ratings for services with and without a learning disability (LD) specialism, as at 31 July 2016**



Source: CQC ratings data

## Market trends

Our ratings information above shows how different parts of the adult social care sector have performed. By looking at this alongside our registration information, we can see what patterns are emerging in the sector, which may point to how services are responding to financial and resource pressures, and which services are more resilient than others.

This information will be of interest to local authorities, which have new duties placed on them by the Care Act to promote and shape efficient and effective adult social care markets that meet the diverse needs for care and support of everyone in their area.

Since September 2010, there has been a 47% increase in the number of domiciliary care agencies in England – from 5,780 to 8,517 (figure 2.4). During the same period there has been a 12% reduction in the number of residential (non-nursing)

care homes, along with an 8% decrease in total beds – from 255,289 to 235,799. The corresponding figure for nursing home beds has been a 9% increase – from 205,375 to 224,843. With an increasing population of older people, this suggests that more people with low care needs are accessing care in their own home or not receiving a service at all.

However, a closer view of the data for the last 16 months in figure 2.4 suggests that the trend towards increasing numbers of nursing home beds has come to a halt. The maps in part 1 of this report (page 44) show how these changes in nursing home provision have played out across the country. They also reflect the small trend that we have noted of some providers changing their focus from the north of England to the south, where (outside of London) there may be more people self-funding their care.

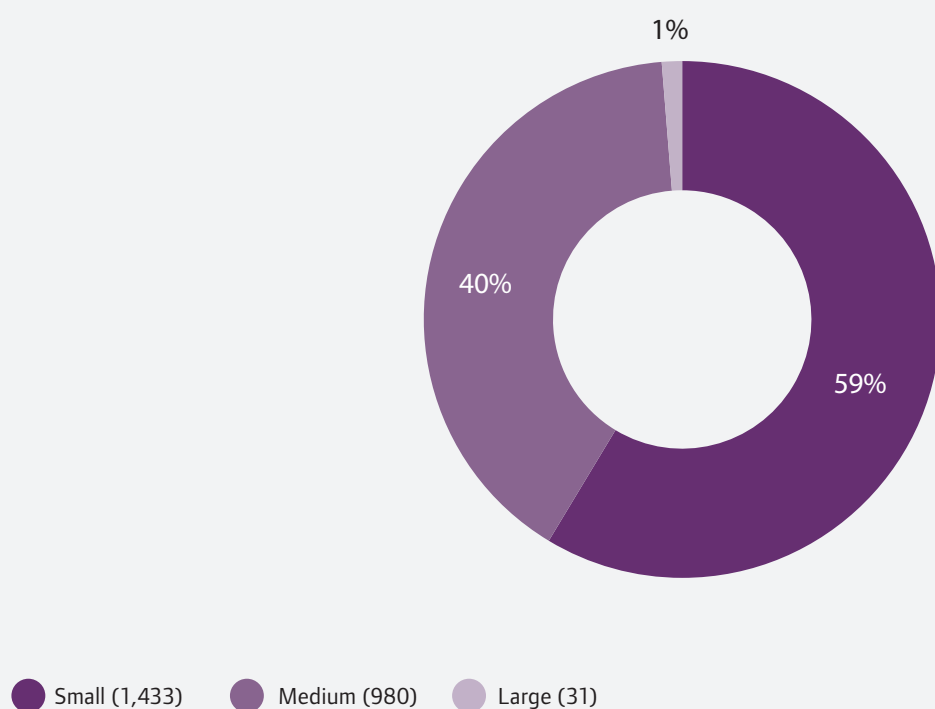
The decline in residential homes can be examined

further by looking at our information on care homes that have exited the market. As shown in figure 2.5, the majority of residential homes that closed were small, which our ratings show perform better than larger ones overall. As mentioned earlier, they are less resilient to financial and resourcing pressures, making them more susceptible to exiting the market. The size profile of these closed homes was different to the size profile of all care homes across the country. For example, 43% of residential homes are 'small', compared with 59% of those that closed.

Of the care homes above that had closed since we started our new inspection methodology (October 2014), 139 had been rated: 37 nursing homes and 102 residential homes. Despite this being a small sample, figure 2.6 shows that the majority of those closures had received an overall rating of inadequate or requires improvement – especially in the case of nursing homes.

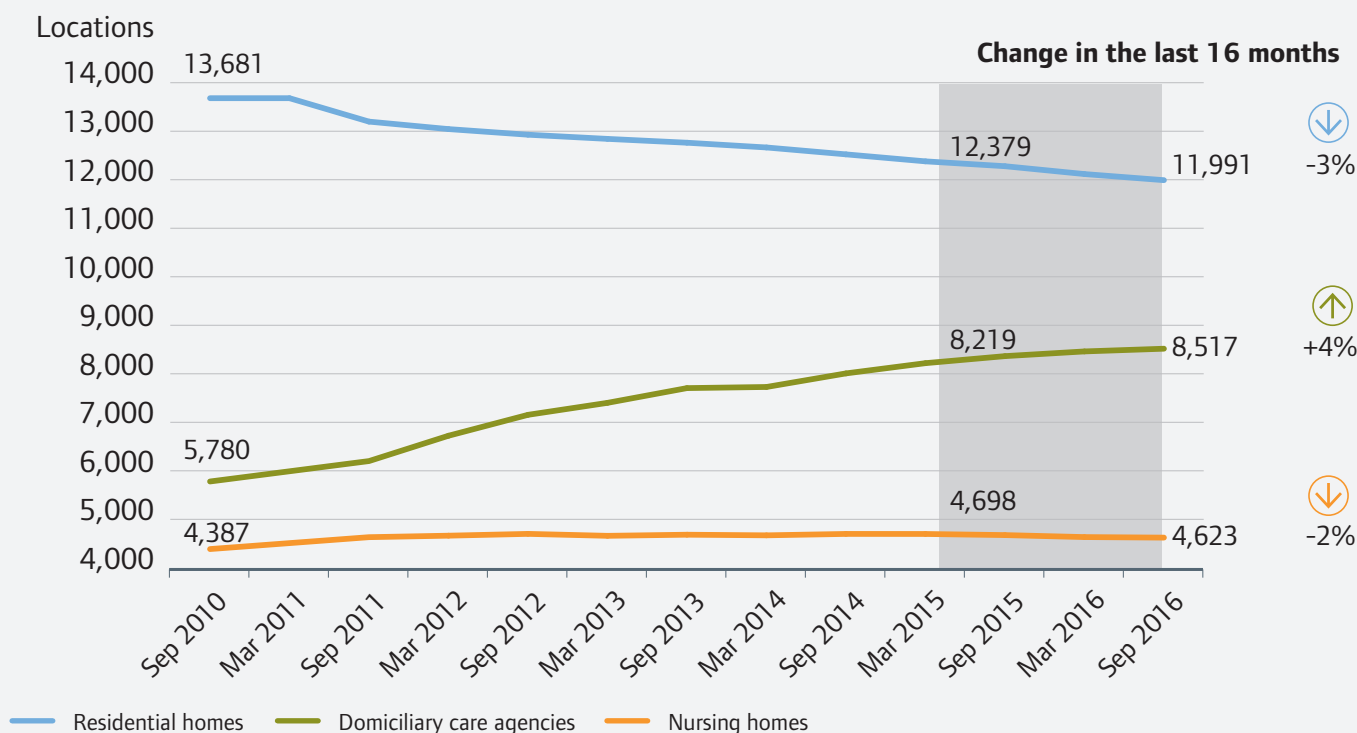
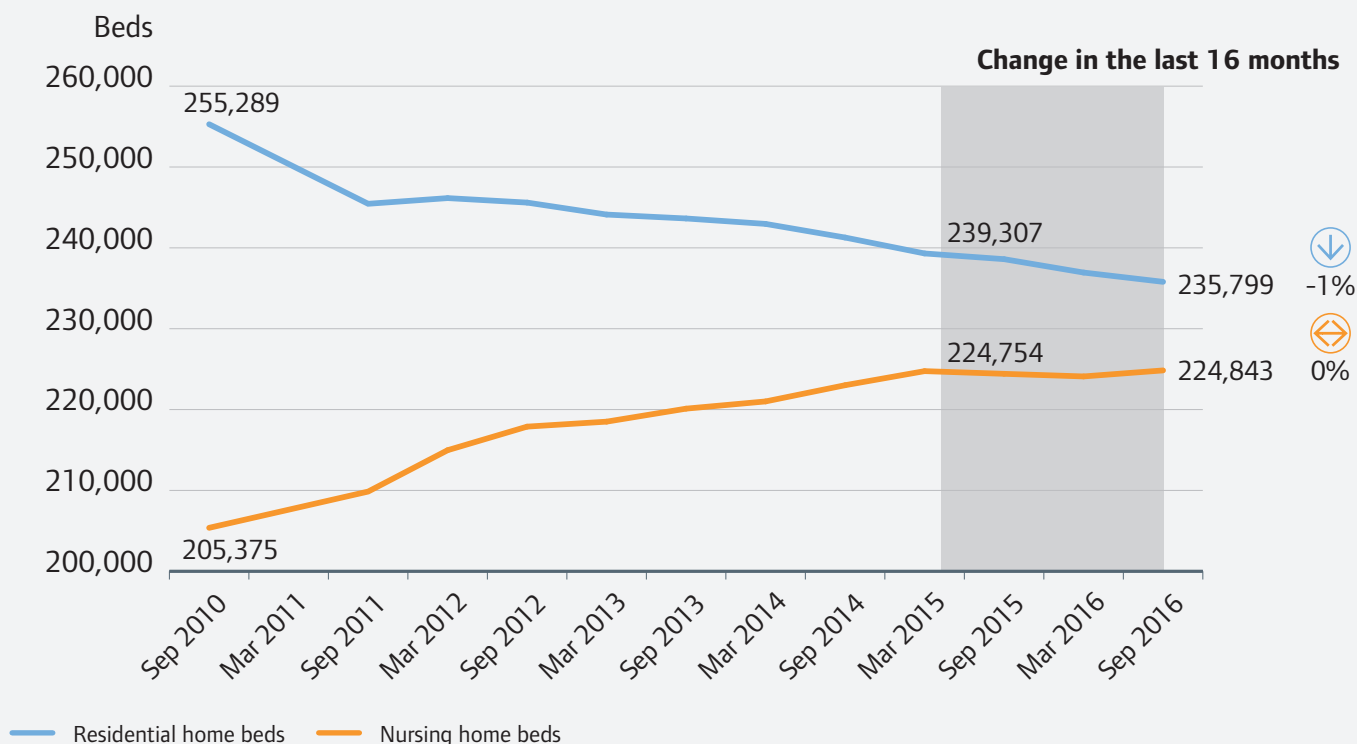
Care home closure can cause a great deal of disruption and anxiety to residents, as well as their families and carers. CQC, alongside partners including NHS England, the Association of Directors of Adult Social Services, the Care Provider Alliance, organisations representing people who use services and carers, providers and Experts by Experience, the Local Government Association and the Department of Health worked together in 2016 to create a good practice guide that seeks to minimise the impact of care home closures on the individuals affected, their families and carers.<sup>63</sup> It starts with the principles that prevention is better than closure, but when it is necessary, all partners need to know what to do to work effectively together and communicate well. Above all, the needs of people who use services must be at the heart of everything we do.

Figure 2.5 Residential home closures by size, October 2010 to December 2015



Source: CQC registration data

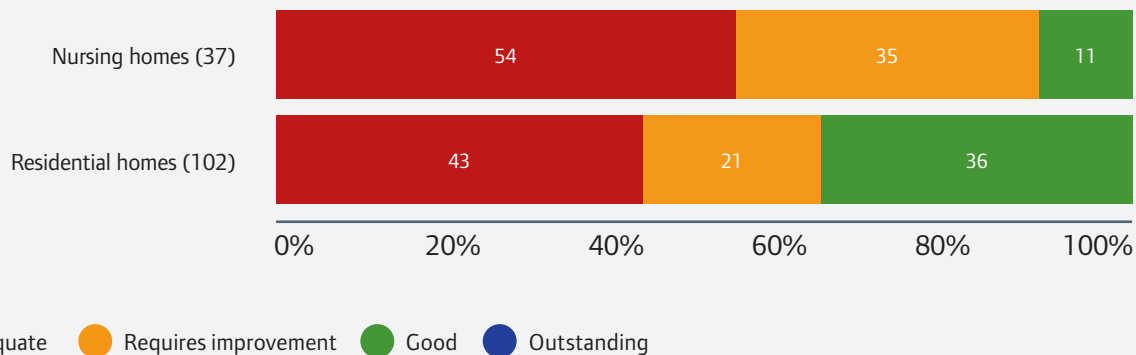
Figure 2.4 Adult social care market trends, September 2010 to August 2016



Source: CQC registration data



Figure 2.6 Care home rating by type of home, prior to market exit, October 2014 to December 2015



Source: CQC registration and ratings data

## How to be good or outstanding in responding to people’s needs

As at July 2016, there were 156 adult social care services with an overall rating of outstanding, and almost 12,000 that were rated as good. We can now see where certain practices, processes, innovations and cultures can make a real difference to people who use services, their families and carers, and the staff working in them. Where we find outstanding care, we share this through the media and on our website so that the local community can celebrate the difference that outstanding leaders and staff can make to the lives of the people using their services.

Engaging with people who use services and their families and carers is central to designing care plans, facilities and activities that meet their diverse needs and preferences. Good and outstanding practice included:

- personalised care planning that focuses on the whole person, their history, preferences and wishes
- tailoring activities to suit people’s wishes, interests and aspirations, and to develop new and existing skills – for example, making best use of the arts to find creative and innovative ways to enable people to have a fuller life

- continuous engagement with people, their families and carers that demonstrably improves the service – for example, involving them to work out how services are provided and to help recruit and train staff
- welcoming families and carers as partners in supporting people and in the life of the service
- homes working in partnership with hospices to develop their ability to enable people to die at their care home rather than in hospital
- bringing the community into homes, and supporting people to remain active citizens by going outside of their home and participating in local facilities and events.

This sort of engagement leads to a culture of delivering person-centred care. We describe an outstanding service as one that is “flexible and responsive to people’s individual needs and preferences”.

We found that learning disability services particularly grasped the concept of person-centred care by focusing beyond meeting clinical needs and looking at the preferences of people using their services.

As shown in the section of this report about Deprivation of Liberty Safeguards, with a small number of exceptions, staff working in outstanding adult social care services understood the safeguards and incorporated them in everyday practice.

We also found that outstanding care did not always rely on providers spending large amounts of money. Small-scale everyday activities often had a big effect on people's lives. Many examples were simple – such as residents helping with drinks or handing out post.

The important thing was that staff asked people who used the service what they wanted to be involved in, shared this knowledge and then responded to it.

In domiciliary care agencies, a key factor contributing to outstanding person-centred care was staff having enough time on home visits to have meaningful discussions with people about their needs and preferences.

## Transforming lives through the arts

### The Old Hall, Billingborough, Lincolnshire

The Old Hall is a residential home for up to 20 older people in Billingborough, Lincolnshire. Staff understood the importance of music to stimulate memory in people living with dementia. People were also supported to attend local groups, such as art classes and choirs that they had enjoyed being part of before they moved into the home. A family member told us, "I've nothing but praise. I've seen a transformation [in my relative] since they have been here."

## Time to develop relationships

### Home Instead Senior Care Agency, Durham

The outstanding Home Instead Senior Care agency in Durham has used its one-hour minimum visits to help develop trusting, meaningful relationships between carers and people using the service. People told us it allowed them time to get to know their carers and feel comprehensively supported. One person said, "They are like family." Families and staff also commented on the benefits of this policy in terms of its impact on people's quality of care. People commended the attitude, patience and dedication of care staff. Relatives described visits by carers as "patient and respectful" and "never rushed". This meant people felt at ease in their own homes and able to build a rapport with care staff.

# Improvement

CQC encourages services to improve through our inspections and re-inspections, and our enforcement regime. However, we are only one part of a system that must commit to improving the lives of people who use services. Providers, their leaders and staff have a direct influence on people’s experience of care, ensuring their needs and choices are met with dignity and respect. Sustained improvement also depends on commissioning and funding bodies commissioning for quality, as well as all partners in the system working together effectively. Everyone involved needs to ensure that the voices of people who use services, their families and carers are heard and acted on.

## Enforcement

Where we find care providers are failing people and breaching regulations, we take action. During 2015/16, CQC took 901 enforcement actions in adult social care, ranging from serving Warning Notices to prosecuting providers. As part of our enforcement framework, we place inadequate services into special measures to give them a clear timeframe in which they must improve, or we will take further action, for example cancelling their registration.

Figure 2.7 shows the number of breaches in each area of the regulations that contributed to inadequate ratings and services being placed in special measures. The most common issue where we took action related to governance, highlighting the need for providers to constantly check the quality of their services, for example by seeking the views of people who use the service, staff, visiting professionals and others, and sharing this to make improvements. Other main issues related to safe care and treatment, and staffing. These findings reflect our feedback from inspectors and inspection reports that showed the main areas of improvement were in medicines management, care planning, safeguarding, quality assurance and auditing, staffing and staff training, and management oversight.

## Re-inspections

When we identify those aspects of care that need to improve, we ask the provider what action they will take. We go back to inspect to find out whether they have kept to their commitments and if these have had the required effect.

Although some services rated inadequate will have stopped operating, when we re-inspected locations that had a first rating of inadequate, there was a clear

## A strong, visible, person-centred culture

### ClarkeCare Limited, Suffolk

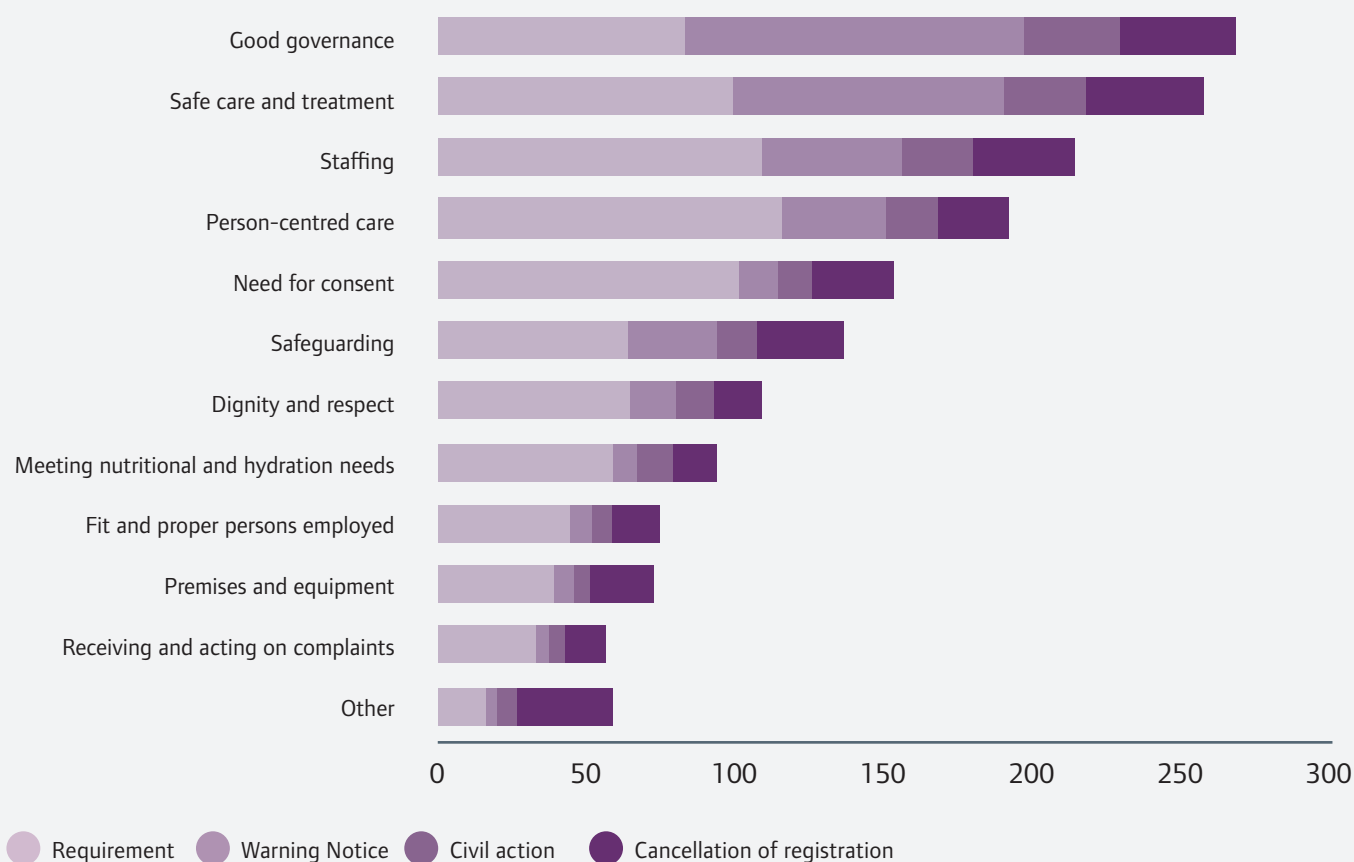
ClarkeCare Limited (Suffolk) is an outstanding service providing care to people in their own homes. It supports people recovering from an illness or operation as well as people living with life changing conditions such as dementia, multiple sclerosis and Huntington’s disease. When we inspected in September 2015, the service had a strong, visible person-

centred culture. A relative said how their family member “looked forward to [the care workers’] visit”. They put this down to the care workers giving them “a sense of importance, [since the family member] makes the decisions” which validated them as a person, making them feel they were “worth something”. Another spoke about how well they “matched their staff”

with people and provided examples such as shared interests, which enabled them to “sit and chat, to take the [person’s] mind off what is going on”. One of the people using the service told us, “I’ve struck lucky with the carers. They are lovely, I can’t fault them, everyone is so nice, I feel when something is good I should sing their praises.”



Figure 2.7 Regulatory actions against locations rated inadequate overall, as at 6 April 2016



Note: Locations may have more than one breach. The average number of regulations breached per location was six.

Source: CQC ratings and enforcement data

picture of improvement. After 520 re-inspections, 399 (77%) locations received improved overall ratings (figure 2.8). Of these 399, 110 locations improved by two ratings from inadequate to good. In care homes alone, which were the bulk of these inspections, services that can care for more than 15,000 people across the country now provide better and safer care.

Locations that were first rated as requires improvement did not improve at the same rate. Of the 1,850 locations re-inspected, 43% had improved. In 49% of cases, there had been no change, and in 8% of cases, quality had deteriorated, resulting in an inadequate rating.

It is good that attention is given to inadequate services to help them address concerns quickly.

But we are clear that the rating of requires improvement is not good enough, and providers and commissioners must work hard to convert those services rated at this level to good and outstanding.

Our analysis has highlighted what some local authorities and clinical commissioning groups, as key influencers of improvement, can do that goes beyond their funding role. Specific initiatives have helped services to improve, such as the provision of a care home team that was set up by a clinical commissioning group to help care homes make changes. One local authority had helped a service to write its action plan to make sure the key issues in its inspection report were addressed.

## How services improve

Our ratings show that 29% of services required improvement or were inadequate when we asked whether they were well-led. It is, therefore, clear that good leaders in care services have a big influence on the quality of care that people receive. This is supported through our wider analysis of our inspections.

Good managers have an important role in shaping a positive culture in a service – including creating a supportive environment for staff, listening to their concerns, and communicating well with them, other professionals, and people who use services and their families and carers. They also genuinely appreciate diversity and seek ways to meet equality, diversity and human rights.

New management and changes in management attitude and behaviours, and a willingness to think imaginatively, were often seen as important factors in bringing about change.

Examples from our analysis included a new manager at a previously failing nursing home who reassessed everyone who remained in the home to make sure the service could fully meet

their needs. At other services, new managers put in place improved quality assurance systems, made sure improved policies were being implemented, addressed cultural issues (such as bullying and favouritism), and improved incident reporting procedures.

Managers also made simple improvements, which made them more available to staff and better able to observe care practice. These included introducing regular walks around the service, having an open door policy to both staff and people using the service and their families, and actively involving themselves in all areas of the service.

We also found that existing managers who were open to challenge, who were willing to work with and listen to our inspection findings, and who chose to move forward and learn, were more likely to make changes that would improve services following an inspection.

Figure 2.8 Change in overall ratings on re-inspection in adult social care, where initial rating was inadequate or requires improvement, as at 31 July 2016



Source: CQC ratings data. Note: The width of each cluster of arrows is relative to the number of re-inspections carried out.









# Acute hospitals, community health services and ambulance services

## Key points

- NHS trusts are up against real challenges that are set to continue, as hospitals face increasing demands on their services and deal with ongoing financial pressures.
- As at 31 July 2016, 51% of core services across NHS acute trusts were rated as good and 5% were rated as outstanding.
- However, there is considerable variation within and between trusts, hospitals and core services. Five per cent of acute core services were rated as inadequate.
- Safety is our biggest concern. All hospital settings had the largest proportion of inadequate and requires improvement ratings for safety, and our inspections highlighted some poor safety cultures.
- Hospitals that achieved good or outstanding ratings effectively planned and coordinated care and treatment with other services, addressed issues from the patient's point of view and had a strong drive to improve services for patients.
- Some acute trusts improved their overall rating on re-inspection. We found that effective leadership and a positive, open culture are important drivers of change. The trusts rated as good ensured that staff at all levels were engaged in learning and improvement.

# Introduction

NHS trusts have faced very real challenges over the last few years. This will continue as hospitals face increasing demand for their services, at the same time as a further need to make efficiency savings. Despite these challenges, many trusts are delivering good quality care and we have seen examples of how the quality of care can be improved.

We have given outstanding ratings to five acute trusts, which between them run 11 outstanding hospitals across England. We have also seen a number of providers make tangible improvements during the year – five acute trusts have improved enough to be able to exit special measures since April 2015, and a number of services were able to improve their rating.

However, we also continued to uncover some very poor care. As a result, six acute trusts and one ambulance trust have been put into special measures since April 2015.

The message from all the inspections we have carried out is that effective leadership, with a strong culture of learning, is central to ensuring high-quality care. In hospitals rated good or outstanding, boards were actively engaging with staff, asking them how they needed to improve. They had worked hard to create a culture where all staff felt valued and empowered to suggest improvements and question poor practice. Where the culture was based around the needs and safety of patients, staff at all levels understood their role in making sure that patients were always put first.

Up to 31 July 2016, we had rated 133 NHS acute trusts (and 264 acute hospitals within these trusts), 35 independent acute hospitals, 13 NHS community healthcare trusts and three NHS ambulance trusts.

We have been very aware during our inspections of the challenges hospitals are facing – both increased activity and growing financial pressures. In terms of activity, emergency admissions, elective admissions and outpatient appointments all rose by 3% in 2015/16 compared with the previous year.<sup>64</sup>

On the central waiting times measure for referral to hospital treatment times (where 18 weeks should be the maximum), there has been a decline in performance during the year: at March 2016, 8.5%

of patients who were waiting had been on the list for more than 18 weeks. This is set against a target of 8% and performance varied across the country from 7.5% in NHS England's north region to 9.7% in London.<sup>65</sup>

Bed occupancy rates for general and acute settings were also very high. In each quarter of 2015/16, they were above the recommended maximum of 85% – reaching 91.2% from January to March 2016, higher than for any quarter in the last six years.<sup>66</sup> In addition:

- While 21 million patients were seen within four hours in A&E, 1.85 million patients spent longer than four hours in A&E in 2015/16. Demand for A&E has increased faster than trusts have been able to keep up: in 2015/16, there were 2.3% more total attendances than in 2014/15, but the number spending less than four hours only went up by 0.4% (figure 2.9).
- 5,700 patients were delayed in being discharged from hospital, at the end of March 2016 – the highest number for March since at least 2008.<sup>67</sup>

Our analysis shows that, although the whole system has struggled with maintaining the A&E four-hour target, better rated trusts have been more successful than those rated requires improvement or inadequate (figure 2.10).

Hospitals operate in a complex health and social care system and the performance of an individual hospital cannot be viewed in isolation. We have seen that hospitals that manage their acute care pathway well have built up strong supportive relationships with their local partners in the system.

The financial situation is also increasingly challenging. By the end of 2015/16, the deficit for all NHS providers had reached £2.45 billion. Deficits are no longer restricted to just a few trusts. At the end of 2015/16, more than 80% of all acute trusts were reporting a deficit.

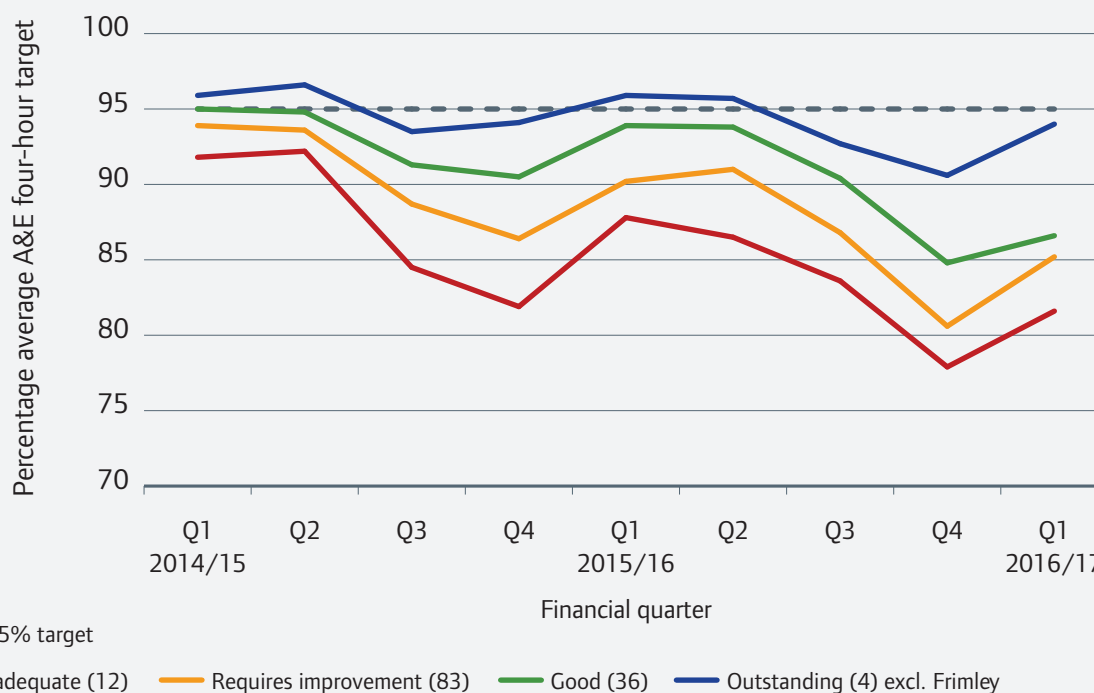
In part 1 of this report, we show that despite the constraints, some providers are managing their finances while keeping a focus on quality. There is a weak correlation between our ratings and the deficits in acute non-specialist trusts – those with higher ratings tend to be better at balancing their

Figure 2.9 A&E attendances, 2011/12 to 2015/16



Source: NHS England

Figure 2.10 Average quarterly A&E four-hour target by rating, April 2014 to June 2016

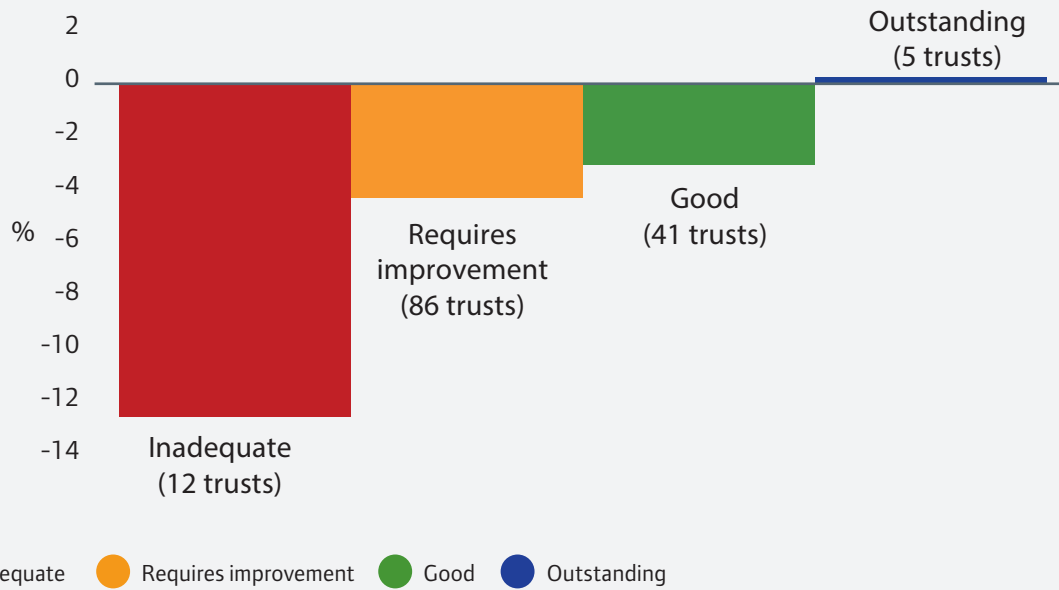


Source: CQC ratings data for 135 acute non-specialist trusts, rated up to 31 August 2016; NHS England

Note: Frimley Health NHS Foundation Trust has been excluded as the time period covers its acquisition of Heatherwood and Wexham Park Hospitals NHS Foundation Trust, which skews the results artificially.

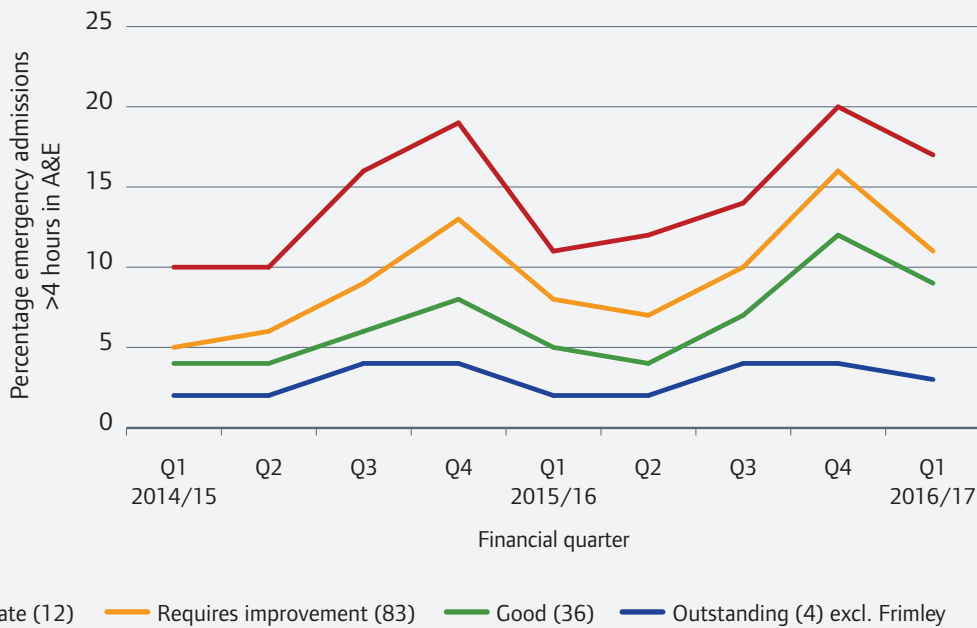


Figure 2.11 NHS acute trust median financial outturn as a percentage of operating income by rating, 2015/16



Source: CQC ratings data, NHS Improvement

Figure 2.12 Percentage of emergency admissions longer than 4 hours in A&E by rating, April 2014 to June 2016



Source: CQC ratings data for 135 acute non-specialist trusts, rated up to 31 August 2016; NHS England

Note: Frimley Health NHS Foundation Trust has been excluded as the time period covers its acquisition of Heatherwood and Wexham Park Hospitals NHS Foundation Trust, which skews the results artificially.

budgets (or have smaller deficits) than those rated inadequate (figure 2.11). We also see that providers with better overall ratings tend to score better in terms of being well-led.

Good and outstanding trusts were able to prioritise their patients well, as they had the lowest percentage of emergency admissions that took more than four hours (figure 2.12). Where we found evidence of hospitals being well-led, we saw that staff had well thought-out plans in place to manage

periods of increased patient numbers and had robust and tested major incident plans.

Through our inspections, we have seen the effect that good leadership has on patient care. Where it was being done well we saw embedded values, engaged staff who listened to patients, and services that used incidents to learn and improve. Where services worked smoothly, leaders had created a culture of sharing information, not just within the hospital but with external care providers, carers and patients.

## Overview of quality

### NHS acute trusts

Our inspections have found that there is often considerable variation in quality between services in the same acute hospital. Our core service level ratings – those that look at individual services such as urgent and emergency care, surgery and outpatients – show that 56% of core services across NHS acute trusts were good (51%) or outstanding (5%) as at 31 July 2016 (figure 2.13). The core service is the level at which patients most directly experience the quality of care being delivered.

A further 39% of NHS acute core services were rated as requires improvement. These services may provide good care in some areas, but they will have a number of specific areas that need attention. In these cases, our inspection reports give detailed advice on how services can improve.

Five per cent of core services were rated inadequate, meaning that they need urgent attention from management to address the problems we have found.

We also provide ratings for a whole acute hospital, by aggregating the ratings that we award at service level. Seen in this way, there were 42% of acute hospitals rated good (37%) or outstanding (5%) as at 31 July 2016 (figure 2.14). Performance at this level was lower than for core services because of the complexity of most acute hospitals. They offer multiple services, treat high (and increasing) numbers of patients and they have complicated pathways for patients with a wide range of needs. It is, therefore, more likely that some hospitals have one or two poorer performing services, which may affect their overall rating.

Likewise we also provide ratings for acute trusts, which often manage more than one hospital and multiple different services in a range of settings. These ratings are calculated by aggregating the hospital or services ratings within that trust. Again this means it is more likely that a few poorer ratings will affect the trust rating. Overall, 32% of NHS acute trusts were rated good (28%) or outstanding (4%) as at 31 July 2016 (figure 2.15).

We have been pleased to rate five acute trusts in England as outstanding. All of these trusts were rated outstanding for the well-led and caring key questions. Four of the five were also rated outstanding for being responsive. Between them, these five trusts operate 11 outstanding hospitals and 45 outstanding core services.

- Frimley Health NHS Foundation Trust
- Northumbria Healthcare NHS Foundation Trust
- Salford Royal NHS Foundation Trust
- The Newcastle upon Tyne Hospitals NHS Foundation Trust
- Western Sussex Hospitals NHS Foundation Trust.

Sixty-one per cent of acute trusts were rated as requires improvement overall. These trusts may provide good care in many areas, but they will have a number of specific areas that need attention. Generally, a rating of requires improvement indicates that problems with the quality of care are not so severe or numerous as to justify a rating of inadequate.



Ten NHS acute trusts (8%) were rated as inadequate as at 31 July 2016. Where the problems are such that they amount to serious failures in the quality of care, we recommend that the trusts are placed into special measures.

As part of our comprehensive inspection programme, we identified a range of core services that we would always inspect if they were provided.

It is not unusual to see one or two good core services in a hospital that otherwise has a poorer rating.

Likewise, a good hospital may have at least one core service that needs to improve.

In acute hospitals, we continued to see variation across core services (figure 2.16). There was a 25 percentage point gap between the proportion of services for children and young people rated good (63%) compared with the proportion of urgent and emergency (A&E) services with that rating (38%). This suggests that experiences for people can vary depending on the services they need within a hospital and, when taken with the variation in quality that also exists between hospitals, the quality spectrum can look very wide indeed.

Of all the core services we rate, critical care and end of life care received the highest percentage of

outstanding ratings (8%). Critical care also received the fewest inadequate ratings (2%). Services for children and young people received the most ratings of good (63%).

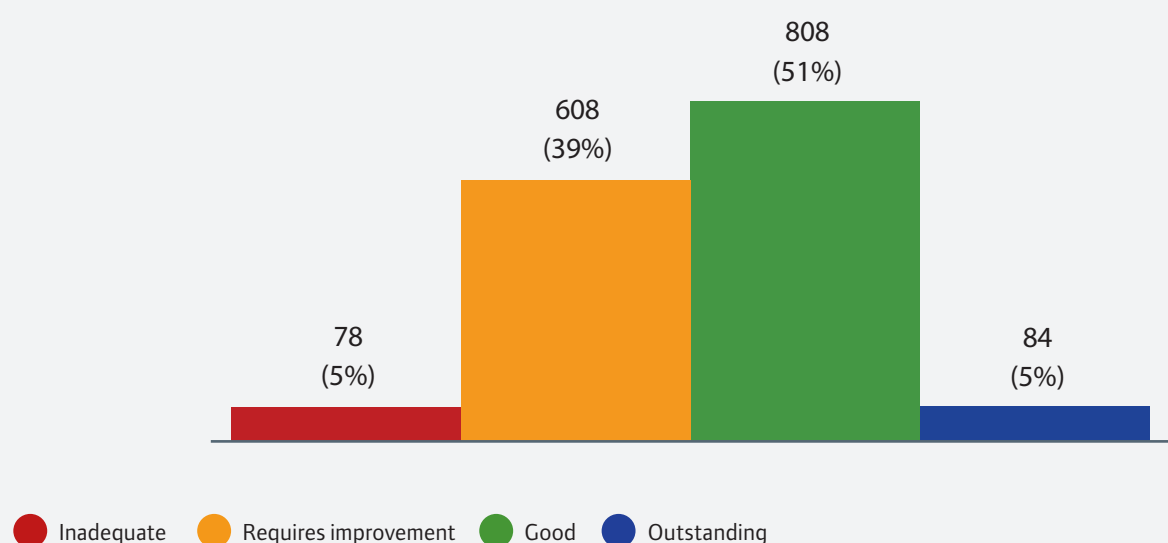
End of life care services are a good example of the variation in quality that exists between hospitals. While 8% of these services were outstanding and provided personalised care that met the needs of individuals, 4% were rated inadequate and 37% were rated requires improvement.

Urgent and emergency services received the highest number of inadequate ratings (9%), followed by outpatients and diagnostic imaging (8%).

### Community health services

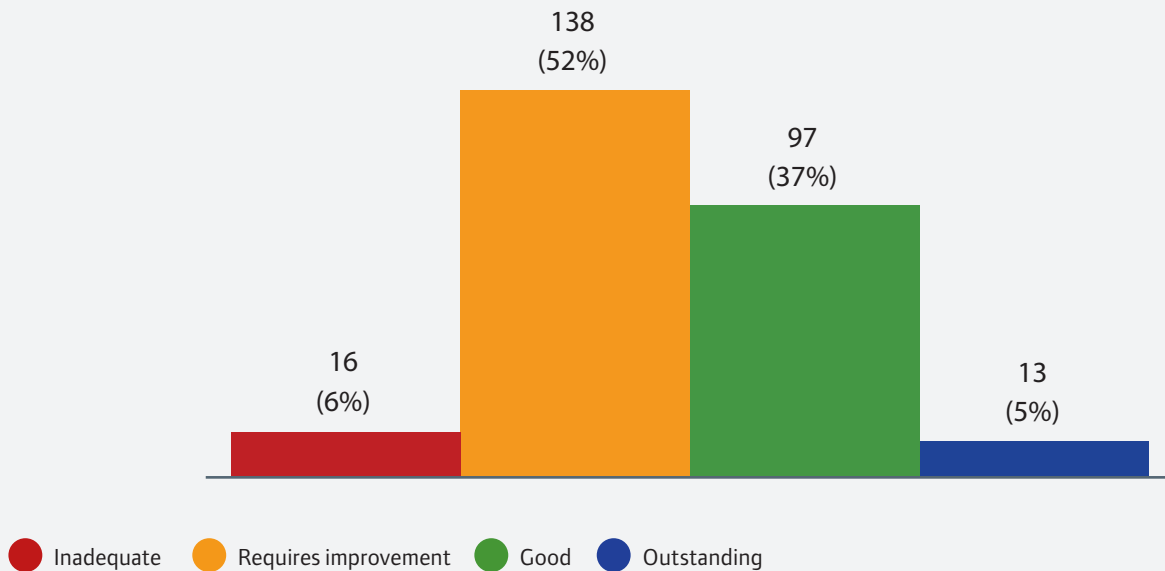
Community health care is provided by a range of different organisations. There are 18 NHS community health trusts that only provide community health services to their local population. Community health services are also provided by more than 30 NHS acute trusts and more than 20 NHS mental health trusts. In addition, there are more than 100 independent community health services – many of these are not-for-profit social enterprises and community interest companies.

Figure 2.13 NHS acute hospital current overall ratings for core services, as at 31 July 2016



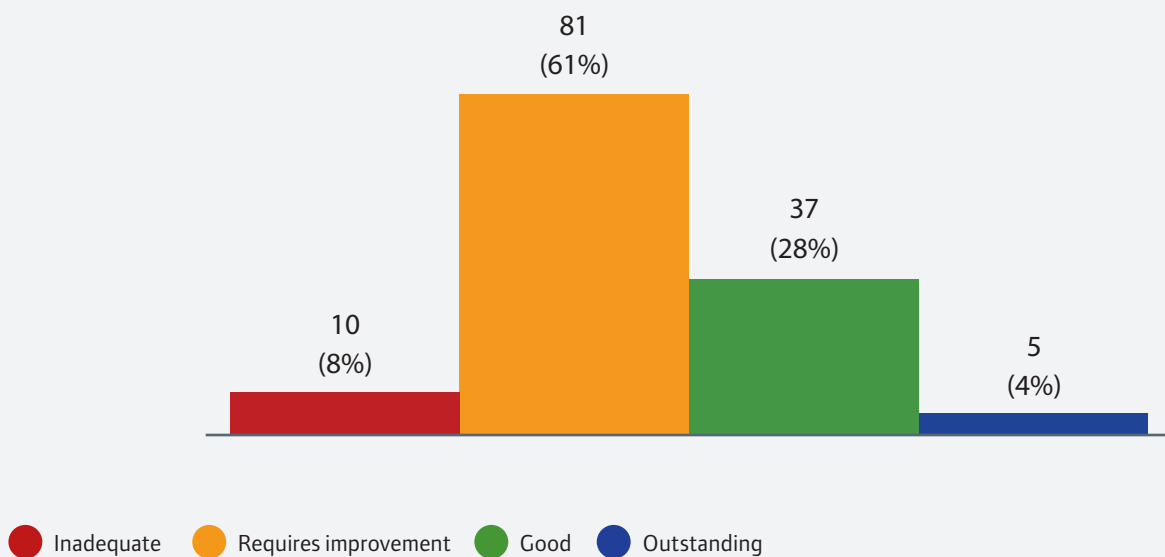
Source: CQC ratings data, total of 1,578 core services

Figure 2.14 NHS acute hospital current overall ratings, as at 31 July 2016



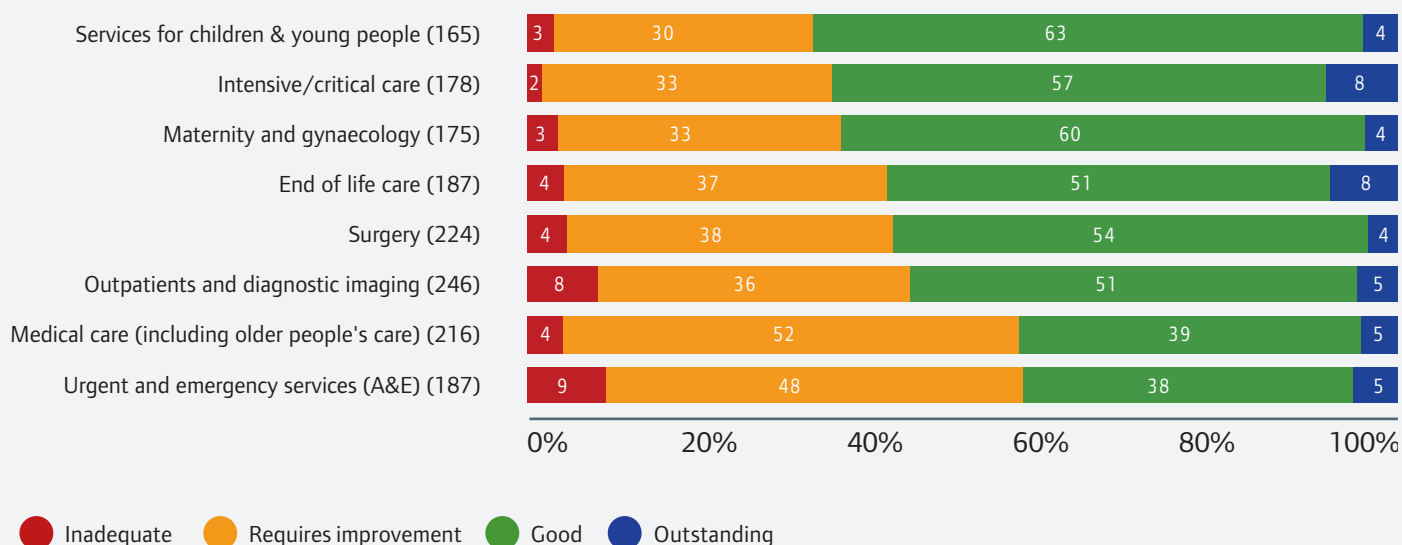
Source: CQC ratings data, total of 264 acute hospitals

Figure 2.15 NHS acute trust current overall ratings, as at 31 July 2016



Source: CQC ratings data, total of 133 acute trusts

Figure 2.16 NHS acute hospital current overall ratings for each core service, as at 31 July 2016



Source: CQC ratings data

## New ideas to improve patient care

### Western Sussex Hospitals NHS Foundation Trust



Western Sussex Hospitals NHS Foundation Trust was rated outstanding in December 2015. The executive team provided an exemplar of good team working and leadership. They had a real grasp of how their hospital was performing and knew their strengths and areas for improvement.

There was strong evidence of learning from incidents. Staff were encouraged to have an open and honest attitude towards reporting mistakes and incidents, which were then thoroughly investigated. Staff talked with great pride

about the services they provided and all agreed they would be happy for their family members to be treated there. We were flooded with requests from staff wanting to tell us about specific pieces of work they were doing, how much they liked working for the trust and how supportive the executive team were of innovative ideas and further learning as a tool for improvements in patient care.

The consultants told us the executive team, and medical director in particular, were supportive, approachable and encouraging of new

ideas. For example, hospital staff worked in partnership with a local charitable trust to provide a cardiac buddy service for people with long-term heart conditions, working on the wards and in exercise classes. The scheme had been developed as a result of patient feedback.

There was also a scheme that encouraged youngsters with cancer and other serious illnesses to become trainee biomedical scientists for the day and tour the hospital pathology laboratories with their families.

Figure 2.17 shows the ratings given to the community core services, as at 31 July 2016, provided across all settings. Overall, the quality of care in community services was good. Community dental services performed the best, with five services out of 29 (17%) achieving an outstanding rating and 20 (69%) achieving a rating of good.

The quality of care for the other core community services was broadly the same as each other, with around 70% of services being given a rating of good or outstanding.

During our inspections, people who use community health services were positive about the services provided. We found that the majority of staff were well motivated, proud and committed to community services. There was clear evidence that most providers had invested time and effort in creating a culture of safety and most organisations had good processes for reporting and learning from incidents.

In combined trusts we have yet to see evidence of truly integrated services across the board. Many services are managed as separate service lines – a number reported to us that they felt at a distance from the central functions of their organisation.

All providers were clear in their role as a provider of care closer to home, but there was variation in the maturity of organisational strategy to deliver this. We have also seen some variation in morale and perceptions of strength of leadership, particularly in community services for adults.

There remains a disparity nationally around the role and function of some services, notably community inpatients and community services for adults where commissioning arrangements vary greatly. While there is a growing body of benchmarking data available for these services, this is still not at a level that enables robust comparisons in all areas.

### **Independent acute hospitals**

Independent acute hospitals range from corporate hospital groups to smaller, specialist providers of specific surgeries and treatments. Independent hospitals provide services to insured, self-paying and NHS-funded patients.

We have rated 35 independent acute hospitals so far. Of these, 23 were rated as good and 12 as requires improvement (figure 2.18). It is important to note that independent acute hospitals are not directly comparable to NHS trusts, because independent hospitals almost exclusively provide elective services. However, the inspection process is the same and hospitals are assessed against the same standards as NHS trusts.

### **NHS ambulance services**

So far, we have rated three NHS ambulance trusts out of the 10 that cover England (we have inspected all of these trusts and the inspection reports will be published shortly). Two were rated requires improvement and one was rated inadequate.

We have picked up a number of key themes from these inspections. The commitment of frontline staff comes through very clearly. There is a real appetite for improvement: staff at all levels in organisations work with key stakeholders on exploring initiatives to improve patients' experiences of care. During our inspections, people who use ambulance services have been positive about the services they have received.

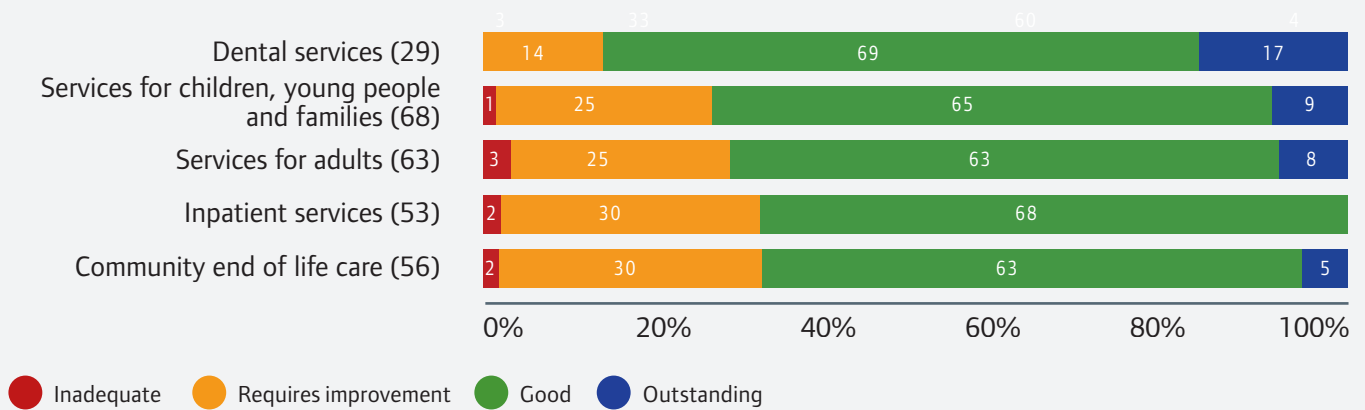
However, there is no doubt that ambulance services are under extreme pressure. Nationally, the targets for ambulance response times and a shortage of paramedics present a significant challenge. The first round of comprehensive inspections of NHS ambulance trusts has provided CQC with evidence of where variation exists across the five key questions, as well as areas of excellent clinical practice. We will continue to work with the sector to improve patient experience and share best practice.

### **Safety**

Staff in all types of trust continue to show that they are caring, treating patients with respect and dignity. We continue to find that safety is our biggest concern. All hospital settings had the largest proportion of inadequate and requires improvement ratings for safety – figure 2.19 shows the overall key question ratings for NHS acute trusts.

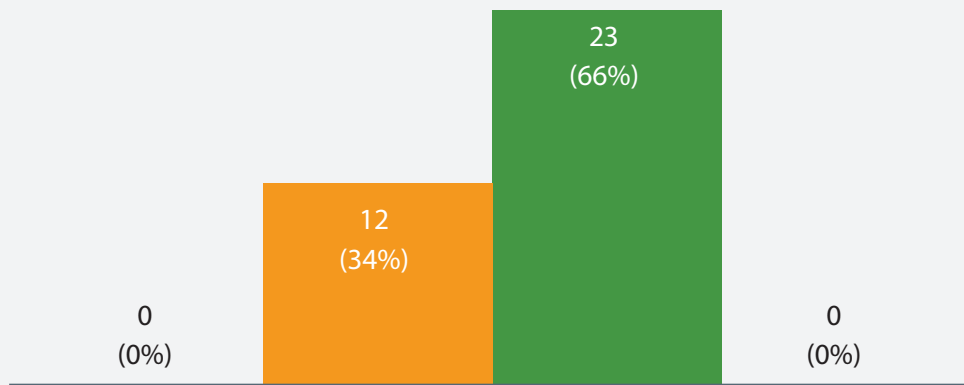
Ensuring consistently safe care remains the single biggest challenge for hospital providers in terms of the quality of care.

Figure 2.17 NHS community health current overall ratings for core services, as at 31 July 2016



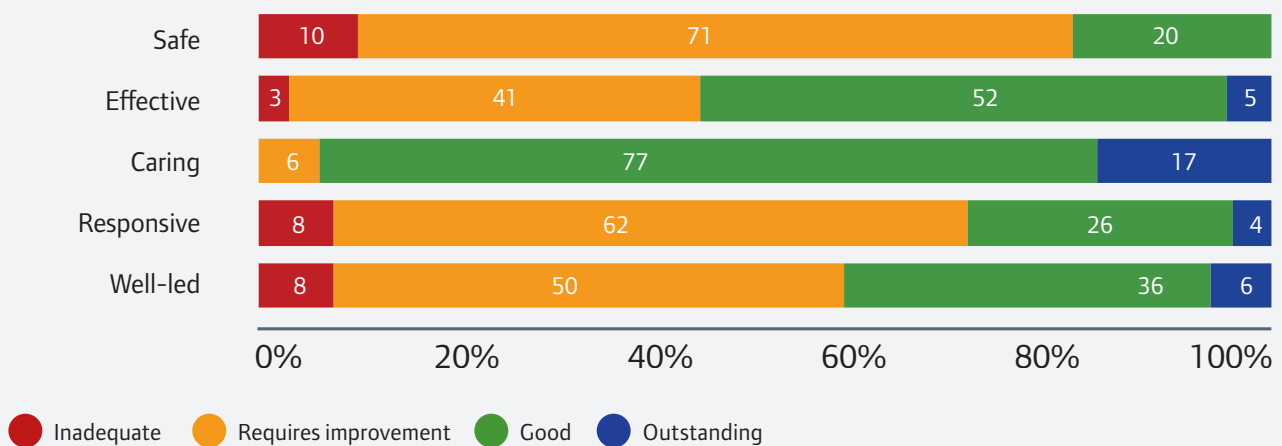
Source: CQC ratings data

Figure 2.18 Independent acute hospitals current overall ratings, as at 31 July 2016



Source: CQC ratings data, total of 35 independent acute hospitals

Figure 2.19 NHS acute trust key question ratings, as at 31 July 2016



Source: CQC ratings data

We are starting to see some improvements in staffing and recruitment, as well as improvements in areas such as changes to premises (including refurbishment), staff training and improved coordination of services.

However, staffing levels and skill mix remain an issue in many hospitals. When we inspect we always take a rounded view of staffing levels. This involves listening to patients and staff, observing staff/patient interactions, looking at staffing rotas, and looking at risk registers where trusts themselves have frequently identified risks because of their staffing and have incident reports related to staffing. The exception to this is in critical care, where there are clear guidelines relating to staffing levels such as 1:1 staffing for patients requiring level 3 care.

Our inspectors have reported that, in trusts rated as requires improvement or inadequate, staffing levels were often not determined by or adjusted to the needs or acuity of the patients. In some cases, there was no tool to identify the numbers or skill mix of staff needed to deliver safe care.

While staffing levels are a factor in determining safety, we have found other concerns that need more effective leadership around safety. Our inspections have highlighted examples of poor safety cultures. In particular we have seen:

- variation in support for reporting incidents and for learning from incidents
- incomplete safety audits
- staff not receiving essential training and not taking mandatory courses
- inadequate management of medicines
- insufficient record keeping and systems that were not fit for purpose – as a result clinicians had created unsafe work-arounds
- poor data sharing – this had led to incomplete care plans and tests being repeated unnecessarily
- poor management of patients at risk of deterioration in their health.

The overall number of patient safety incidents continued to increase in 2015 (figure 2.20). High reporting levels for incidents resulting in no harm or low harm are generally considered to be a positive measure of the safety culture within a trust. Indeed, we found a moderate statistical correlation between the staff survey results on incident reporting and better ratings. Where we saw evidence that patient safety was the hospital's main priority, staff were confident in reporting incidents. Staff in trusts rated as good reported witnessing fewer potentially harmful errors, near misses and incidents than those in trusts rated inadequate, but more said that they report the ones they had witnessed.<sup>68</sup>

## Leadership

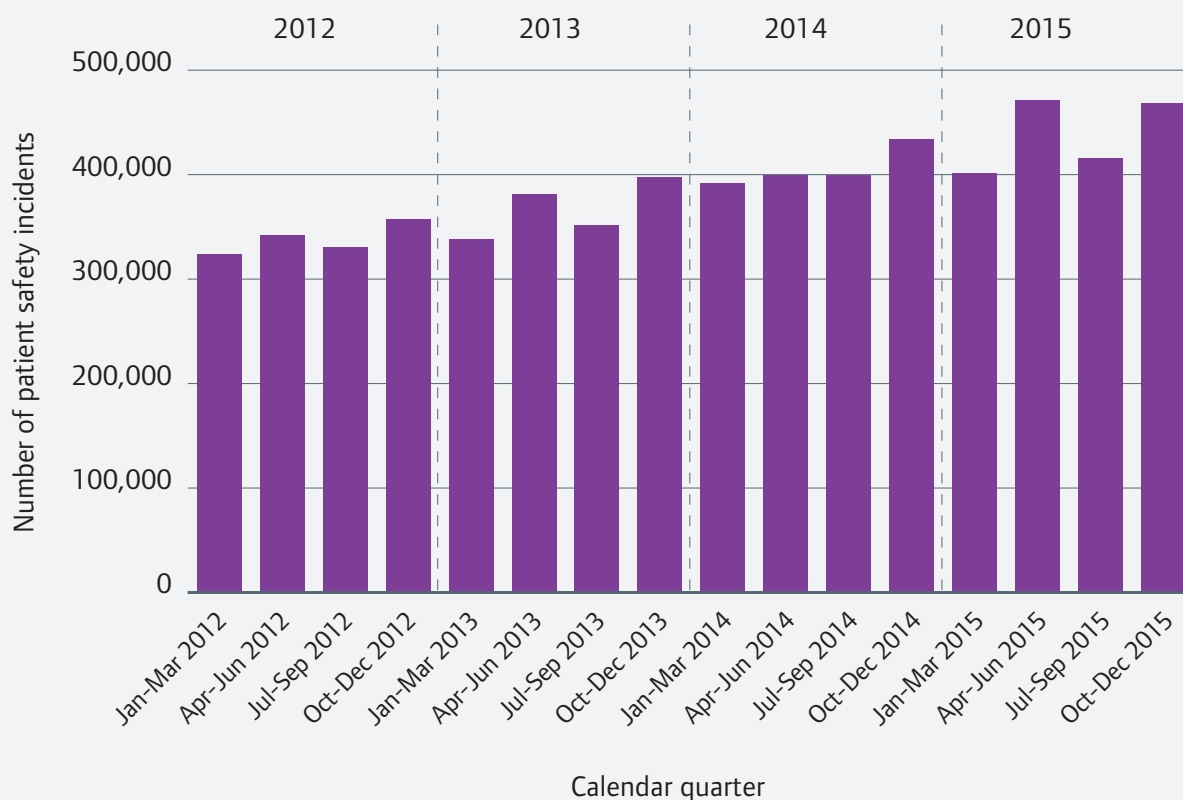
Effective leadership is central to providing good and safe hospital care. Where it was done well we saw embedded values, engaged staff who listened to patients, and services that used incidents to learn and improve. Where services work smoothly, leaders have created a culture of sharing information, not just within the hospital but with external care providers, carers and patients.

Above all, we found a culture of staff working towards the same goal, confident in raising issues, concerns and whistleblowing, learning from errors and being transparent with patients and families.

- Trusts with good leadership had embedded values, engaged staff who put the needs of patients first, shared information and learned from incidents.
- Inspectors found the key to a well-led organisation was having a visible and approachable leadership team.
- In good and outstanding hospitals, boards actively engaged with staff and there was an open or no blame culture where staff were open and honest, and trusts were transparent when things went wrong.
- In poorly-led organisations, staff were not actively reporting concerns or learning from incidents.
- Where services were failing patients, we found a culture of leaders taking false assurance from inadequate information and a lack of challenge from the board.

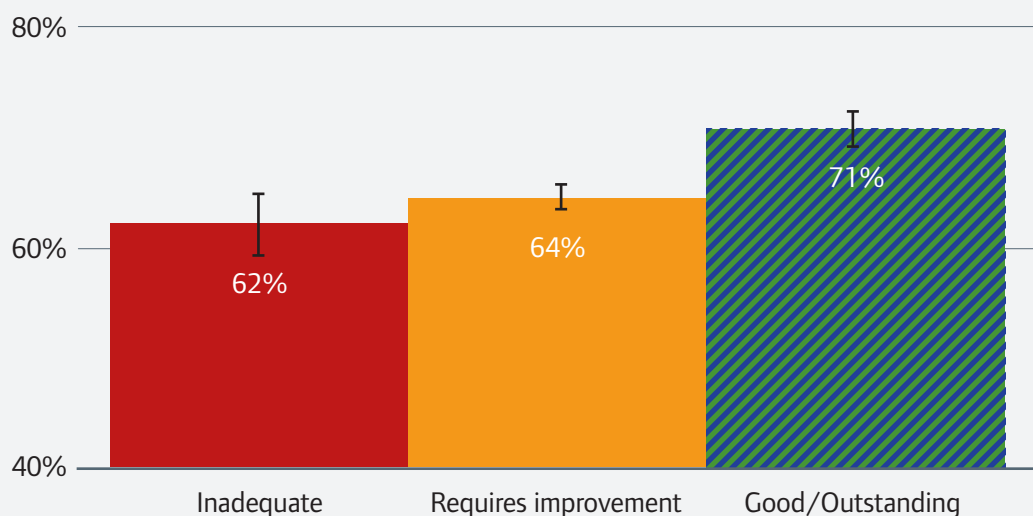


Figure 2.20 Number of patient safety incidents submitted in England, January 2012 to December 2015



Source: The National Reporting and Learning System

Figure 2.21 NHS staff survey 2015, key finding 1: Staff recommendation of the organisation as a place to work or receive treatment



Source: CQC ratings data covering 106 acute non-specialist trusts rated up to 22 April 2016; NHS staff survey 2015

The 2015 NHS staff survey further supports our findings. Staff in trusts that have received higher ratings tend to recommend their organisation as a place to work and/or receive treatment (figure 2.21).<sup>69</sup> Creating the

right culture in which staff feel valued and motivated, and where patients are at the heart of all decisions, is only possible through good leadership and strong clinical engagement.

## How good and outstanding hospitals respond to people's needs

How providers organise their services so that they meet the needs of local people is the focus of our 'responsive' key question and, in terms of overall performance, one that we pay close attention to. Almost a third (30%) of acute trusts were rated good or outstanding for responsiveness, while more than six in 10 (62%) needed to improve. A small minority of trusts (8%) were rated inadequate for responsiveness.

The picture in the standalone NHS community health trusts was better: nine of the 13 trusts were rated as good for responsiveness, and four as requires improvement.

We have carried out qualitative analysis to understand the differentiating factors between acute hospital trusts that are rated outstanding and those rated inadequate. Most important 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.

Being person-centred and addressing issues from the patients' point of view was a key factor in trusts achieving good and outstanding ratings. Our inspectors noted that the best trusts often had a stronger drive to improve and were focused on how to make services better for patients. Importantly they looked at this from the patient's point of view. This was in contrast to some poorer trusts where patient groups and external organisations and bodies were sometimes perceived by staff as presenting a problem.

### Responsive: what good looks like

- Services are planned and delivered in a way that meets the needs of the local population. The importance of flexibility, choice and continuity of care is reflected in the services.
- The needs of different people are taken into account when planning and delivering services.
- Care and treatment is coordinated with other services and other providers.
- People can access the right care at the right time. Access to care is managed to take account of people's needs, including those with urgent needs.
- Waiting times, delays and cancellations are minimal and managed appropriately.
- Complaints and concerns are always taken seriously, responded to in a timely way and listened to. Improvements are made to the quality of care as a result of complaints and concerns.

Our inspectors highlighted some outstanding examples of facilities and services that had been planned to match the needs of people who use services, for example:

- patients with dementia being 'flagged' on admission so that staff had access to relevant information
- a dedicated centre run by health visitors for single mothers and children in an area with a large Black and minority ethnic (BME) community, including a significant number of refugees, which provided non-medical as well as clinical support
- a hospital that liaised with other providers to make sure a family with young children could access specialist treatment as outpatients, rather than needing overnight stays.

Strong patient engagement was a clear factor. Our inspectors gave examples of trusts inviting key community members (for example from BME populations) to sit on their board, or using local projects led by people with a learning disability to train staff about their experience of using services.

Inspectors also saw trusts with a culture of innovation to identify and meet patients' unmet needs, for example:

- a trust that set up a new clinic to support patients following a period of critical care
- services being provided for people in remote areas by using telemedicine
- consultants travelling to patients, rather than them travelling to the consultant
- identifying particular groups in an area, for example refugees or a traveller population, and providing a tailored service for them
- addressing bereavement needs with a chaplaincy service and volunteers
- ensuring rights to privacy, for example so that same sex partners can visit patients without fear of discrimination from others.

Also important was where trusts worked with other bodies, such as:

- community outreach provision that was set up to identify the best places to provide services

## Inspirational leadership and remarkable consistency

### Northumbria Healthcare NHS Foundation Trust

Northumbria Healthcare NHS Foundation Trust was rated outstanding in 2016. The trust has four main hospitals that were all rated as outstanding. Berwick and Alnwick Infirmaries were rated as good. The trust's community services were also rated outstanding.

The consistency of outstanding ratings across all four hospitals was remarkable. To achieve this across so many sites was a first. It

shows that it is possible to achieve excellence even when services are widely dispersed geographically.

There were many factors that contributed to the outstanding rating including:

- Inspirational leadership and strong clinical engagement had ensured that a recent reconfiguration of services had been managed effectively.
- There was strong integration of all services

between the hospital and community, particularly in end of life care services.

- Staff delivered compassionate care, which was polite and respectful, going out of their way to overcome obstacles to ensure this.
- The number of consultants was higher than average, and the trust used advanced nurse practitioners to support doctors.

- community services that responded to local flooding, by linking people with appropriate services beyond health and helping to keep track of people and families in vulnerable circumstances
- working with GP partners, for example by offering training

- providing free legal advice to patients who had concerns about their family income while in hospital.

Another key factor was the quality of engagement between the consultant team and the executive team.

## Improvement

Up to 31 July 2016, four out of seven NHS trusts that were originally rated inadequate had improved enough for us to rate them as requires improvement when we re-inspected them. Of 18 trusts that were originally rated as requires improvement, two improved their rating to good following re-inspection, 14 stayed the same, and two deteriorated to a rating of inadequate.

We were pleased to see that some acute trusts improved their overall rating. These trusts are complex organisations and, in many cases, need to attend to a variety of different problems affecting the quality of the care they provide across a range of services and locations. For some trusts, the step from requires improvement to good is a large one (for example, where almost all the services have been rated as requires improvement). For others, they may only need to improve on a small number of aspects of care to achieve an improved rating. We are looking to better understand the reasons why some providers do not improve enough to warrant a change in their rating, as part of our commitment to help people get safe, high-quality and compassionate care.

We have seen variation in the ratings of the core services on re-inspection, with the greatest improvement being in services for children and young people (16 out of 23, or 70%) and the smallest improvement in urgent and emergency care (15 out of 42, or 36%). Improvements have been achieved in a number of areas, including staffing and recruitment, staff training, the physical environment, leadership and learning from incidents.

We have found that effective leadership and a positive, open culture are important drivers of change. Where trusts needed to improve, staff were

keen for CQC's follow-up inspection to happen: our inspectors have reported examples where they had met people at the trust who wanted them to come back and see the changes and improvements that had been made.

Where trusts were performing well, the culture almost always meant that staff at all levels were engaged in the ethos of learning and improvement. One example was a programme of cross-working between office and operational staff to allow them to understand each other's roles better. This was in contrast to trusts that worked in a 'top-down' way, which inspectors felt was ineffective, or where there was a cultural or structural disconnect between ward and board that could be a significant barrier to change.

Also important was the development of effective links and partnership working between different areas of trusts. Our inspectors noted that, in acute trusts that had taken on responsibility for community health care, there had often been a disconnect between the acute and community sides, with community being "forgotten about" or "out on a limb". Northumbria Healthcare (rated outstanding) provides an example where the acute and community sides of the trust work well together.

The importance of a visible and listening senior leadership team cannot be underestimated. Our inspectors said that this was a crucial element in turning around trusts where improvements were needed, and vital to a trust becoming a high-performing provider. Where we have seen an improvement in ratings, hospital staff commented that leadership had improved and they felt better connected with the rest of the hospital.

At Northumbria Healthcare, the management team was aware of the trust's strengths and areas for improvement and had strong clinical and public engagement. In another service, the executive lead and matron acknowledged the importance of visible leaders and were looking to ensure that leaders were accessible to staff and able to support them.

### **Special measures**

We want to ensure that services found to be providing very poor care do not continue to do so. Special measures were introduced in 2013. They apply to NHS trusts and foundation trusts found to have serious failures in the quality of care (usually with inadequate ratings in at least two out of the five key questions at trust level) and where there are concerns that existing management cannot make the necessary improvements without support.

When we rate a trust as inadequate, we normally recommend to NHS Improvement that it should be placed in special measures. Exceptions to this can occur if strong leadership has very recently been put in place in the trust. To date, CQC's recommendations for special measures have always been accepted.

Trusts in special measures are offered support to make the necessary improvements. We usually re-inspect the trust within one year unless we have significant concerns, in which case we will carry out another inspection sooner. We expect trusts to exit special measures following the first inspection a year after they enter special measures, though this timeframe can be extended where a trust has not yet had time to make the required improvements.

At the start of 2015/16, there were 14 NHS trusts in special measures. During the year, four trusts improved enough to be able to exit the scheme, while six trusts entered. From April to August 2016, one additional trust entered special measures, and one exited (figure 2.22).



## Holistic understanding of performance

### North Bristol NHS Trust



In December 2015, we carried out a focused re-inspection of North Bristol NHS Trust to follow up on the areas that we rated as inadequate and requires improvement in our inspection of November 2014.

We found that there had been significant improvements, particularly in urgent and emergency care services.

Learning from previous gaps in assurance of the quality and safety of patient care was evident in the emergency department, as a quality dashboard was implemented and reported on through the integrated performance report. This report set out performance across the trust in terms of CQC's five key questions. This enabled a holistic understanding of performance, including safety, quality, activity and financial performance. People's views were taken into account to gain

assurance at trust board level through patient stories and the visibility of incidents and complaints. A greater focus was also planned over the next year following the appointment of the head of patient experience reporting to the director of nursing.

There had been a review of nursing and midwifery staffing across the trust which had resulted in increased numbers of staff in urgent and emergency care, medical services, critical care, surgical services and maternity services.

There had been a focus on ensuring that staff were competent and confident to carry out their roles, particularly those who were new to an area or in their first role. This was particularly evident in the emergency department and critical care where there were more staff in particularly skilled areas. Nurse education practitioners had been employed to provide targeted support in these

areas.

In the emergency zone there was a complex assessment and liaison service, which was aimed at developing a treatment and rehabilitation plan to avoid admission or shorten length of stay. The service was staffed by consultant physicians, advanced nurse practitioners, occupational therapists and physiotherapists.

As one of two major trauma units serving the south west, the department was required to report all treatment results of major trauma patients to the national trauma audit and research network (TARN). Results for 2015 showed that the emergency department at Southmead Hospital had the best survival rate of any trauma unit in England and Wales.

Figure 2.22 Trusts in special measures, April 2015 to August 2016

	Entry	Exit**
Tameside Hospital NHS Foundation Trust	July 2013	September 2015
Burton Hospitals NHS Foundation Trust	July 2013	October 2015
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	July 2015
Colchester Hospital University NHS Foundation Trust	November 2013	
Barking, Havering and Redbridge University Hospitals NHS Trust	December 2013	
University Hospitals of Morecambe Bay NHS Foundation Trust	June 2014	December 2015
East Kent Hospitals University NHS Foundation Trust	August 2014	
Wye Valley NHS Trust	October 2014	
Hinchingbrooke Health Care NHS Trust	January 2015	August 2016
Norfolk and Suffolk NHS Foundation Trust*	February 2015	
Barts Health NHS Trust	March 2015	
Cambridge University Hospitals NHS Foundation Trust	September 2015	
East Sussex Healthcare NHS Trust	September 2015	
West Hertfordshire Hospitals NHS Trust	September 2015	
London Ambulance Service NHS Trust*	November 2015	
Worcestershire Acute Hospitals NHS Trust	December 2015	
Walsall Healthcare NHS Trust	January 2016	
Brighton and Sussex University Hospitals NHS Trust	August 2016	

Source: CQC enforcement data

Notes:

\* All of these trusts are acute trusts, except for Norfolk and Suffolk NHS Foundation Trust (mental health trust) and London Ambulance Service NHS Trust (ambulance trust).

\*\* Heatherwood and Wexham Park Hospitals NHS Foundation Trust was also placed in special measures in 2014/15, and exited special measures on acquisition by Frimley Health NHS Foundation Trust – a process that started in 2014/15 and completed in 2015/16.

## Clear commitment from senior leadership

### The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust



The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust was placed into special measures in October 2013 due to a number of serious failings in the quality of care it provided. By July 2014, when we carried out another full comprehensive inspection, the trust had made a number of improvements and we rated the trust as requires improvement. However, this was not enough at that time for the trust to be allowed to come out of special measures.

We carried out a focused inspection in June 2015 to review a range of its services. Urgent and emergency care, medical care and surgery, which had previously been rated as requires improvement, were now good (alongside critical

care and children and young people's services, which had been rated as good in 2014).

We noted the clear commitment from the senior leadership team and a concerted effort by staff to improve the quality of care, underpinned by a package of support made available to the trust. Our inspectors particularly noted the clear vision of the trust's leadership and good communication throughout the organisation.

We saw several areas of outstanding practice including:

- The waiting area for children in the emergency department, while small, was designed in a way that responded to the needs of all children visiting the service.

- The commitment of midwifery staff to develop effective midwifery services for women from the King's Lynn area. Midwifery staff rotated throughout the service to maintain their knowledge and skills.
- Relatives and staff told us the paediatric team were well organised and effective, providing a good service for the children and families of the King's Lynn area.

Although some improvements were still needed, particularly in maternity, we were pleased to recommend that the trust come out of special measures.





# Mental health

## Key points

- We have seen some excellent examples of good practice over the last year, with 16 NHS trusts rated as good as at 31 July 2016. We are pleased to have rated our first two NHS trusts as outstanding in September 2016.
- We have also seen good and outstanding practice in independent mental health providers, with 103 rated as good and seven rated as outstanding.
- Good leadership – both at a provider and ward level – is key to both providing a good service and helping organisations to improve.
- However, overall our ratings suggest that care for people with mental health problems is not good enough and needs to be improved.
- In particular, the safety of patients in NHS trusts remains an area of concern, with 40 rated as requires improvement and four rated as inadequate for the key question ‘are services safe?’.
- Other areas of concern include:
  - the safety of ward environments
  - the safety of patients withdrawing from alcohol and opiates
  - long-stay patients in mental health wards
  - providers continuing to apply to register residential services that are not consistent with the new service model for people with a learning disability.



# Introduction

The landscape of mental health care in England is complex, with organisations caring for people with a wide range of mental health needs in a variety of settings. We register and inspect mental health NHS trusts, independent mental health hospitals and substance misuse services. In addition, we monitor how providers are applying the Mental Health Act 1983 (MHA). We look at how the provider is fulfilling its duties overall through our comprehensive inspection programme and we publish these findings. We also monitor how it is being applied to individuals through our MHA reviewer visits, and use this information to inform our inspection activity.

A high proportion of mental health services are provided by independent mental health hospitals. Unlike other health sectors, independent hospitals provide a lot of the same services that are provided by NHS trusts, many of which are commissioned by the NHS.

Due to the size and spread of some NHS providers, we have identified 11 core services that, if they are provided, we will always include in an inspection. We rate small, independent providers by location rather than by core service. This means that we cannot

always directly compare the quality of care between NHS and independent providers.

The findings from our inspections and ratings sit against a backdrop of wider developments and concerns relating to the sector. It is encouraging that mental health care continues to be high on the government's agenda. Analysis has suggested that commissioners have planned to shift some spending away from the acute sector towards community services, and to a lesser extent towards mental health, although there is substantial variation across the country, and we have yet to see these plans materialise fully.<sup>70</sup>

A number of important reports were published during 2015/16, including *The Five Year Forward View for Mental Health* and *Winterbourne View – Time for Change* (Sir Stephen Bubb's final report). The reports highlight that there are still worrying inequalities that are putting lives at risk and preventing a large number of people from realising full mental health. They also show that there is more work to be done to improve the care of people with mental health problems, learning disabilities and/or autism.

## Core services for specialist mental health services

The 11 core services that we will always inspect if they are provided include:

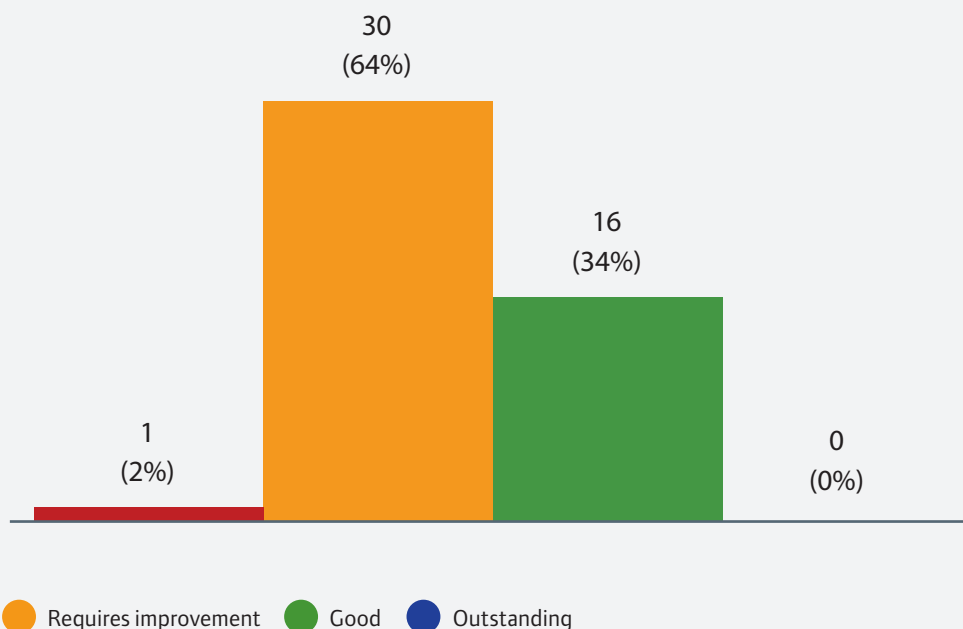
### Mental health wards

- Acute wards for adults of working age and psychiatric intensive care units
- Long stay/rehabilitation mental health wards for working age adults
- Forensic inpatient/secure wards
- Child and adolescent mental health wards
- Wards for older people with mental health problems
- Wards for people with learning disabilities or autism.

### Community-based mental health and crisis response services

- Community-based mental health services for adults of working age
- Mental health crisis services and health-based places of safety
- Specialist community mental health services for children and young people
- Community-based mental health services for older people
- Community mental health services for people with a learning disability or autism.

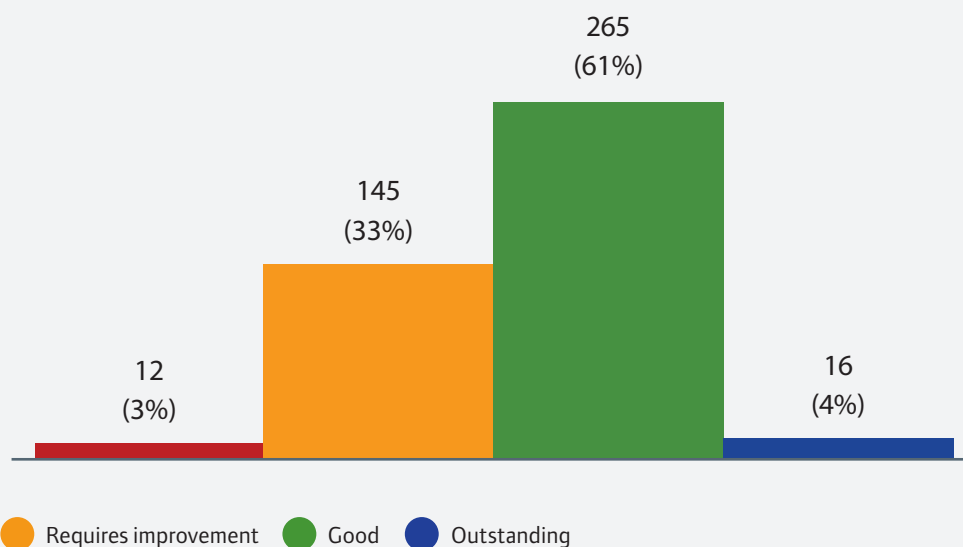
Figure 2.23 NHS mental health trusts current overall ratings, as at 31 July 2016



Source: CQC ratings data

Note: Since 31 July 2016, we have rated two NHS mental health trusts as outstanding.

Figure 2.24 NHS mental health trusts current overall ratings for core services, as at 31 July 2016



Source: CQC ratings data

## Overview of quality

We have completed our comprehensive inspections of all 57 NHS mental health trusts. By July 2016, we had published the inspection reports and ratings of 47 trusts. Of these, 16 were rated as good (figure 2.23).

Since this data was collated, we have rated the first two mental health trusts – Northumberland, Tyne and Wear NHS Foundation Trust, and East London NHS Foundation Trust – as outstanding. However, our overall ratings for NHS providers also suggest that care for people with mental health problems needs improvement, with 30 rated as requires improvement and one rated as inadequate. Looking at the overall ratings for NHS trusts at core service level, 61% of services were rated good and 4% outstanding (figure 2.24).

By July 2016, we had rated 161 independent sector mental health hospitals. Of these, we rated seven (4%) as outstanding, 103 (64%) as good, 43 (27%) as requires improvement and eight (5%) as inadequate (figure 2.25).

Our inspections have given us a benchmark of the quality of mental health services in England, and examples of good practice in action.

Over the last two years, we have re-inspected seven trusts. We are pleased to report that two of these (Worcestershire Health and Care NHS Trust and Oxford NHS Foundation Trust, whose reports were published in August 2016) have improved their overall ratings from requires improvement to good. More generally, our inspectors have seen a broad range of improvements including changes to the physical environment, quality of staffing and restrictive practices.

Where our inspectors saw improvements, they found that leaders were properly engaged. This meant that not only were they more likely to spot problems themselves, but were also able to make improvements more quickly when they arose. In these trusts, our inspectors often found that teams worked well together – even if they were under-resourced – and that there was a culture of flexibility and delegation that empowered staff to make necessary changes.

### Focused on recovery

#### Turning Point Douglas House, Manchester



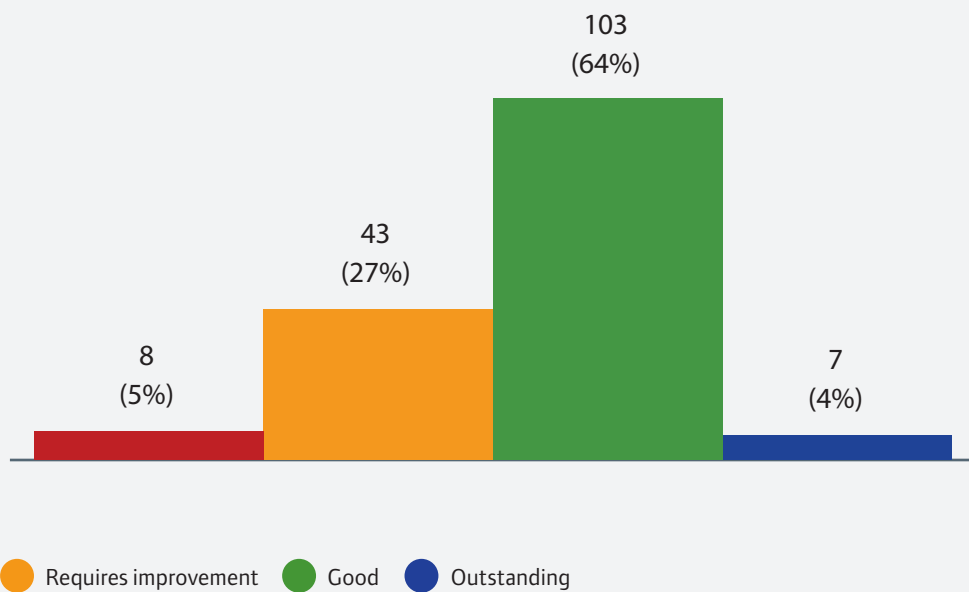
Turning Point is a national charity providing health and social care services for people with a learning disability, mental health needs and substance misuse problems. In March 2016 we visited Turning Point – Douglas House, a 12-bed independent mental health hospital in Manchester, and found that it was providing an outstanding service to its patients. Patients worked in true partnership with staff, and were both involved in decisions about their own care and in developing the charity's national

policy and campaigning work. The hospital was focused on recovery and used the mental health recovery star tool to develop support plans. In addition, staff encouraged, and were enthusiastic in supporting, patients to fulfil daily tasks such as planning and shopping for meals, cooking and tidying. There were good systems in place to make sure that the requirements of the Mental Health Act 1983 (MHA) were met. The MHA coordinator attended ward rounds on a

weekly basis to monitor how the MHA was being implemented.

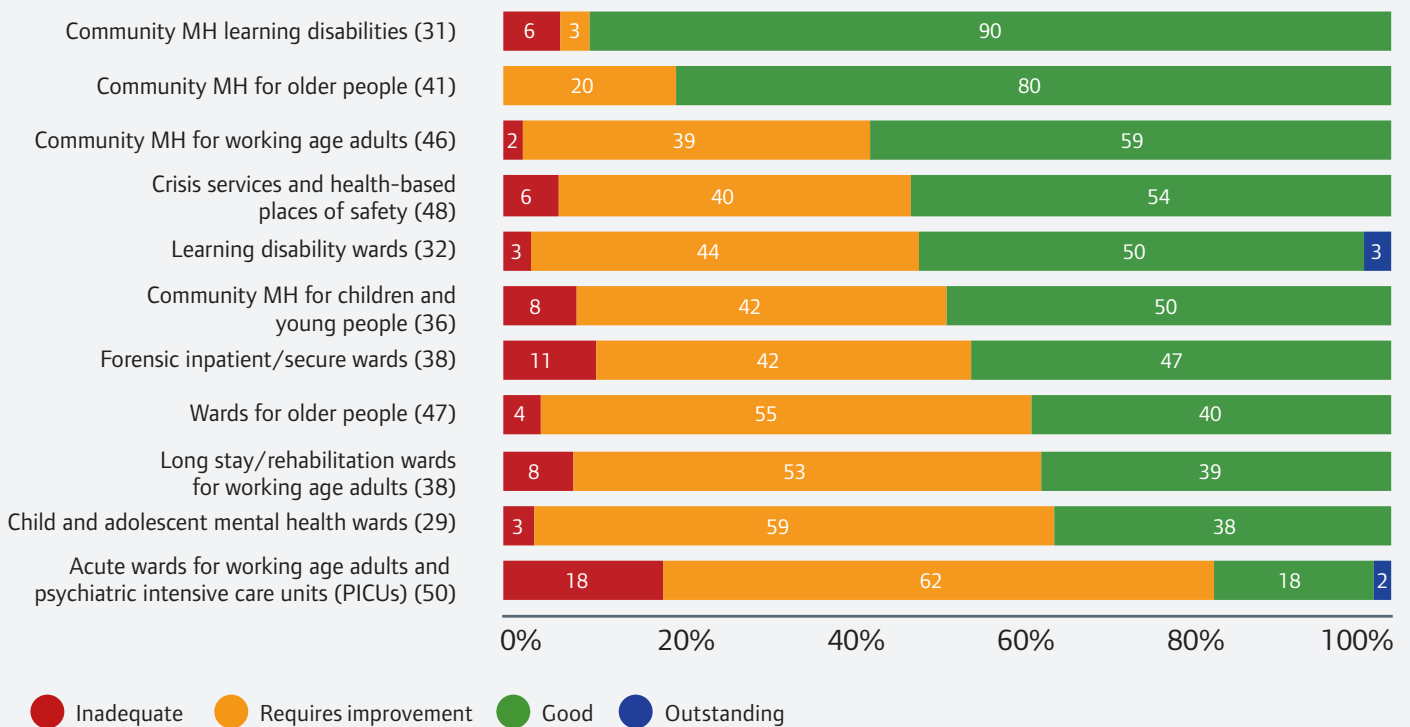
The hospital had strong management team that was person-centred, and was led by a well-respected registered manager. The service was focused on improvement. Staff had completed a range of clinical audits and made improvements as a result of these. Staff, patients and other stakeholders were told of all changes made at Turning Point Douglas House.

Figure 2.25 Independent mental health current overall ratings, as at 31 July 2016



Source: CQC ratings data

Figure 2.26 NHS mental health current safe ratings for core services, as at 31 July 2016



Source: CQC ratings data

## Unsafe practices in managing withdrawal and detoxification from alcohol and opiates in substance misuse services

We began the roll out of our substance misuse inspection programme in October 2015. At the end of July 2016, we had published inspection reports for 58 substance misuse services. We found some serious and concerning issues:

- no written protocols for assisted alcohol or opiate withdrawal
- staff who were not trained and/or competent to

provide safe care to people who were undergoing assisted withdrawal

- staff failing to create care plans that addressed the potential risks for people undergoing assisted withdrawal
- services not carrying out adequate physical health checks before starting assisted withdrawal and/or failing to carry out regular physical health checks.

- learning disability or autism.

As well as taking enforcement action where needed, we wrote to all providers of residential substance misuse services in January 2016 to alert them to our concerns. We then held a joint event with Public Health England in June 2016 about their responsibilities in relation to clinical care and governance, as part of our commitment to encouraging improvement.

## Compromised privacy and dignity



We visited a ward at a mental health hospital in December 2015 as part of our comprehensive inspection. At the time of the inspection, plans were progressing for the redevelopment of the site, but the timescale for this work had not been confirmed.

This ward for female patients was one of three acute wards on the site. The layout of the ward did not meet the needs of the patients. Most of the bedrooms were shared, with up to four beds in one room separated only by curtains. This compromised the privacy and dignity of the patients. In addition, the ward shared a dining area with another ward. This meant that there

was a timetable for meals, with patients from one ward using the dining room and then vacating it for patients from the second ward to eat. This affected the flexibility for mealtimes.

The communal lounge space on the ward was very small. If patients needed higher levels of observation, it would be very cramped for patients and staff to be in the lounge together. If staff needed to use the seclusion room for a female patient, they would need to escort the patient across a public corridor and through a male bedroom area to reach the facility. Although this did not happen frequently, it could again compromise

the patient's privacy and dignity. The layout of the ward meant that the clinic room was through two locked doors. Emergency drugs and equipment was stored in this area, which meant they were hard to access by staff in an emergency.

The inspection made it clear in the report, and at the quality summit, that the physical environment at the hospital for the three acute wards was not fit for purpose. We expect the trust to work with commissioners to redevelop the ward quickly.



# Ratings by key question

Looking in more detail at the ratings by key question, the picture is more mixed. While there are pockets of really good practice – which is reflected in the ratings for the key question ‘are services caring’ – other areas, such as safety, need to improve dramatically.

## Safe

Last year, we highlighted the safety of mental health services as a key concern. We reiterate our concerns this year, with all but three NHS trusts rated inadequate or requires improvement overall for the key question ‘are services safe?’.

Due to the size and complexity of NHS mental health trusts, and the variability between core services, it is possible that in some hospitals a few poorer performing core services may affect their overall rating. For example, only three core services out of 11 need to be rated as requires improvement for the whole trust to receive a rating of requires improvement for the key question ‘are services safe?’ Figure 2.26 shows the ratings for safety across the core services in NHS trusts.

It is important to note that mental health services place a different emphasis on some aspects of safety than acute hospitals. Problems with the physical environment frequently contributed to a rating of requires improvement or inadequate for inpatient core services. The most common problems mentioned in our inspection reports were:

- problems with the layout of some wards, meaning that staff had poor lines of sight and difficulty in observing some parts of the ward
- risks from potential ligature anchor points that staff had not adequately assessed or mitigated against
- failure to follow the guidance on getting rid of mixed-sex accommodation
- poor state of repair or decoration
- seclusion rooms that did not meet modern requirements.

During 2015/16, we issued Warning Notices to four NHS trusts relating to concerns with

the environment of the service. In three cases, we specifically noted that there was a lack of governance or that governance was not effective in identifying environmental issues.

In a number of reports, inspectors explicitly linked the problems they found with the fact that the wards were housed in old or unsuitable buildings.

In the long term, there needs to be greater investment in purpose-built wards that are more suitable for mental health care. However, in the medium term, providers must manage the risks posed by older buildings to improve patient safety. Through our inspections, we have found examples where providers have made changes to the environment, which enabled people to use the services more safely.

This year, we began inspecting specialist substance misuse services using our new approach. After completing the first 16 inspections of residential substance misuse services, we found an alarming

## Long-stay patients

An area of concern that we have seen across a number of providers, largely in the independent sector, is people with severe mental health problems staying in hospitals for months and years at a time. We are particularly concerned that some long-stay units are not focused enough on people’s recovery.

This is reflected in:

- poor discharge planning
- a lack of motivating and recovery-oriented activity for patients
- patients not being involved in developing their treatment plans, or care that is not person-centred or holistic
- poor assessment and/or treatment of physical health problems.

number of services with inadequate practices that were putting people at significant risk of harm.

When things go wrong, it is important for healthcare professionals and organisations to learn lessons and make sure the same mistakes are not repeated. Nowhere is this more important than when someone dies. Following the NHS England commissioned report on the investigation of deaths at Southern Health, we are looking at how NHS acute, community healthcare and mental health trusts investigate deaths and learn from their investigations.<sup>71</sup> We also want to assess whether opportunities to prevent deaths have been missed. Findings from our review are due to be published later this year.

Problems with staffing also contribute to the poor ratings for trusts in terms of safety. National figures show a continuing decline in the number of mental health nurses.<sup>72</sup> At the same time, the number of staff reporting that they are working extra hours remains high, at almost three-quarters, in the 2015 NHS staff survey.<sup>73</sup> Our inspectors have also flagged a problem with experienced staff reaching retirement age, and not enough nurses being trained or retrained.

Despite this, feedback from inspectors flagged staffing as an area in which they had found examples of improvements over the last year. Solutions to some of the problems identified included moving staff to where they are most needed and recruiting from abroad.

## Effective

To assess the effectiveness of services, we check whether people receive care, treatment and support that follows good practice, achieves good outcomes and promotes a good quality of life. At a provider level, our data suggest that services need to improve in this area, with 28 NHS trusts rated requires improvement for the key question 'are services effective?'. However, as we highlighted in the section on safety, the complex nature of NHS mental health trusts means that the picture is both different and variable at a core service level, with 67% of core services (293 out of 436) rated as good or outstanding.

Of the 162 independent hospitals inspected and rated, 105 (65%) have been rated as good and outstanding for this key question. Where we rated services as good or outstanding, we found that care plans were kept up-to-date and reviewed regularly, patients had good access to psychological therapies, and there were comprehensive multidisciplinary teams (including medical staff, nursing staff, social workers, psychology staff and occupational therapists) who worked well together to care for and support patients.

Under this key question, we also check that people who are subject to the Mental Health Act 1983 (MHA) are assessed, cared for and treated in line with the MHA and Code of Practice. Through our monitoring activities we have found that services across England are striving to provide innovative, caring services for patients subject to the MHA despite resource pressures. However, we are

## Staffing improvements

### St Andrew's Healthcare, Nottinghamshire

On our initial inspection of St Andrew's Healthcare, we raised concerns about the number of staff and skill mix on the wards. When we went back, we found that the hospital was using a risk-based safer staffing tool to evaluate the

required number of staff and grades of staff per shift. This was reviewed daily in response to requirements such as a patient's condition getting worse, sickness, training needs and section 17 leave under the Mental Health Act 1983.

Wards were running above the base numbers due to increased observation levels and the adoption of new working models, in particular Newstead and Thoresby wards.



## Tailored for individual patients

### Lincolnshire Partnership NHS Foundation Trust

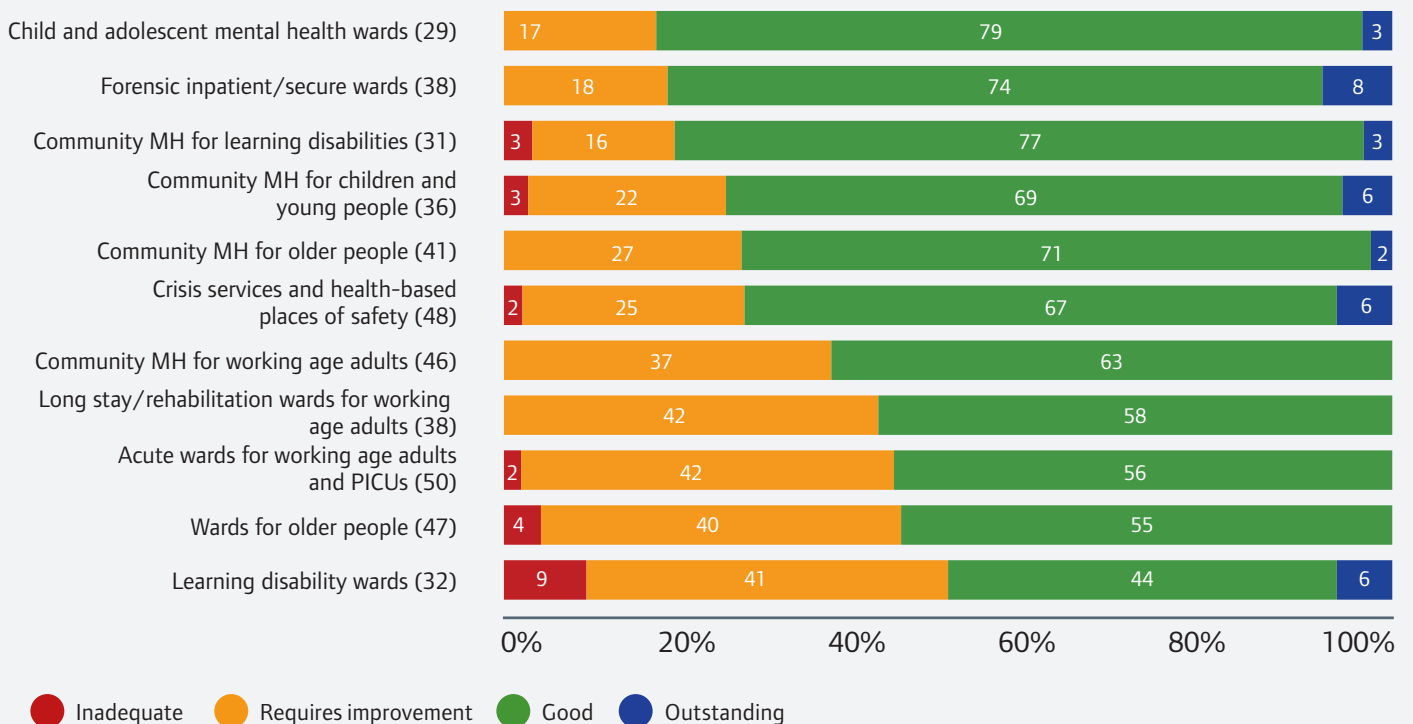


We visited the specialist community mental health services for children and young people at Lincolnshire Partnership NHS Foundation Trust in December 2015, and rated the service as outstanding for the key question 'are services effective?'.  
We were impressed with the way in which staff had developed an outcomes-

oriented model for the child and adolescent mental health service. The model, which had been recognised in NHS innovation awards, showed clear, positive outcomes for young people using the service. This was supported by feedback from social workers and school staff, who described good outcomes for young people who had used the service.

The service was also innovative in the way it created new interventions that were tailored to meet the needs of individual patients. Staff completed comprehensive assessments, which were kept up-to-date. There were also clear treatment plans in place that were recovery focused.

Figure 2.27 NHS mental health current effective ratings for core services, as at 31 July 2016



Source: CQC ratings data

concerned that we are still finding variation in the way that the MHA and Code of Practice are being applied. Further detail about our monitoring activities will be published in our MHA annual report in November 2016.

## Caring

Similarly to last year, our inspectors found that overall NHS mental health services were treating people with compassion, kindness, dignity and respect. To date we have rated 96% (416 out of 435) of NHS core services as good or outstanding for the key question 'are services caring?'.

Through our inspections, we have found some great examples where services had supported people with mental health problems to make decisions about their own needs and involved people in a person-centred way.

While a similar proportion of independent hospitals received an outstanding rating for this key question (eight services, 5%), 10 services have been rated as requires improvement or inadequate for caring. Areas for improvement include services having an increased focus on involving patients in making choices.

## Responsive

Key factors underpinning good and outstanding responsive practice in mental health providers are:

- assessing people promptly and starting treatment quickly
- enabling people to leave hospital as soon as they are ready
- wards and care settings that are comfortable and adapted to people's individual needs
- responding promptly to concerns and complaints, and learning lessons from them.
- involving patients in designing and planning services
- identifying unmet needs and changing provision to meet this.

Feedback from our inspectors highlighted examples where people were involved in the design and development of the service, for example through service user groups and staff interviews, to identify and meet their preferences, aspirations and unmet needs. Trusts offering services to patients from areas where services were not available was another example of a good responsive service. In addition, trusts working with other organisations, such as

## Innovative approaches to communication

### Cheshire and Wirral Partnership NHS Foundation Trust



Cheshire and Wirral Partnership NHS Foundation Trust is one of three NHS trusts that we have rated outstanding for the key questions 'are services caring?' up to 31 July 2016. When we visited the trust in June 2015, we found that staff went the extra mile to make sure that patients' and their families were involved in their care, and that their needs and wishes were met.

Feedback from patients and carers was positive. Staff involved patients, families and carers in decisions about care, and developed care plans in collaboration with the patients. In particular, we were impressed with the care on the learning disability wards. On these wards we found some examples of outstanding interactions between staff and patients, with staff using innovative approaches to communicate effectively with patients.

The trust had also signed up to the 'Triangle of Care' initiative. This is a national programme developed to improve carer engagement in mental health acute inpatient and home treatment services. The trust had received recognition for its commitment to improve support for unpaid carers and their families, with a second gold star from the national Carers Trust.

## “Significantly changed the culture”

Calderstones Partnership NHS Foundation Trust, Lancashire



Calderstones Partnership NHS Foundation Trust provides specialist and forensic learning disability services to more than six million people across the North of England, as well as Scotland and Northern Ireland.

We initially inspected the trust in July 2014 and found major concerns with the application of the Mental Health Act 1983, medicines management, staffing and how patients were being protected from harm. Following the inspection, the trust developed a comprehensive action plan and worked with external stakeholders to address

the issues raised. We held monthly meetings with the trust and Monitor (now NHS Improvement) to oversee the implementation of this plan. When we returned to the trust in October 2015, we found significant improvements including a reduction in the number of episodes of restraint, seclusion and the use of rapid tranquillisation, and the eradication of the use of emergency response belts.

Dr Paul Lelliott, the Deputy Chief Inspector of Hospitals (lead for mental health), said, “Since our first comprehensive inspection in July 2014, the

trust has implemented a new model of working called ‘safe wards’ that focuses on reducing restrictive practices and improving patient outcomes. The new model has significantly changed the culture in the trust, and enabled staff to work collaboratively with patients and reduce the need to use physical interventions to manage behaviour that staff find challenging. When we re-inspected the trust, managers, staff and patients all commented on the improvements made.”

## Patients supported through transition

Cambian Sherwood Lodge, Nottinghamshire



Cambian Sherwood Lodge is a specialist learning disability rehabilitation service for men with a learning disability and other complex needs. When we visited the service in November 2015, we found some excellent examples of the service responding to patient needs. We found that the hospital started planning for a patient’s discharge as soon as they arrived. Staff put patients at the centre of their care and made sure that they

were fully engaged with their rehabilitation and plans for leaving.

The team worked well with external agencies to make sure that patients left the service at the right time and were well supported through the transition from being in hospital to living elsewhere. Patients also had the opportunity to apply for paid therapeutic jobs. Jobs were advertised and patients were interviewed for them.

In hospital, patients had access to a wide range of activities, seven days a week and could decide what they preferred to do each day. Patients could influence this through suggestion boxes, the morning planning meeting or by asking a member of the occupational therapy team. Staff made plans to meet patient preferences, and patients could access services in a way and at a time that suited them.



joint-working between police and mental health services, was regarded as a sign that the service was responsive to people's needs.

We found pockets of good practice in developing integrated care. For example, proactive and coordinated approaches to planning a patient's discharge from the point they were admitted. Our inspectors viewed this as essential for improving the experience of people receiving mental health care. Being responsive to the patient's preferences and needs, and planning discharge into good quality and suitable housing, can help to avoid a patient being readmitted to hospital.

However, with 20 NHS trusts rated as requires improvement, and 33 independent hospitals rated requires improvement or inadequate, there is still more work to be done. Our inspectors found that some services did not consider accessibility beyond often limited wheelchair access, leaving people with visual or hearing impairments unable to fully access

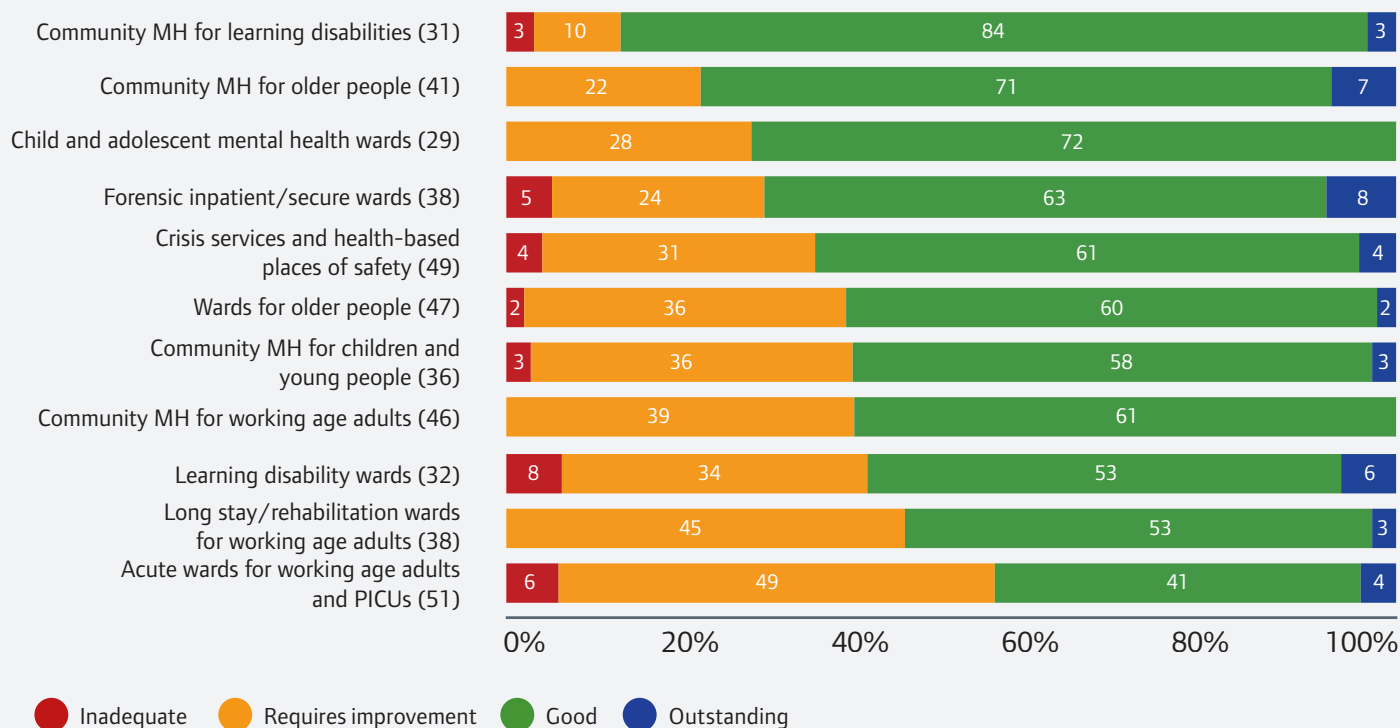
the care they needed. We also found:

- long waits from referral to assessment or referral to treatment in community mental health services – especially in child and adolescent mental health services
- long waits for specialist psychological therapies
- delays in making Mental Health Act assessments when people are taken to a health-based place of safety
- failing to plan discharge for people in rehabilitation and learning disability wards
- failing to respond to concerns and complaints.

### Well-led

The quality of leadership can have a direct effect on the quality of care offered by a provider. Good leadership – both at a provider and ward level – is key to providing good care. We can see this in the ratings for NHS trusts and independent hospitals,

Figure 2.28 NHS mental health current overall ratings for each core service, as at 31 July 2016



Source: CQC ratings data

with 78% of trusts and 93% of independent hospitals having the same overall rating as their well-led rating. Our ratings reflect both the quality of local leadership of clinical services and the quality of leadership and governance at board level. However, as noted in the introduction, many mental health trusts are large and geographically dispersed, making good governance particularly challenging. This is highlighted through our inspections of larger trusts, where we have found examples of poor practice in one or two wards when the rest of the trust is performing well.

Trusts that we have rated as good or outstanding for well-led, or have shown improvement following an initial less good inspection, often have senior

leadership teams that have engaged actively with the frontline staff. Our inspectors stress the importance of senior leaders making themselves more available. An example of good practice given was one trust holding a “big breakfast” informal meeting with staff and the chief executive. Other improvements relating to the well-led key question included improved staff recruitment processes, such as taking better account of the fit and proper person requirement, and actions to improve staff morale.

The two trusts that we rated as outstanding overall in September 2016 were characterised by the quality and style of leadership. Both trusts had an open culture in which the senior leadership team valued their frontline staff. Nevertheless, our ratings for the

## Waiting list actively managed

### Berkshire Healthcare NHS Foundation Trust



We visited Berkshire Healthcare’s community CAMHS in December 2015 and found that the waiting list for the service was actively managed. This included face-to-face as well as telephone

contact with young people and their families. Patients on all of the referral pathways were seen within an acceptable time with prioritisation according to urgency, risk or need. A substantial proportion

of people on the autistic spectrum disorder diagnostic pathway, where waits were longest, were seen within 12 weeks based on need.

## Focus along care pathways

### 2gether NHS Foundation Trust, Gloucestershire



2gether was highlighted as an example of a mental health trust working well in close partnership with other agencies. It has a social inclusion team that works closely with NHS providers, voluntary sector organisations, clinical commissioning groups, local authorities (social services and education).

2gether was viewed as innovative, notably for working with schools and in other local organisations to raise awareness of mental health and the profile of mental health services. It was seen as an example of good, joined-up thinking – not just seeing a patient, but also seeing the person in their entirety. Inspectors highlighted

its focus along care pathways and across a range of providers to ensure there were no out of area placements for adults. This ensured bed availability and transitions between services were monitored and managed well. Inspectors thought that this had a huge impact on bed availability, as support systems keep people healthier in the community.

key question 'are services well-led?' show that there is more work needed, with just over half (24 out of 47 trusts, 51%) of NHS trusts and 122 out of 161

## Ratings by core service

The picture of quality at a core service level is variable, with some NHS community services achieving higher ratings than their NHS inpatient counterparts and vice versa. Of all core services, NHS community services for people with a learning disability or autism performed best. Out of 31 services, we rated 26 (84%) as good and one (3%) as outstanding. In these services, we found that staff were skilled and appropriately trained, patients were involved in planning their care, and there were systems in place to deal with urgent referrals. In contrast, we rated 17 out of 32 (53%) NHS inpatient services for people with a learning disability or autism as good and two (6%) as outstanding (figure 2.28).

Of the NHS community-based mental health services, those for children and adolescents performed least well; we rated 21 out of 36 (58%) as good and one outstanding, compared with 21 out of 29 (72%) child and adolescent mental health wards rated good. Our ratings show that community services for children and young people performed worse across the effective, responsive and well-led key questions.

In particular, inspectors found an increase in referrals to community CAMHS and long waiting times. This supports other evidence that has shown that the longest waiting times between referral and the start of treatment were nearly 10 months.<sup>74</sup>

Our findings support those of *The Five Year Forward View for Mental Health*, published in February 2016. This highlighted children and young people as a priority group. It called for a substantial reduction in the waiting times, and stated that by 2020/21 at least 70,000 more children and young people should have access to high-quality mental health care when they need it. It also recommended that CQC and Ofsted should consider assessing how the health, education and social care systems are working together to improve children and young people's

(75%) independent mental health hospitals rated as good or outstanding.

mental health outcomes, as part of the joint targeted area inspection programme.<sup>75</sup>

Our inspections have identified examples of good practice that show how referrals and waiting lists could be managed to ensure that patients are seen in a timely way, and in turn improve their outcomes.

Nevertheless, our findings in CAMHS reflect a wider concern that, despite calls for better integration, some community services are becoming less integrated. Inspectors reported that joined-up working between NHS trusts and local authorities was becoming more strained because of financial restrictions with, for example, social workers being 'pulled back' and joint working groups being disbanded. In particular, inspectors noted that better integration was essential to improve transition planning from child to adult services.

Other inspectors highlighted 'pockets of good practice' of integrated care, for example proactive approaches to discharge planning from mental health hospitals and raising awareness of mental health services.

### Learning disabilities

Following the publication of *Transforming care: A national response to Winterbourne View* in December 2012, CQC has been an important part of the Transforming Care Delivery Board. We are committed to ending the institutionalisation and isolation of people with a learning disability, through integrating care into the community. As part of this, we are tightening the regulation and inspection of providers of learning disability services, and are strengthening providers' corporate accountability.

In February 2016, we published our revised policy on registering new services and changes to services. Our policy outlines the requirements that providers seeking to register with us will need to develop their services in line with *Building the right support*.<sup>76</sup> This is a national plan to develop community services and

close inpatient facilities for people with a learning disability or autism who display behaviour that challenges, including those with a mental health condition. CQC will not support the development of institutional facilities for people with a learning disability, whether these are designated as a hospital or a care home. We will not consider applications from providers that seek to register an inappropriate assessment and treatment unit or hospital, care home or location for independent living.<sup>77</sup>

Changes can and should be made to improve the quality of care and outcomes for patients. The clearest example we have to date are the improvements made at Calderstones Partnership NHS Foundation Trust. We have described above the transformation of the culture of Calderstones led by the managers following our initial inspection in 2014. As part of the transforming care programme, Calderstones has now been taken over by Mersey Care NHS Foundation Trust. The improvements

made put the hospital, its staff and patients in a far better position to adopt the new model of care.

As part of our commitment to the Transforming Care Delivery Board, we have further developed our methods for inspection of services for people with a learning disability. We have worked with partners to clearly mark out enforcement routes for failing providers, and we are already looking at how our inspections of GP practices and acute hospitals can give greater prominence to the quality of care that people with a learning disability receive, including for their physical health.

We are pleased to see that, while the number of learning disability beds available has fallen steadily over the last few years, bed occupancy rates have remained stable or also slightly fallen, suggesting that a transition to community settings is taking place. We will be continuing our work to support this transition in 2016/17.

## Developing independent life skills

### Example of a good application



Provider A applied to increase the number of places at a care home service from six to 12 places. The existing six places are currently provided in two single independent flats and a small group home – all have their own front door, accessed by the main entrance. The proposed additional places are six individual flats that are accessed through the main entrance or their own front doors, which are at the side or rear of the building.

The new flats are modern and individually designed, with an open plan kitchen/lounge and separate bedroom with full en-suite facilities. They have access to a communal lounge, for the

sole use of the new flats, where people can meet and socialise together. There is also an independent staff room at the rear of the flats for support staff.

The additional places will be offered as a supported living service. Each tenant will have independent care packages, and staff will be recruited according to the needs of each person. Service objectives include supporting people to develop their independent life skills before moving on to homes of their own. The supported living service will have a dedicated staff team. It is not proposed that staff will work across the care home and supported living service.

The current care home, which is located in a village on the outskirts of a town, is rated good. The service is on a main bus route, and people are well supported to build and maintain relationships and access community services in the village and beyond.

The provider has supplied evidence that they have consulted local commissioners. They have confirmed that there is a local need and they will be willing to seek placements. The provider has also consulted people who currently use the service, some of whom have shown an interest in transferring to the supported living service.







A person in a white lab coat is seen from the side, looking at a computer screen. The background is slightly blurred, showing what appears to be a clinical or office setting.

# Primary medical services

## Key points

- The vast majority (83%) of GP practices we inspected were rated as good and 4% were rated as outstanding. However, there is variation in the quality of care across general practice, ranging from outstanding to inadequate.
- Where improvements are needed, general practices have shown that most of the time they do improve after a CQC inspection (75% of inadequate ratings were improved on re-inspection). It is too soon to know if improvements are sustainable.
- Safety remains a problem. Although most GP practices deliver safe care, there is a small number of practices where we had concerns: more than 800,000 people are registered with services that are rated inadequate on our question of safety.
- Some general practices came out of special measures when they improved communication between staff and introduced systems to enable learning – better quality improvement processes, including incident reporting, analysis and action were seen as factors behind ratings that went from inadequate to good.
- CQC monitors the quality of all dental practices across England and inspects 10% every year. Although CQC does not give ratings to dental practices, the vast majority (90%) that we inspected were providing safe care. The care provided by larger dental practices tended to be better quality, particularly on safety.
- Integration of services involving primary medical care is happening in some places and there are some good outcomes for people but it is too soon to fully assess their impact because new models of care are only just emerging.

# Introduction and context

CQC is responsible for regulating and inspecting a wide range of primary medical services across about 20,000 locations (figure 2.29).

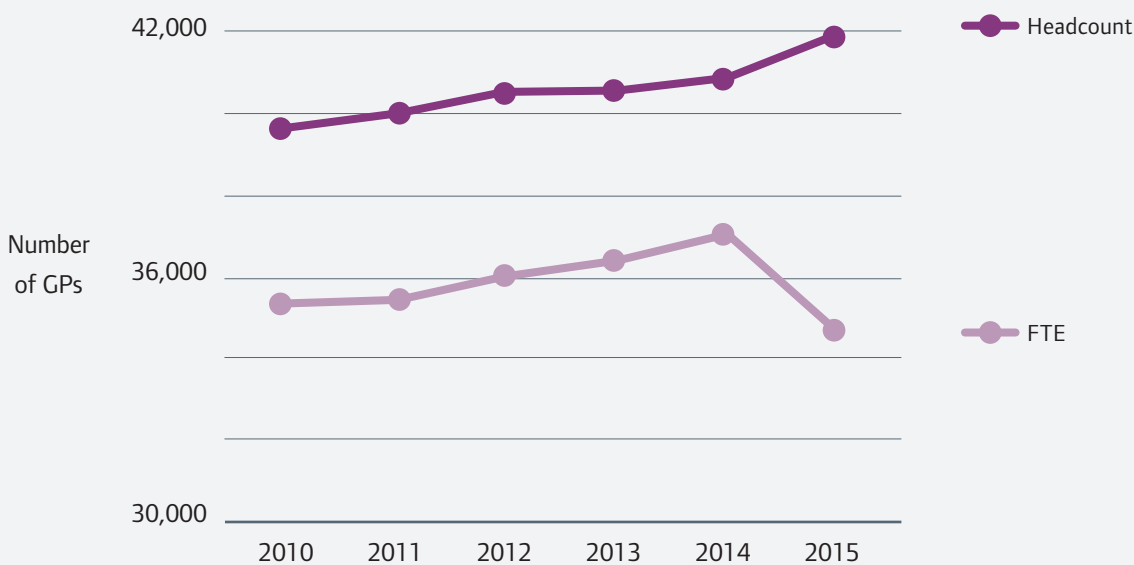
These services are operating in an increasingly challenging environment and they face greater demand that is putting pressure on their ability to deliver effective services. This is coupled with a shortage of general practitioners (GPs), who provide the majority of primary care. Despite this context, the sector is performing well and quality overall remains high.

The shortage of GPs combined with increasing vacancy levels means that practices may be understaffed. The number of full-time equivalent GPs has recently started to fall (figure 2.30) while the number of people registered with GPs is rising. One projection suggests certain areas of the country will need to increase the number of GPs working in the community by at least 50% over the next five years.<sup>78</sup> NHS England's *GP Forward View* describes a plan to create an extra 5,000 doctors in general practice by 2020.

General practice is at the heart of the system, but these frontline services must be flexible to cope in a fast-changing environment: some services have shown they are able to innovate and rise to challenges by transforming into modern, patient-centred organisations; others are struggling with the pace of change and increasing demands, such as ageing populations with needs that are more complex. We have found from our inspections that strong leadership and culture are important to cope with change and we will point to this where we find it.

CQC is a signatory to the *GP Forward View* and recognises the challenges facing the sector. The primary care environment is changing fast – some general practices are joining together in federations, forming larger group practices and developing new models of care. This is a significant change for general practice in a fast-evolving health and social care environment where GP and other services, along with wider system partners, are expected to consider what changes may be needed to maintain the quality and range of services for patients.

Figure 2.30 Changes in GP headcount and full-time equivalent (FTE), 2010 to 2015



Source: NHS Digital

Integration of services, for example in Yeovil, Somerset and Northumbria, is happening and CQC is supporting providers that want to innovate, collaborate and

improve services for people through new models of care. We are helping with registration and regulation.

Figure 2.29 CQC’s regulation of primary medical services

<b>GP practices</b>	There are around 8,000 GP practices in England. As at 31 July 2016, we had inspected and rated 4,511 GP practices and 15 out-of-hours services. We aim to have inspected and rated all GP practices by March 2017. We are also seeing an increasing number of multisite practices, both through mergers and acquisitions between trusts and GP surgeries, and consolidation and federation of GP practices.
<b>Dental services</b>	There are around 10,300 dental care locations on our register. We inspect these services but we do not give them ratings.
<b>GP out-of-hours, urgent care services and NHS 111</b>	We inspect and rate a range of GP out-of-hours services, urgent care services such as NHS 111, walk-in centres, minor injury units and urgent care centres.
<b>Digital healthcare services</b>	There is an increasing number of applications to register new providers of digital services. There are more than 50 online services already registered with CQC. We are piloting a new methodology for inspecting providers of digital services, such as video consultations.
<b>Independent doctors</b>	CQC only directly regulates a small number of independent doctor services - around 700 across just over 1,000 locations in primary medical services.
<b>Health and justice</b>	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.
<b>Children’s health and children’s safeguarding</b>	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. In 2016, we published <i>Not seen, not heard</i> , a summary of our findings in this area so far. <sup>79</sup>
<b>Medicines optimisation</b>	Medicines are the most common form of healthcare intervention in all care settings and crucial to almost all care pathways. The medicines team provides support across all directorates, focusing on how providers use medicine safely and effectively, and how they support patients to get the best outcomes from their medicines.

# Overview of the quality of care

## General practice

More than half of all GP practices in England have been inspected and we have the best picture yet of the quality of care they provide. After all inspections and ratings are completed by the end of 2016/17 we will have a comprehensive assessment of the quality of general practice across England.

Most practices (87%) were rated as good (83%) or outstanding (4%) as at 31 July 2016 (figure 2.31). One in 10 practices was rated as requires improvement and 3% were rated inadequate overall.

We have concerns about safety. There is still a proportion of practices delivering unacceptable standards of care – about 800,000 people were registered with practices that were rated inadequate for safety (31 July 2016).

Where there were problems with safety, inspectors found:

- Health and safety incidents were regularly not recorded and action was not taken to prevent reoccurrence.
- Equipment and training for medical emergencies was often incomplete.
- Some premises were not suitable or are poorly maintained.
- Not all practices had safeguarding policies in place or staff members trained to the appropriate level.
- Regular equipment checking and servicing was not always carried out.
- In the management of medicines, important things were not happening, such as checks on storage conditions and expiry dates, correct administration, and appropriate audit trails and prescription logs.
- Clinical waste was sometimes not stored correctly or disposed in the right way.

Where we have rated practices as good or outstanding for safety, there are some common characteristics about leadership and learning. We

found a culture of, and proactive approach to, anticipating and managing risks to patients. Also, learning about problems is shared, not only within the practice and following a thorough and open investigation, but also in the local health community so other practices can work to best practice, and learning can be maximised so the likelihood of problems is reduced.

Nurses are sometimes involved in such safety improvements, and they have an important wider role in general practice care delivery. Policy for many years has been to shift care from hospitals to general practice, and this puts greater emphasis on the nursing role in general practice.

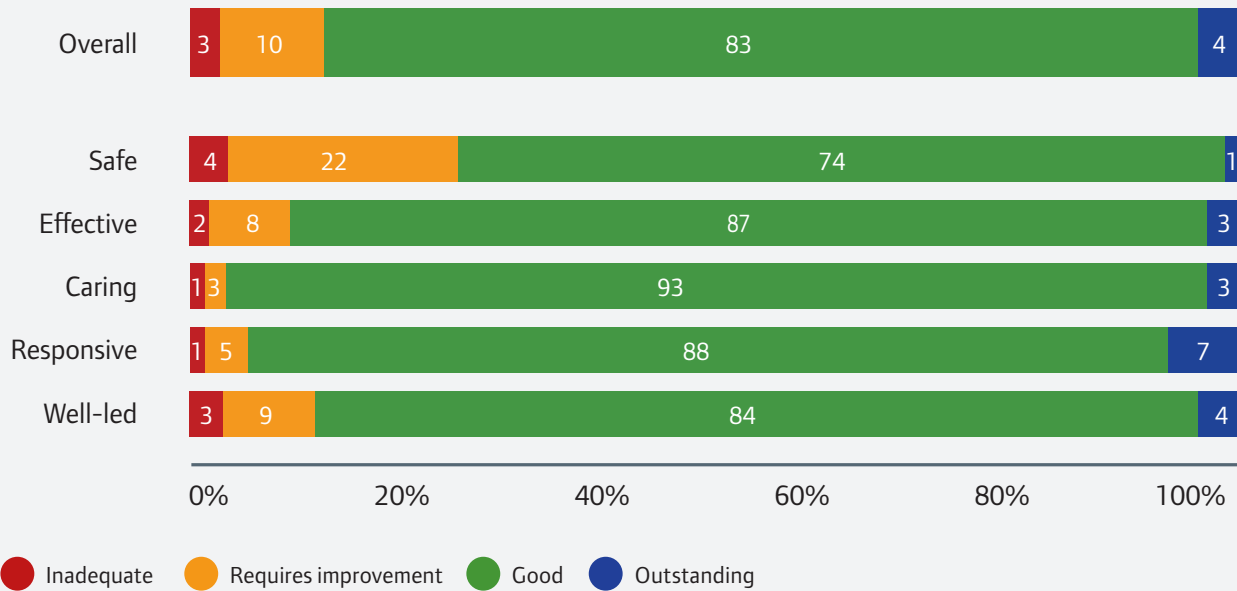
The skill mix in general practice increasingly includes healthcare assistants, practice nurses, advanced nurse practitioners and physician associates who are involved in the decision-making for the practice.

GPs also learn from one another about good practice – for example, some have responded to problems by designating a specific member of staff to take responsibility for improvement. Our inspection programme is helping to drive improvements in quality, particularly in practices that are isolated professionally, or those perhaps unaware of what standards are expected – or possible. There are problems with a lack of learning and management that usually underpin ratings of inadequate in safety.

Most GP practices are performing well on leadership, with 84% that were rated as good for well-led and a small number (4%) that were outstanding as at 31 July 2016. Twelve per cent (covering about 3.3 million people registered to those practices) were rated inadequate or requires improvement (figure 2.31).

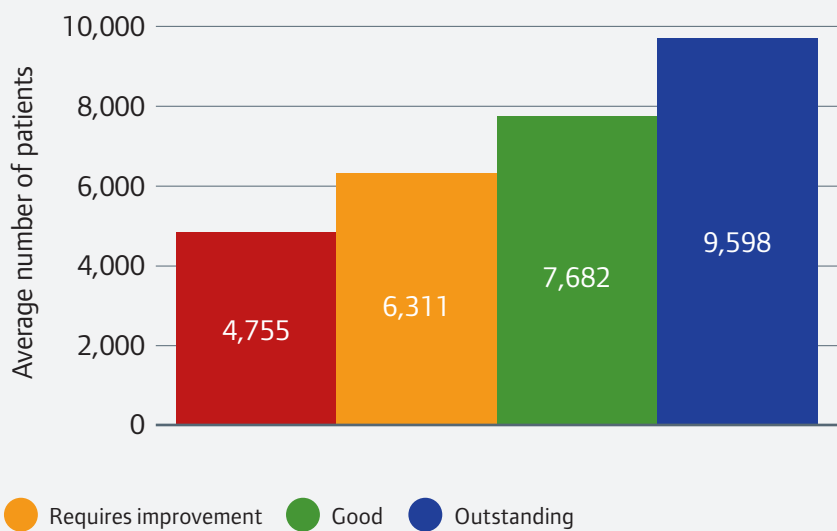
Where there is poor leadership, sometimes through governance issues or lack of support for staff, inspectors have noted the importance of a more open culture. This helps drive improvements, as well as a clear vision, a strategy and values that are known and shared by staff.

Figure 2.31 GP practice current ratings, as at 31 July 2016



Source: CQC ratings data, total of 4,511 GP practices

Figure 2.32 Average patient list size of rated general practices, as at 31 July 2016



Source: CQC ratings data, NHS Digital

Note: Average is based on weighted patients.



There are concerns around information sharing: we frequently see there is no effective process for recording and sharing national and local information, and guidance about best practice or alerts about patient safety.

The vast majority of general practices are performing very well across the questions of effective, responsive and caring. At least 90% of practices were rated either good or outstanding in each of these categories as at 31 July 2016.

We also saw weak correlations between particular types of practice and their overall ratings – for example, while there were many outstanding smaller practices, larger practices tended to be rated better (figure 2.32). Smaller practices that work in isolation have often struggled, but we have seen good results where smaller practices have worked together.

Where there were concerns about leadership, they included:

- Staff training and supervision – adequate training or evidence of training was not always provided and there could be a lack of staff appraisals to identify development.

- Referrals – the process was not always monitored effectively (effective practices demonstrate quality improvement activity).
- Complaints and concerns – a robust system was not always in place or accessible, or if it was in place then action was not taken quickly enough.
- Some practices were not aware of the needs of the population they serve.
- Dignity – patients' privacy was not always protected.
- A lack of support for carers and poorer patient satisfaction.

### Population groups

We look at the quality of care of services for specific population groups, including:

- older people
- people with long-term conditions
- families, children and young people
- working age people (including those recently retired and students)

## Caring for carers

### Windhill Green Medical Centre, West Yorkshire



Windhill Green is rated outstanding overall and it is outstanding for caring. The practice's computer system alerts GPs if a patient is also a carer.

The carers are often identified by district nurses on community visits, or by GPs and practice nurses during consultations or on home visits.

Carers were also identified in 'Community 4' meetings, where GPs from five practices met with district nurses, physiotherapists, social workers, mental health team workers and voluntary

agencies to discuss specific cases and management plans to improve the care of the patients, as well as how they could help carers to cope. This was a result of greater clinical input, community involvement and social interventions.

Carers are sent invitations for health checks and carer registration cards were on display in the waiting areas. They are encouraged to complete carer registration forms and the practice then makes sure the people are clearly marked on the computer records.

The practice encourages carers to maintain their own health and it supports carers by working with groups and charities. These in turn can support carers (for example, Age UK, Windhill & Baildon community centres, luncheon clubs, expert patient groups and the Alzheimer's Society).

The resource groups were frequently invited to attend meetings to update the practice teams on the services they could offer to patients, which the practice team shared with patients.

- people whose circumstances may make them vulnerable
- people experiencing poor mental health (including people with dementia).

The ratings for these groups were fairly consistent with ratings for a whole population. However, we identified some practices that deliver outstanding specialist care for particular groups of people.

Many of those rated good or outstanding for responsive will actively identify the needs and preferences of people and groups of people. This might include working with local organisations and engaging with staff and local people to seek out unmet needs, and ensuring provision reflects the perspectives of people who use – or who may need to use – GP services.

We have received positive comments from practices about CQC's methodology and our reporting on population groups, which some say has enabled them to showcase their work with certain groups.

### **Ratings and survey findings**

There are some weak correlations between CQC ratings and patient survey findings. Among practices that are rated good or outstanding overall, there are some common characteristics. Patients said:

- They would recommend the practice to others.
- The GP showed care and concern.
- The GP involved them in decisions about their care.
- They had a good overall experience of care.

The 2016 GP Patient Survey showed that 73% of people surveyed had a good overall experience of making an appointment. However, over the last three years, the number of people waiting a week or more to see a GP rose by almost a third, to 18% of patients.

The number of survey respondents who said they had failed to get an appointment at all was 11%, which is an increase from 9.6% in 2012.<sup>80</sup>

### **Dental care services**

On the whole, most dental care in England is safe. For over a year, we have been inspecting dental practices under a revised methodology and with the support of dental specialist advisers.

CQC monitors all of the dental surgeries in England every year and inspects 10% of them each year, and we have demonstrated that most of the practices are safe.

We visited 1,023 dental practices in our 12 months of inspections. We found that 90% of practices were providing care that is safe, effective, caring, responsive and well-led (figure 2.33). However, practices have told us that even where no breaches were found, inspectors' feedback has been helpful.

Where there were breaches (in 10% of those inspected), there were a relatively small number of concerns about governance and safe care and treatment. These include:

- completion of appropriate risk assessments
- infection control
- medical emergencies
- safeguarding
- managing complaints and concerns
- recruitment and supervision
- support and staff training.

In addition, where we found problems, dental care records were often incomplete or did not have current information.

Some practices did not complete audit cycles or take action to deal with identified risks.

Importantly, where we found regulatory breaches and carried out follow-up inspections, all but one practice made the necessary improvements.

## Tailored for the population's needs

### The Doctor Hickey Surgery, Central London



Most patients at the practice were homeless. However, the practice recognised that even within a homeless population, there were people who were particularly vulnerable.

The GPs provided medical outreach to rough sleepers in Westminster. They ran a street doctor programme where GPs and practice staff, along with the city council outreach teams, would carry out night walks through the local streets

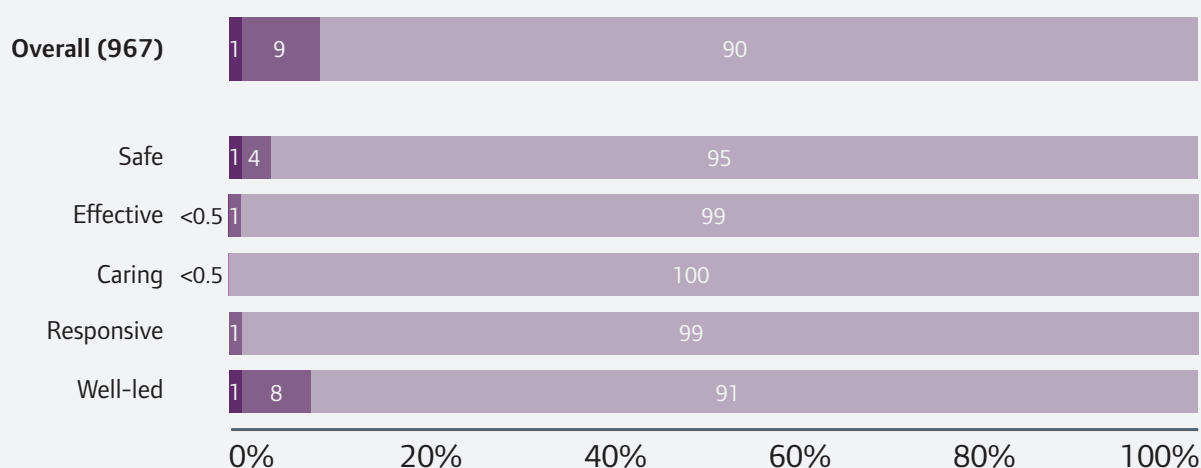
and parks. They spoke with rough sleepers, identified their medical needs, and addressed those needs in ways that were likely to improve both their overall health and their ability to use general homelessness services, with the aim of permanent resettlement.

From its own research and analysis, the surgery believes that life expectancy among the homeless people they help is more than 10 years longer than

the UK average for homeless people.

The practice had developed a bespoke clinic for hepatitis C because this condition was common among homeless people and a cause of preventable death. The practice also provided services for failed asylum seekers and undocumented migrants, who were frequently referred to the practice because of its reputation for access.

Figure 2.33 Outcome of dental care inspections, as at 30 June 2016



● Enforcement action ● Required action ● No action

Source: CQC inspection and enforcement data

## GP out-of-hours services, urgent care services and NHS 111

Providers delivering this range of services are an important part of the system – and they can also help to relieve pressure on often stretched accident and emergency services.

NHS 111 and out-of-hours services can be provided by NHS trusts or the independent or third sectors. In line with the NHS England urgent and emergency care national review<sup>81</sup> and the *Five-Year Forward View*, we are seeing changes in the way urgent care services are provided.

Some providers are moving to a more integrated system of care. For example, an integrated NHS 111 and out-of-hours service might mean a person contacting NHS 111 may be seen by the same organisation in their out-of-hours service. NHS 111 staff are able to book appointments with the out-of-hours service, and also refer people to a range of other services.

As at 31 July 2016, 14 of the 15 out-of-hours providers we had inspected were rated good; 12 out of 17 urgent care services was rated good, and one service was outstanding. There were no services rated inadequate.

For NHS 111 services, a challenge is to get the right staffing levels to meet demand, as well as good governance and quality monitoring.

## Independent doctors

The private healthcare sector is diverse, with providers delivering services from an array of settings and in different ways. Independent doctors provide services mainly in consulting rooms or surgeries, but some are private call-out mobile services (for example to a patient at home).

There is a wide range of people and services in this category, including specialist consultation and treatment, slimming clinics, online consulting and prescribing, travel medicine and private GP services.

CQC does not have the regulatory powers to give ratings to these providers, but in 2015 we consulted on an approach for regulation and inspection with a pilot programme among 40 services.

The pilot included a range of independent services such as ‘single-handed’ medical practitioners providing services to private organisations that employ specialists offering a range of private, non-acute, out-of-hospital treatment. They may operate for one day a week in a private practice, moving between NHS and independent services. And patients using services may move between private and NHS providers.

We found a few areas for improvement under safety, effectiveness and leadership. These included issues around managing emergencies and supply of unlicensed medicines, as well as safeguarding systems and processes, information sharing and governance arrangements.

## Serious problems at NHS 111 service

The NHS 111 service provided by one NHS foundation trust was rated inadequate after inspectors found too many calls were being abandoned or callers had to wait too long for an answer.

There were significant staffing problems – people reported long hours, high levels of stress and fatigue – and calls were sometimes answered by

staff who were not trained to assess patients’ symptoms.

CQC has worked with strategic partners to help address the many problems uncovered on inspection in this example. Among things we asked the service to put right, it had to make sure that call queues awaiting initial assessment and call-back were robustly monitored –

and managed by staff with clinical authority to intervene and allocate resources.

Inspectors found that patients were at risk of harm because the triaging system was not good enough. CQC is monitoring the service’s progress on a series of required improvements.

## Digital healthcare services

Care delivery is changing in many ways and there is an increasing use of new technology.

We are considering how we can develop the right regulatory approach for these services. So far we have registered more than 50 providers of digital healthcare services.

These providers' services are offered as digital-only. These might be online prescription requests, for example, or video consultations provided on a computer or smartphone.

A programme of inspections will start in 2017/18, preceded by publication of our new methodology.

## Health and justice

CQC was a partner in 53 joint inspections, conducted from 1 July 2015 to 30 June 2016, at a variety of services providing care to people in secure settings.

There were also eight focused follow-up inspections. These were led by CQC and resulted because we found breaches of regulations.

We inspected 35 prisons/youth offender institutions, two immigration removal centres, five secure training centres, five youth offending services, and custody suites in six police force areas.

Among the concerns from our inspections, we saw that recruitment and retention of healthcare staff across the criminal justice services remains challenging. This commonly means that a high level of agency staff are used, sometimes leading to a lack of continuity of care and specific skills.

We also found:

- Prisoners' use of illegal psychoactive substances is a growing problem. These are difficult to detect and cause health problems and frequent medical emergencies. This puts a strain on the prison healthcare team as well as local ambulance and accident and emergency services.
- The older prison population requires health and social care services that better meet their needs. Progress is variable and some prisoners cannot access the services they require. For example, bowel cancer screening and specialist dementia support services are not available to prisoners in some areas.

- Healthcare providers deliver clinical services in secure environments that are largely outside their control, which limits their ability to provide a safe and positive experience for patients. Common environmental issues include poor cleanliness, inadequate maintenance of fixed clinical equipment and a lack of privacy.

CQC does not rate health and justice services, but we inspect and regulate criminal justice services in an integrated way that encompasses people's experiences of health and social care services.

Many of the people in these places are less likely to have engaged effectively with mainstream health and social care services. By ensuring that health and social care services within the criminal justice system are as proactive, accessible and effective as possible, we can improve the way that health needs are met in this vulnerable group.

We work closely with the joint inspectorates and we share information. Where we find that substandard environments in prisons or prison staffing issues are adversely affecting the delivery of health services, we can work with HMI Prisons to recommend that prisons make the necessary improvements.

A revised joint framework for the inspection of secure training centres was consulted on and published by Ofsted in 2015. This has enabled us to report separately on healthcare provision and to improve the way we seek the views and experiences of young people and staff.

And since the introduction of the Care Act (April 2015) we have been influencing how prisoners with personal care needs are supported through our regulation of the adult social care services provided to prisoners.

## Children's health and children's safeguarding

Not all children get the help they need, when and where they need it.

CQC is responsible for inspecting all registered health services provided to children. We evaluate the effectiveness of safeguarding arrangements and the quality of health provision to looked after children and their carers.



## CQC's joint health and justice inspections

- Inspections of prisons, youth offending institutions and immigration centres in partnership with HMI Prisons (Includes Ofsted and HMI Probation)
- Inspections of secure training centres in partnership with Ofsted (Includes HMI Prisons)
- Inspections of youth offending teams in the community in partnership with HMI Probation (Includes HMI Constabulary and Ofsted)
- Inspections of police custody suites in partnership with HMI Prisons (led by HMI Constabulary)

## “Meticulous in planning” Young Offenders Institution, Feltham



Our inspectors found many positive aspects in the health and care services at this prison for young people and young adults.

For example, a visiting consultant described the prison's overall sexual health service as the best seen in any prison – services were age appropriate and included screening for chlamydia and other sexually transmitted diseases.

Boys were able to influence developments in health care through monthly prisoner forums – and there was a project to improve health literature, to make it accessible

to the age group. There were several new initiatives to encourage boys to take responsibility for their health, such as teaching boys to re-order their medicines before supplies ran out.

Healthcare staff were reported as “meticulous in planning appointments”. Boys received a reminder before their appointments and those who did not attend were followed up. Non-attendance rates had fallen from 33% to 8% (2013 to 2015).

For dental care, appointments were triaged and then prioritised according to clinical need. There was liaison with

community dentists to ensure continuity of treatment, which was excellent practice.

Other positive aspects in health and care included “high-quality mental health services” with a rich skill mix available from specialist practitioners in learning disability, nursing, occupational therapy, psychiatry, psychology and speech and language therapy. A consultant child and adolescent psychiatrist visited weekly and a psychiatrist offered 24-hour advice to officers.

This was part of a joint inspection with HMI Prisons.

CQC's July 2016 report, *Not seen, not heard*, has findings from our first 50 reviews and shows considerable variability across the health system. We recommend that much more must be done to listen to, and involve, children in their care. Services should improve outcomes, strengthen the quality of information sharing and joint working, and identify and protect those at risk from hidden harms.

Services have to be reactive to new and emerging forms of abuse and harm to children. But they should be constantly aware and up-to-date with information about risks – and they should be engaging with

children to understand their needs and concerns.

The independent inquiry into child sexual exploitation in Rotherham from 1997 to 2013 further highlighted the need for services to focus on the prevention of such abuse in the future.<sup>82</sup> When resources are tight it is possible to lose focus on support for those people who would benefit from early help and support. This need is also particularly relevant to protecting children who are at risk of neglect. The importance and effectiveness of early intervention cannot be overstated and must be addressed with urgency.

## How good and outstanding GP practices respond to people's needs

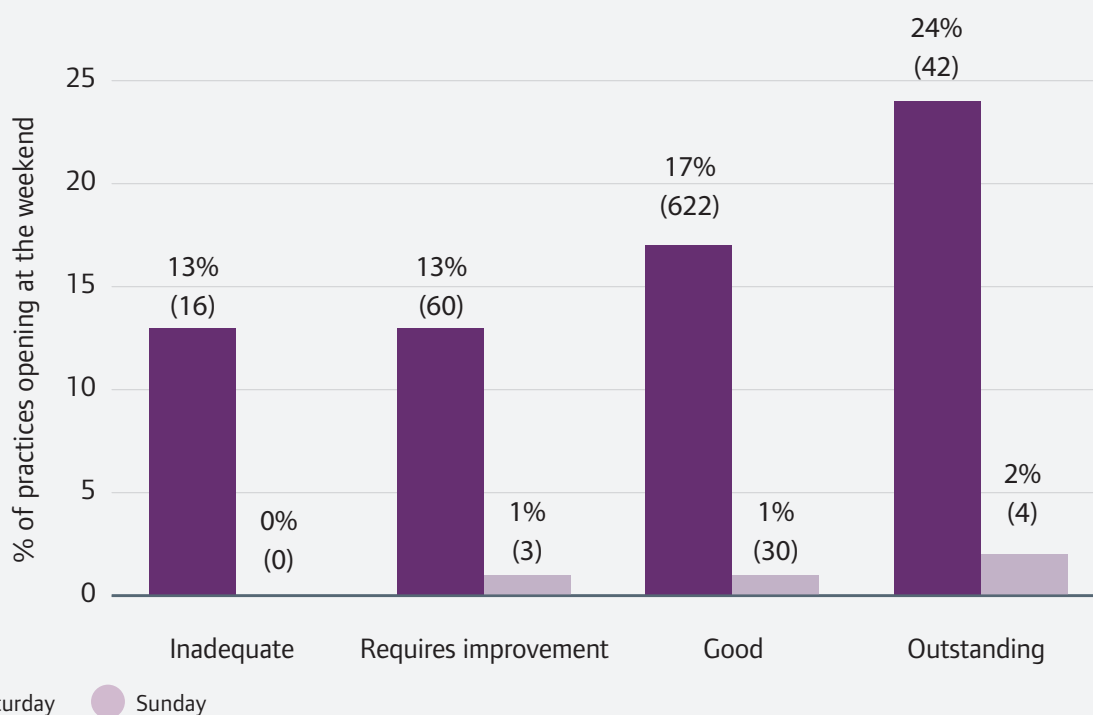
We have seen a number of examples of outstanding care across general practice.

Inspectors told us that outstanding services tend to have a detailed understanding of the communities they serve. They also demonstrate their responsiveness to people's needs in terms of

the services they offer both within and outside the practice. These practices also involve patients in improvements for services.

Many of the GP practices that we have rated outstanding are providing care to some of the most vulnerable people in society, particularly homeless

Figure 2.34 GP practice weekend opening times and ratings



Source: CQC ratings data; NHS Choices

people. There is a lot that can be learned from the way in which these services are delivered, and how responsive they are to the needs of particular population groups.

Some characteristics are common among outstanding practices – those that are stronger on person-centred care are more likely to receive a higher rating.

Providers' attitudes towards people in different population groups reflect their approach and commitment to being person-centred. One inspector summed this up by saying that the better practices "don't just pay lip service to involving patients in coming up with solutions". Some practices have active patient engagement strategies that support patient groups (for example, older adults at risk of isolation) and they help the organisation or coordination of activities for these groups.

Some practices are better at understanding the needs of the population they serve – they gather information from people's perspectives and then use it to plan facilities and services that match needs and

preferences. For example:

- A practice provided information about safe needle disposal in bathrooms, acknowledging the needs of their patients who used intravenous drugs.
- Telephone appointments were offered in response to patient feedback.
- A dedicated 'child's hour' before and after school was set up for same-day GP appointments.
- Social prescribing for patients with mental health conditions.
- Practices promoting that they saw emotional and social needs as being as important as medical ones.

Staff engagement is an important factor in responsive provision. For example, inspectors described a practice where each GP partner had 'led' on a particular area, for example care homes or schools. This built expertise and rapport on specific issues and with particular groups.

Some practices are especially responsive: they identify and react to potential unmet needs, or

## "One of the best"

### Bevan House, Bradford, West Yorkshire



Rated outstanding in all areas of our inspection, Bevan House is an exemplar in meeting the needs of people in all the population groups that we identify.

This practice serves homeless people and people in temporary or unstable accommodation, refugees, people seeking asylum and others who find it hard to access the health and care they need.

After the CQC inspection, it was described as "one of the best practices in England". Among the many

positive examples of its work, inspectors commented on staff at the practice, who were described as "motivated and inspired" to offer kind and compassionate care.

Risks to patients were assessed and well managed. And the practice has improved access to services in numerous ways.

An example of extending access is its street medicine team, which holds mobile outreach clinics in city centre locations for vulnerable people. There is also a late night (until 11pm) clinic for female sex workers, as well as an early

morning clinic, in liaison with a local women's support team.

Among inspectors' findings, they noted how patients were given 'cold weather packs' consisting of gloves, socks, a hat and scarf, water and a bar of chocolate. Several staff told the inspection team that on winter mornings they would take a pack to people they had noticed sleeping rough on their way to work, and encourage them to come to the surgery. A similar and appropriate pack was available for the summer.

to specific population groups in their areas where particular attention is needed. Others were proactive in their links with community groups, or churches and other organisations.

Among the GP practices that we have rated, those with better ratings tend to be open more often outside core hours. For example, out of the 178 practices rated outstanding as at 31 July 2016, 42 of them (24%) were open on a Saturday (figure 2.34).

In October 2013 there was a government-led £50 million fund set up to help improve access to general

practice and stimulate innovative ways of providing primary care services.

In the first year, across the 20 sites selected to participate, approximately 400,000 additional appointments were provided in extended hours (weekday evenings and weekends) and 520,000 additional appointments were provided in core hours. It was also reported that in May 2015 there had been a 15% reduction in minor self-presenting A&E attendances across the pilot schemes, compared with the same period in the previous year.<sup>83</sup>

## Improvement

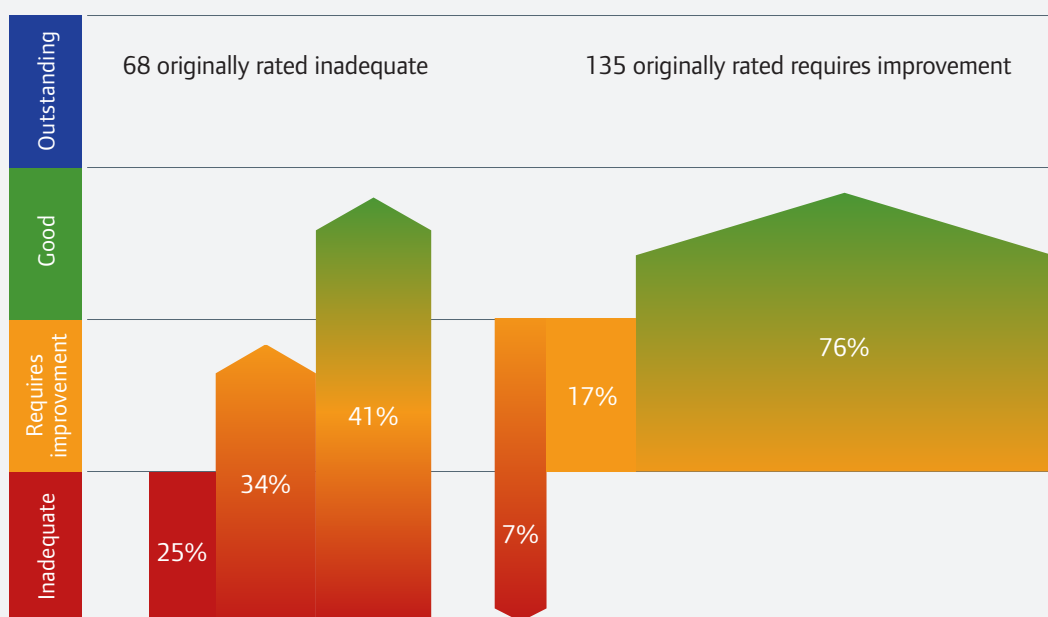
The majority of the general practices that we have re-inspected have improved.

Although some practices we have rated inadequate may have subsequently closed, three-quarters of the inadequate practices that we re-inspected had improved sufficiently to receive a better rating (figure 2.35). Twenty-eight improved their rating to good, and 23 changed to requires improvement.

Inspectors usually remark that a positive change is more likely in services that have an open culture where continuous improvement is encouraged.

Among the numerous examples of safety improvements, cleanliness, hygiene and infection control are covered in detail in inspectors' reports. Many practices appointed specific members of staff (often nurses) to lead on this area.

Figure 2.35 Change in overall rating on re-inspection in primary medical services, where initial rating was inadequate or requires improvement, as at 31 July 2016



Source: CQC ratings data. Note: The width of each cluster of arrows is relative to the number of re-inspections carried out.

Governance and governance frameworks are important areas of improvement identified in inspection reports – for example, introducing a new electronic management workflow system to provide an automatic audit trail for all documents that were read and reviewed by staff. Other improvements included the implementation of comprehensive assurance and audit systems, and putting in place a compliance officer.

Other factors behind good ratings included evidence of fostering an organisational culture of continuous learning, improvement and innovation – and having a clear vision, strategy and values.

An open culture at a practice often enables higher performance or improvements. Inspectors gave examples of where CQC’s intervention provided support to staff. In poorer practices, a change of management or partners often stimulated improvement.

Inspectors have emphasised that every practice is different and that culture can be more important than how things appear on paper. There was an example of where a practice appeared to have good systems and processes in place, but on inspection was found to be “chaotic and badly organised”.

This contrasted with a practice that appeared to have ‘absent’ practice owners, but which was found to be well organised and supported by the partners nonetheless.

A common characteristic in practices rated outstanding is that they have a well developed learning culture. They have a ‘no blame’ culture among the staff – everyone is aware of their own role and feels important in supporting and promoting change.

Inspectors told us that in poorer practices that had improved on re-inspection, they had seen a considerable change in culture and greater patient involvement had played an important role.

We have found that professional isolation can have a serious impact on quality of care and be a major barrier to improvement. GPs who work with other GPs, or practices that work with one another, can share knowledge and good practice, and collaborate to improve.

Where practices have got better, inspectors have seen notable improvements in how they manage and learn from significant events and quality improvement methods including clinical audit. They also pointed to factors including cleanliness, hygiene, infection control, medicines management, governance frameworks, safeguarding and staff engagement.

Our analysis shows that the attitude of general practice to CQC inspections is often cited as a major factor in whether providers are likely to improve from ratings of inadequate or requires improvement. While some GPs have told us of their apprehension about CQC inspections, there is also much positive feedback and GPs have acknowledged the “robust” role of inspection teams in helping practices to improve.







A photograph of a man with glasses, wearing a dark shirt, speaking. The image is partially obscured by a large orange text overlay.

# Equality in health and social care

## Key points

- We continue to see variation in the access, experience and outcomes for people in equality groups using health and social care services.
- The link between equality for staff working in services and the quality of care is now well-established. Providers need to reduce the difference in experiences and outcomes for their staff and to learn from best practice, such as through the NHS Workforce Race Equality Standard.
- People in particular equality groups are more likely to get their specific needs and preferences met if they are involved in planning their own care and the service delivers more personalised care.
- Action on equality also needs to be taken at a service level. This requires leaders to embed equality into working practices to achieve good quality care for all, including those who are often less-considered by services such as lesbian, gay, bisexual and transgender people using adult social care services.
- Good practice in equality means that services are more likely to be rated good or outstanding for being responsive.
- Equality in health and social care cannot be achieved by providers alone. The whole system needs to be involved, including through commissioning and joint working such as Sustainability and Transformation Plans.

# Introduction

We know that equality of access, experience and outcomes in health and social care services is very important – providers cannot meet the needs of their communities without this.

This is why equality runs throughout our work. Our examples of good practice and significant findings throughout the year are reflected in this chapter. We also consider how equality issues affect staff working in health and social care services.

The chapter meets our statutory duties under the Equality Act 2010 to report on what we know about equality for groups that are affected by our statutory functions. The Act covers eight protected characteristics related to service provision: age, disability, gender, gender reassignment, pregnancy

and maternity, race, religion and belief, and sexual orientation.

There are some challenges in reporting progress on equality. For example, data collection for different equality groups is inconsistent in national health datasets. Despite these limitations, through our inspections and analysis we have been able to identify examples of good and poor practice in equality, which in turn encourages improvement in the quality of care.

## Addressing equity of experience from board to ward

### Mersey Care NHS Foundation Trust, Liverpool



We inspected Mersey Care NHS Foundation Trust and rated it as good in October 2015.

We found that the trust was committed to equality across all protected characteristics and was piloting the use of a human rights-based approach. The trust was using the NHS Equality Delivery System effectively. It had an equality and human rights steering group, chaired by a non-executive director. Coordinators were in place across the trust to oversee how local action plans were implemented for each service. There had been visible effects on frontline services, for example:

- The trust had been awarded a Navajo Merseyside and Cheshire LGBT Charter Mark for recognition of its approach to lesbian, gay, bisexual and transgender (LGBT) people.<sup>84</sup>
- A human rights-based approach in older people's services had resulted in developing a person-centred assessment tool incorporating the values of human rights law. We saw this being used on the ward.
- People had good access to interpreting services. The dietary requirements of people were met, with a choice of food available that was appropriate to different religious and cultural needs.
- There was an active learning disability advisory group that promoted the involvement of people using the service and used human rights principles. The group had produced a booklet about human rights for people with a learning disability, written by people with a learning disability.
- The trust had been improving its recording of incidents of discrimination for both people who use the service and staff.

# Good practice in equality

## Responsiveness

Good practice in equality means that services are more likely to be rated good or outstanding for being responsive. We have found that these services:

- understand the needs of people using – or likely to use – their services
- enable people to regularly discuss how their service is developed
- develop the service to address any unmet needs
- empower staff to be innovative in responding to different needs.

Personalisation of health and care services is the foundation for achieving equality, as it helps people to have control over how services meet their needs, preferences and aspirations. As well as personalisation, responsive services tackle institutional barriers to equality – for example, giving people equal access to services, providing interpreting services, and helping people to feel equally safe and ‘at home’ when services are delivered in a shared environment such as a care home or inpatient ward.

In larger services, such as hospitals, many providers rated good or outstanding for being responsive promoted a culture that understands the needs and preferences of different groups. They did this through, for example, strong patient engagement and encouraging staff to innovate in how they meet people’s needs and preferences. This was similar to many of the GP practices rated good or outstanding for being responsive.

## Leadership

We have found that good leadership is needed to continually improve equity in the delivery of services and to support staff to do so. In all services, it is necessary to move beyond a tick-box approach – for example when staff attend equality training but there is no follow-up afterwards.

Leadership of equality at a system level is also very important. For example, in our most recent Mental

Health Act report, we reported on the importance of providers working alongside commissioners in the local implementation of new guidelines to monitor and address long-standing inequalities in the experiences of Black and minority ethnic (BME) groups using mental health services. One issue that providers and commissioners need to tackle together is higher rates of detention for people from BME groups.<sup>85</sup>

## Equality in adult social care: addressing people’s diverse needs

We collect information about the work carried out by adult social care services to meet the needs of people with particular equality characteristics. We do not currently collect equivalent data for healthcare services. We looked at information returned to CQC from April 2015 to March 2016 by 9,076 adult social care services.

Although we have seen some examples of good practice in adult social care during the year, comparison with equivalent evidence from last year suggests that the amount of work on equality for people who use services is, at best, relatively static. There may be a widening gap between policy and putting this into practice in residential services.

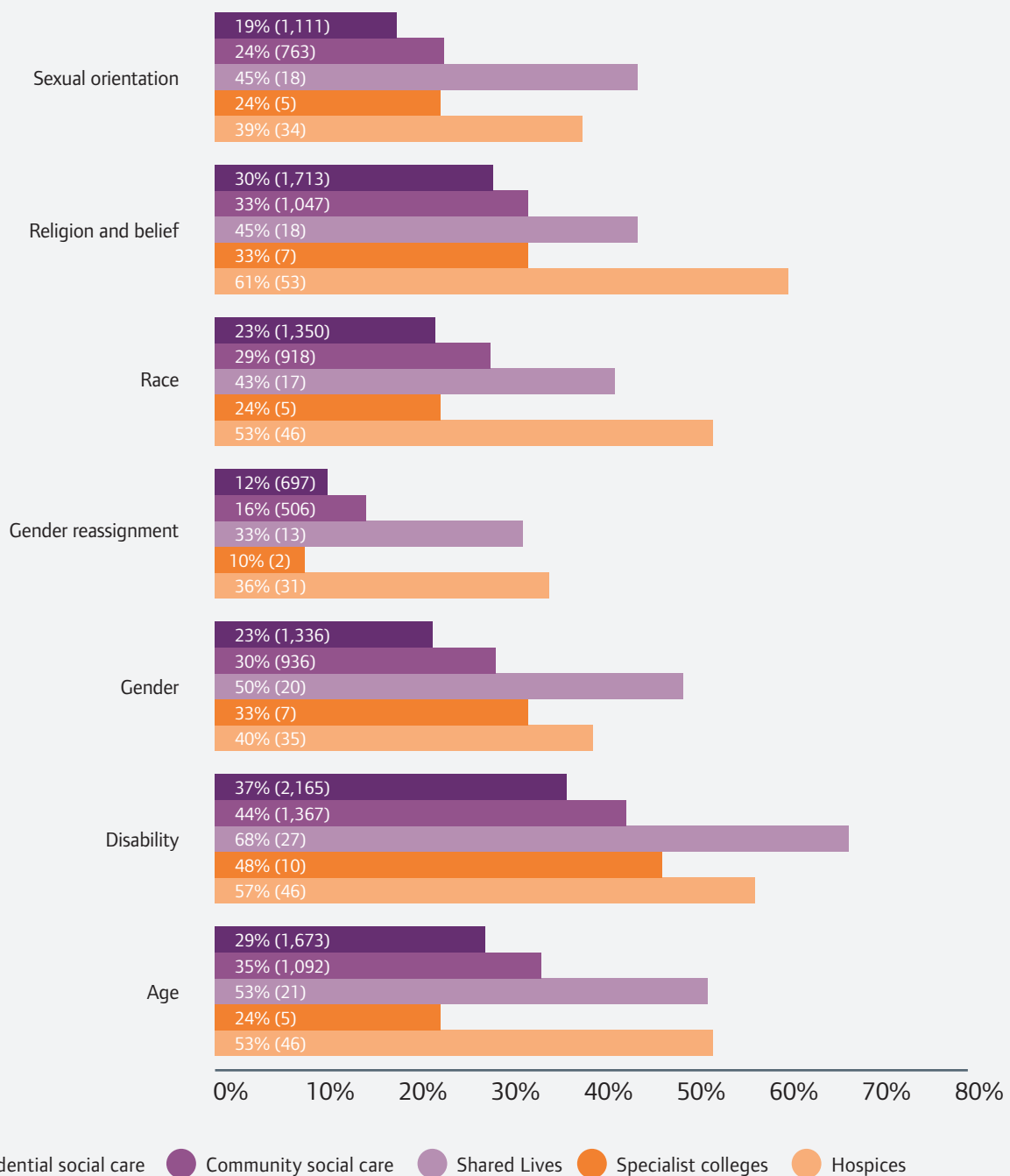
We found that 99.6% of services had policies covering equality and diversity. However, the percentage of services that said they had carried out work in the last year to meet the needs of people with particular equality characteristics was much lower, at 45.3% of services overall. This was a drop from 53.7% in the previous six months. A particular change was found in residential services, where the numbers saying ‘yes’ to this question dropped from 58% in 2014/15 to 43% in 2015/16. It should be noted that these figures were based on provider information returns sent ahead of inspections, so the sample of providers in each year would have been different.

The percentage of services reporting that they had carried out work on equality in the last 12 months varied by service type and protected characteristic

from 10% to 68% (figure 2.36). All service types, except hospices, had carried out most work around equality for disabled people, and the least work around gender reassignment and sexual orientation.

In our inspections, we found that staff often found it difficult to engage with people using their service around issues of sexual orientation.

Figure 2.36 Percentage of adult social care services that reported they had carried out work on equality in the previous 12 months, by service type and protected characteristic, April 2015 to March 2016



Source: CQC provider information returns



## Equality work in adult social care

### Shadon House Dementia Resource Centre, Tyne and Wear



Shadon House is an assessment and respite service providing residential care for older people, some of whom live with mental health conditions or dementia. We rated the service outstanding in June 2016, including a rating of outstanding for being responsive. We found that:

- The service's vision was to "improve people's health, wellbeing and quality of life; give people choice and control; help them make a positive contribution; maintain personal dignity and respect; and keep them free from discrimination and harassment".
- Staff were committed to upholding people's human rights, treating everyone with respect and dignity and tailoring care to the individual.
- People received advice on a range of advocacy services that were specific to their needs.
- The service worked closely with a local arts charity to deliver stimulating creative projects for older people with communication difficulties – musicians, storytellers, poets and writers used people's experience and local culture as a focus.
- The building had been customised to meet the needs of people living with dementia, with decoration and large signs to help people orientate themselves.
- All staff members had been trained in equality and diversity issues. They were able to access detailed information about a wide range of religious and cultural beliefs and traditions.
- There was a culture of mutual respect between people using the service, their families, staff and professionals.

## Equity of access: the role of providers

There are many ways that providers can ensure equity of access to their own services, and help people in different equality groups to access other health and social care services. The availability of services is a separate issue that may result from national policy or commissioning issues that are outside the control of providers.

We have found that providers rated good or outstanding for being responsive actively identify the needs and preferences of people currently using their services, as well as those who may need to use them in the future – through identifying unmet needs. For example, at the Tavistock and Portman NHS Foundation Trust, community mental health practitioners from the largest refugee communities in the area had been employed to help reach out to their communities. Examples included producing leaflets in local languages for Somali and Congolese people, and providing refugee outreach

projects for children and their parents, sports clubs, and mental health awareness sessions.

### Primary medical services

Registering with a GP practice and using GP services is the cornerstone of the NHS, as it helps people access a range of other health services.

We analysed the 2015 GP patient survey results for different equality groups and found that Gypsies and Irish Travellers, Pakistani and Bangladeshi people were less likely to say that they found GP practice receptionists to be helpful compared with people from other ethnic groups. The percentage of people saying they found receptionists to be helpful rose with age group from the 18 to 24 group to the 75 to 84 group (with a slight decrease after this age for the 85 and over group).

These results mirror national reports by the Equality and Human Rights Commission (EHRC) and Doctors of the World which indicate that people from some groups are finding it difficult to register with a GP practice, particularly refugees and vulnerable migrants, Gypsies and Travellers and homeless people.<sup>86, 87</sup> GP practices have only a limited degree of discretion, under the GP contract and regulations, about whether to register the person. Practices may only decline to register a patient if they have reasonable grounds to do so. These grounds must not be related to equality characteristics. CQC has produced guidance to GP practices on the entitlements of refugees and asylum seekers,<sup>88</sup> and the British Medical Association has clarified its guidance on GP patient registration.<sup>89</sup>

However, in our inspections we found a number of examples of good practice that were improving equity of access to primary medical services for these groups, such as:

- A GP practice providing support for a local programme offering sanctuary to refugees and asylum seekers to help ensure people's access to health care, and an outreach service for two local Traveller communities, targeting young families.
- Travellers represented on a patient participation group at a GP practice and good engagement with the Traveller community. Positive outcomes included high rates of immunisation for Traveller children.<sup>b</sup>

### Hospital services

We have little evidence on equity of access to hospital services, as surveys and inspections focus on people who are already using hospitals.

Although we can compare population data with hospital use, it is difficult to draw conclusions from this about equity of access because there are a large number of factors that may influence patterns of access.<sup>90</sup> RightCare data provides good evidence about variation in access to a range of health services based on geography and deprivation, but this does not cover other equality characteristics.<sup>91</sup>

We can, however, use the 2015 NHS inpatient survey to look at differences in how well people are directed to or

referred to other services after a stay in hospital.<sup>b, c</sup> We found that:

- People with a mental health condition were significantly less likely to say that hospital staff discussed other services with them before discharge in both the 2014 and 2015 surveys. And in 2015, people with a learning disability and people from a range of BME groups were still significantly less likely to say that they had been asked about equipment and adaptations before leaving hospital, compared with other people.
- In 2014, people with a learning disability and people from Asian and Asian British backgrounds were significantly less likely to say that hospital staff discussed with them whether they needed any health and social care services after leaving hospital, compared with other people. In 2015, there were no significant differences in answers to this question for people in these groups. This could represent an improvement but would need to be observed over a longer period of time before we could be certain.

### Specialist secondary services

Some equality groups need to access specialist secondary services. For example, transgender people need to access gender identity clinics (GICs). Referrals to GICs are increasing rapidly – in October 2015, there were almost twice as many people waiting for a first appointment at a GIC compared with the year before.<sup>92</sup> Transgender people can also face difficulties accessing other types of services, particularly inpatient mental health services arranged on a single-sex basis.

### Adult social care

As we say in part 1 of this report, the number of people eligible for local authority funded adult social care has fallen. This has a particular effect on equality groups that are more likely to use adult social care, for example older people and disabled

Footnote:

- b For further detail, see the annex to this chapter at [www.cqc.org.uk/stateofcare](http://www.cqc.org.uk/stateofcare)
- c Note that when analysing some surveys at the level of respondents' protected characteristics, some groupings may involve small numbers which result in very wide confidence intervals or potentially skewed results

people. The EHRC has highlighted spending on social care for older people as an important challenge to whether Britain is a fair country.<sup>93</sup>

In 2014/15, only 9.6% of adults receiving long-term social care support from local authorities were from a BME background, which is lower than the population percentage in England (14.6%).<sup>94</sup> This could be due to factors such as:

- Differences in need – while 17% of people in White ethnic groups are aged over 65, only 5% of people in BME groups are in this age range.<sup>95</sup> However, the prevalence of disability is higher in some BME groups, so the level of need is not easy to compare from population data alone.
- Greater difficulties in accessing appropriate care due to information barriers – the 2014/15 survey of people who use adult social care services showed that people from BME groups were more likely than people from White ethnic groups to have tried to find information, but were also more likely to say that they found it fairly or very difficult to find information or advice.<sup>96</sup>

## Equally good experience when using services

People from different equality groups perceive their experiences of health and social care in different ways – both positively and negatively – depending on a range of factors.

The 2015 NHS inpatient survey showed that age is an important factor in how people perceive their experiences of hospital care. Sample sizes may have some influence on differences between groups, but the following points are worth considering:

- Younger people (aged 16 to 35) were significantly less likely to report being treated with dignity and respect than older people (aged 66 to 80). They also reported significantly less confidence and trust in both nurses and doctors.
- People with a mental health condition were significantly less likely to say that they were treated with dignity and respect while in hospital, compared with people with no long-term condition.

### Gender identity clinics

#### West London Mental Health NHS Trust and Tavistock and Portman NHS Foundation Trust



During the year, we inspected the largest gender identity clinic in England for adults (part of West London Mental Health NHS Trust) and the only service for those aged under 18 (part of Tavistock and Portman NHS Foundation Trust). In both services we found very skilled and specialist staff who were highly committed to their roles and we received a lot of positive feedback from people using the services. Both services had taken positive steps to raise understanding of transgender

issues within the local community, for example with religious leaders and in schools.

But we also found some access issues:

- Long waiting times were a significant issue for people using the gender identity clinic at West London Mental Health NHS Trust, and at times inefficiencies in administration contributed to the challenges faced by people waiting for appointments or attending the clinic.

- There was geographical inconsistency around the age that young people could transfer from young people's gender identity services into adult services, and also around processes, for example deciding when young people needed to be reassessed.
- People who used these services could be particularly anxious about the risks of complaining about a scarce service that can be hard to access.

- These results were similar to last year. They show that the self-reported experience of inpatient care continues to be poorer for certain groups of people.
- A number of groups were less likely to say that they received enough emotional support from hospital staff during their stay, including younger people, Muslim people, people with a mental health condition, and Asian, Asian British, and Chinese people.

In the 2015 NHS maternity services survey, there were some differences in the support people received around childbirth:

- Asian, Asian British, Black, Black British and Arab people were more likely than people from White ethnic groups to report being given the information or explanations they needed during their care in hospital after birth.
- Respondents from White ethnic groups were the least likely to report being given consistent advice about feeding their baby. This is an interesting pattern, as it differed from many other health and social care surveys, which show that people in BME groups are less likely than people in White ethnic groups to say that they are given adequate information. There could be some learning from maternity services around good communication to people from a range of ethnic groups.

In the GP patient survey, there were similar findings to the NHS inpatient survey around patient experience and age. Positive responses increased with age, with a slight decrease for the oldest age group for questions on confidence and trust in nurses, doctors treating the person with care and concern, and overall experience of using the GP surgery.

People from Pakistani, Bangladeshi, Chinese and White non-UK ethnic backgrounds were also less likely to say that doctors and nurses treated them with care and concern and were less likely to have confidence and trust in nurses. People from all these groups were significantly less likely to report a good overall experience of using a GP surgery compared with White British people. Muslim, Sikh and Hindu

people reported a poorer overall experience of GP surgeries than Christian people.

### **Involvement and person-centred care**

People in particular equality groups are more likely to get their specific needs and preferences met if they are involved in planning their own care and the service delivers more personalised care.

For example, in adult social care we found that many residential services rated good or outstanding for being responsive had achieved this through focusing on person-centred services in care planning, and through regular discussions with people using the service and local groups representing diverse communities. These discussions included what types of activities they would individually like to do, and creating their own care plans. Often these improvements did not take many resources, just thought and attention.

In the analysis of patient surveys for our review *Better care in my hands*, we found that:

- Women who use maternity services were particularly positive about being involved in their own care.
- Disabled people and people with long-term conditions were consistently less likely to say that they were involved in their own care than those without long-term conditions. This was across a range of surveys: A&E, inpatient, maternity and cancer care. We hope that the new NHS Accessible Information Standard will help to improve this in future years.<sup>97</sup>
- People from BME groups were also less likely to say that they felt involved in their own care (including in GP practices) in a range of surveys, as were lesbian, gay and bisexual (LGB) people.
- Older people were more likely to say they were involved in their health care than younger people, but this decreased again for people aged over 75.<sup>98</sup>

# Equality of outcomes

## Health outcomes

This year, the EHRC reported that some health inequalities are improving.<sup>99</sup> There has been a decrease in the difference in mortality rates for men and women, and an improvement in infant mortality rates for White, Pakistani, Bangladeshi, African and African Caribbean children.

However, some inequalities are not improving – including the poorer health of disabled people, higher levels of mental ill-health among people from LGB and BME groups, lower life expectancy for people with a serious mental illness and over-representation of people from BME groups detained under the Mental Health Act. Gypsies and Travellers have a persistently poor health status and higher mortality rate. In our analysis of the GP patient survey responses, we found that Gypsies and Irish Travellers were significantly less likely to say that they felt confident managing their own health, compared with any other ethnic group.

Lower life expectancy for people with a learning disability, including a high number of avoidable deaths, has been a concern for a number of years. We welcome the learning disability mortality review launched by NHS England as part of the *Five Year Forward View*.<sup>100</sup> Our review of how NHS trusts investigate and learn from deaths will also have a particular focus on deaths of people with a learning disability. To fulfil one of our equality objectives, we have introduced a set of questions for acute hospital inspection teams to help them consistently consider the quality of care for people with a learning disability.<sup>101</sup>

A review by Public Health England and Lancaster University of 30 CQC acute trust-wide inspection reports and 61 reports on specific acute hospitals (from April and November 2015) (not yet published) showed that the majority of comments about care for people with a learning disability in our inspection

reports were positive (78%) and the proportion of positive comments increased as ratings increased. This suggests that hospitals that provide better care overall are also likely to provide better care to people with a learning disability.

Another concern about equality in health outcomes is the poorer health status of some newly arrived migrants. This can be addressed not only by providing better access to primary care, but by improving care in settings such as immigration removal centres.

## Quality of life outcomes

How people rate their quality of life and their satisfaction with services provides important information about outcomes from using social care services. The 2015 adult social care survey showed that:

- People from White ethnic groups were significantly more satisfied with the care and support services they received, than people from BME groups.
- People aged under 65 were more satisfied with care and support services than those aged 65 and over. This contrasted with some of the age-related findings from health settings, where younger people tended to be more dissatisfied than older people, but it was in line with our ratings of care services. As reported in the adult social care chapter of this report, domiciliary care agencies and residential care homes for people with a learning disability (mostly people aged under 65) were more likely to be rated good or outstanding compared with equivalent services for other people (mostly older people).



## The role of the local care system

Responsibility for improving equality does not lie solely with providers. Others in the health and social care system, such as commissioners and oversight bodies, play an important role.

Clinical commissioning groups (CCGs) have a responsibility to commission services to meet the needs of their local communities. Their progress in this can be tracked by looking at the Equality Delivery System (EDS2) reports that they produce.<sup>d</sup>

There is some progress. We could find gradings for more CCGs than last year, and a higher proportion were either achieving or excelling in commissioning services to meet the needs of their populations (figure 2.37). However, there is considerable room for improvement. Almost four out of five CCGs were not able to show that they were ‘achieving’ the commissioning of services to meet the needs of different equality groups. There is no national system in place for adult social care commissioners to benchmark and develop their commissioning of

services to meet the needs of local communities. The Local Government Association does, however, organise an equality peer challenge award based on the Equality Framework for Local Government. This is voluntary and not specific to adult social care.<sup>102</sup>

Our report *My diabetes, my care* found that people who attended structured diabetes education courses felt it improved their ability to manage their condition. People with a learning disability and people from BME groups were more likely to have Type 2 diabetes than others, yet many courses did not meet the needs of these groups of people. Where CCGs were tailoring outreach and education programmes to the needs of people from BME groups and people with a learning disability, and were delivering personalised care and support, this was having positive outcomes.<sup>103</sup>

Our pilot reviews of the quality of care in a place (in North Lincolnshire and Salford) found that their health and wellbeing boards (HWBs) had developed approaches to ensure that partners valued equality, diversity and inclusion and that equality objectives had been set.<sup>104</sup>

It is too early to comment on the impact on equality of Sustainability and Transformation Plans or the developing new models of care that cross

Footnote:

d EDS2 is designed to help local NHS organisations, in discussion with local partners including local populations, review and improve their performance related to the Equality Act 2010. For further details: <https://www.england.nhs.uk/about/gov/equality-hub/eds/>

### Improved care in response to findings Yarl's Wood Immigration Detention Centre, Bedford



We first inspected Yarl's Wood Immigration Detention Centre in 2015. We re-inspected the service in March 2016 and found improvements in healthcare services in response to our previous findings, including:

- staffing improvements to better match, assess and meet the needs of people at the centre
- new care pathways, particularly to meet people's long-term health, sexual health and mental health needs – for example with better input from mental health professionals, mental health assessments by trained staff, mental health awareness training for staff, and referrals to specialist teams
- better care for pregnant women
- feedback from patients noting improvements in staff attitudes and in how care is delivered.

traditional provider boundaries. However, there is an expectation that these will reduce health inequalities and therefore improve equality of outcomes, and

will be designed to promote person-centred care – improving equality of access and experience is also fundamental to the success of these new initiatives.

## Workforce equality

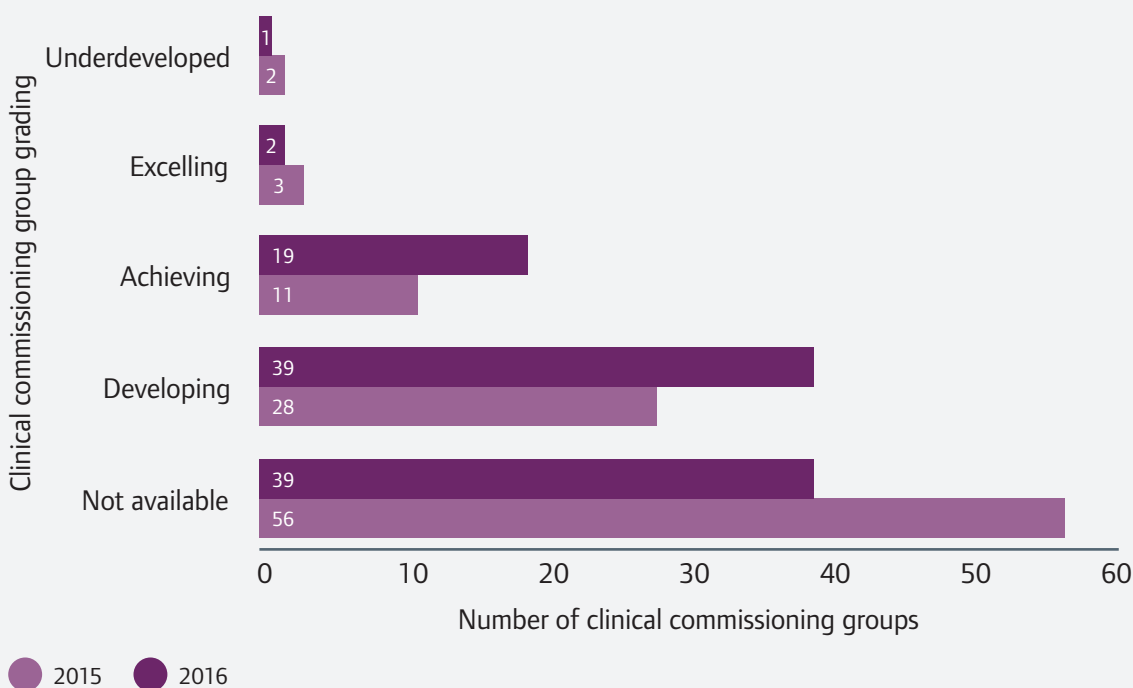
The link between staff equality and the quality of care is now well-established. Workforce equality in the NHS is gaining greater attention due to the NHS Workforce Race Equality Standard (WRES).<sup>105</sup> We are considering workforce race equality in all our inspections of NHS trusts and independent healthcare organisations and our findings contribute to our ratings for being well-led. We are also using the WRES in CQC to look at race equality in our own workforce.<sup>106</sup>

### Diversity in the health and social care workforce

Workforce profiles change relatively slowly, so there is little change compared with last year. This year:

- Nearly two in five (38%) of NHS medical staff, 15% of NHS non-medical staff and 20% of adult social care staff are from BME backgrounds. This compares with 11% of the UK workforce being from BME backgrounds.
- Staff from BME groups are still under-represented in management roles – they hold only 10% of NHS non-medical and 13% of adult social care management jobs.
- Women make up 82% of the adult social care workforce and 81% of the NHS non-medical workforce, compared with 47% of the UK workforce. However, only 44% of NHS medical staff are female.

Figure 2.37 Clinical commissioning group gradings: how well services are commissioned, procured and designed to meet the needs of local communities, July 2015 and May 2016



Source: 100 clinical commissioning group websites

- Women are under-represented in health and social care management roles – men make up 19% of NHS non-medical staff, but fill 30% of management roles. The difference is not so large in adult social care – where men are 18% of the workforce and 22% of managers.
- These broad categories mask some differences between grades within roles. For example, nurses from BME groups are more likely to be in the lower grade posts (for example band 5, which accounts for 66% of Asian or Asian British nurses, 57% of Black or Black British nurses, and only 46% of White nurses). They are also less likely to be in the highest grade posts (bands 8 or 9, which account for 1% of Asian or Asian British nurses, 31% of Black or Black British nurses and 5% of White nurses). Female NHS managers are more likely to be in lower grade management roles than their male management colleagues.<sup>107</sup>
- The indicators with the largest difference between staff from BME groups and staff from White ethnic groups, across all types of trust, were those relating to personal experience of discrimination and belief that the trust provides equality opportunities. This was also the case last year. For example, in 2015, 14% of staff from BME groups working in acute trusts said that they had experienced discrimination, compared with 6% of staff from White ethnic groups.
- There has been some improvement in mental health trusts, as there was a fall in the number of trusts where staff from BME groups were reporting a worse experience of bullying and harassment from other staff.
- These differences are not inevitable. On each indicator, there were some trusts where staff from BME groups responding to the survey reported the same or better outcomes than their colleagues from White ethnic groups. NHS England is using the 2014 analysis to identify good practice that other trusts can learn from. We encourage providers to use the advice and resources on the national WRES team to improve.<sup>e</sup>

The King's Fund report *Making the difference: diversity and inclusion in the NHS* has found that levels of reported discrimination vary significantly by type of trust, location, gender, age, ethnicity, sexual orientation, religion and disability status.

### Staff experience

From our analysis of the NHS 2015 staff survey results, we found that:

- Staff from BME groups were more likely than staff from White ethnic groups to experience bullying and harassment from other staff across all types of trust. However, the picture was much more mixed around staff experiencing bullying and harassment from members of the public. This is similar to the analysis of the 2014 results carried out by NHS England.<sup>108</sup>

Footnote:

- e For further detail, see the annex to this chapter at [www.cqc.org.uk/stateofcare](http://www.cqc.org.uk/stateofcare)

## Equality-led approach to end of life care commissioning Central Manchester CCG



In our end of life care review, *A different ending*, Central Manchester CCG stood out as an example of good practice in commissioning to meet the needs of the local population. The CCG has made equality a central part of its approach to end of life care by:

- embedding equality analysis into its decision-making processes, including considering people who are homeless, Gypsies and Travellers and migrant workers, as well as those with protected equality characteristics
- setting up yearly equality performance monitoring
- taking action as a result of equality analysis – for example, adding whether people’s gender identity differed at birth into the development of the Electronic Palliative Care Coordination System
- working with Macc, Manchester’s voluntary and community sector support organisation, to respond to feedback from patients and advocates – for example, commissioning a care home project to make sure that frail, older people with non-cancer diagnoses have access to the right end of life care services
- delivering training to staff in care homes to enable them to be more confident in discussing people’s preferred place of death and advance care planning, and to deal with a crisis more effectively – as a result, admissions to hospital have reduced by 68%
- commissioning the Manchester Pathway (MPath) service to reduce A&E attendances and hospital readmission for homeless people, so that people who are likely to be approaching the end of their lives are identified earlier.<sup>109</sup>









# The Deprivation of Liberty Safeguards

## Key points

- We have seen examples of good practice in all sectors, including individual providers who have improved after we have taken enforcement action. Providers who applied the Deprivation of Liberty Safeguards (DoLS) well had a culture of person-centred care, robust policies and documentation of DoLS procedures, and good leadership in place to provide a focus to staff understanding of DoLS and how to apply it.
- There is variation in the effective application of DoLS both between providers and within individual providers across the different services that we inspect. This could lead to individuals not receiving care that is in their best interests.
- Not enough providers are applying capacity assessments effectively. Many providers made assumptions that individuals lacked capacity without having carried out or documented assessments. Some providers used the 'blanket approach' to capacity assessments, which suggests that their focus may be more on managing organisational risk than delivering person-centred care.
- Lack of staff training remains a problem. Although many staff showed good understanding of the DoLS and wider Mental Capacity Act 2005, there were many other services where training and staff understanding were not good enough.

# Introduction

The Mental Capacity Act 2005 (MCA) exists to protect and empower individuals who are unable to make some or all of their own decisions. It ensures that decisions are made in a person's best interests – setting out who can make decisions, and when and how these decisions can be taken, on behalf of someone who does not have capacity. It also ensures that people are empowered to make their own decisions wherever possible.<sup>110</sup>

Within the framework of the MCA,<sup>f</sup> the Deprivation of Liberty Safeguards (DoLS) are used to protect the rights of people who are deprived of their liberty so they can receive necessary care or treatment. The DoLS apply in hospitals and care homes. A deprivation of liberty is described as:

- when a person is under **continuous or complete supervision and control**, and
- is **not free to leave**, and
- the person **lacks capacity to consent** to these arrangements.

As set out in the Deprivation of Liberty Safeguards Code of Practice, DoLS provide a legal process to ensure that, where it is necessary to deprive a person of their liberty, it occurs in the person's best interests.<sup>111</sup> The DoLS ensure that people who lack capacity and are deprived of their liberty have a representative voice, access to advocates and the

Footnote:

f Note that in this section, we comment on the application of the MCA as it relates to the use of DoLS. We do not consider other issues relating to the MCA.

## Improvements in practice

In our inspection reports in 2015/16, we saw examples of good practice in all sectors. We have also seen examples where individual providers have been able to improve, particularly where we have re-inspected them after previously highlighting concerns.

chance to challenge whether their liberty should be deprived.

Care homes and hospitals must apply to local authorities to ask if they can deprive someone of their liberty. The DoLS set out the processes that must be followed. The local authority must make sure that a number of specific assessments are carried out before granting authorisation. A hospital or care home can grant an urgent authorisation for a short timeframe in exceptional cases.

CQC is responsible for monitoring the use of the DoLS in hospitals and care homes. Each year, we report on how they are being implemented. Our inspectors look at both DoLS and the wider MCA in inspections, and our findings inform the ratings we give to providers. We are committed to working with providers to show them where they are doing well, and what they need to do where they may need to improve. We also challenge providers by taking enforcement action where we have concerns that legal requirements are not being met. We take seriously our role to carry out enforcement where needed to protect the human rights, dignity and wellbeing of people receiving care.

In previous years, we have highlighted the variation in how effectively providers implement DoLS. In 2015/16, our inspection findings showed evidence of improvement among providers that have been re-inspected. We saw pockets of good practice of DoLS specifically, and the wider MCA generally. However, some hospital and care home providers were still not adequately implementing their responsibilities and improvement is needed.

### Improvement among providers

We have particularly seen examples of improvements in adult social care. We looked at a sample of care homes whose ratings had improved. The vast majority were not meeting the DoLS and wider MCA requirements when we first inspected, but were doing so when we re-inspected.



## DoLS: the broader context

In March 2014, the Supreme Court ruled that a deprivation of liberty occurs when a person is under continuous or complete supervision and control, and is not free to leave, and lacks capacity to consent to these arrangements.

In our previous reports on DoLS, we have highlighted the challenges that have been faced since this judgement, including the unprecedented number of applications for authorisation.

These challenges have continued. Data from NHS Digital shows that, in 2015/16, applications received by local authorities rose to the highest levels ever, to 195,840 applications.<sup>112</sup> This compares with 137,540 received in 2014/15. Of the 105,555 applications that were processed in 2015/16, 76,530 (73%) were approved. There has also been a large increase in the number of applications with urgent authorisations: 95,495 (49%) of the applications received in 2015/16. In addition, we are aware that there was a general upward trend for section 21A applications (where the person to whom the application relates challenges a standard or urgent deprivation of liberty authorisation) to the Court

of Protection in 2015/16.

Providers of other health and care services outside of hospitals and care homes, such as supported living services, must apply to the Court of Protection for authorisation to deprive someone of their liberty in the course of offering care. We are also aware that Deprivation of Liberty applications to the Court of Protection continued to rise, more than doubling from 525 applications in 2014 to 1,499 in 2015. This upward trend continues in 2016.

The situation has continued to place significant pressure on local authorities. Our inspectors have noted that local authorities have been overwhelmed with applications.

Discussions with the Association of Directors of Adult Social Services and the Local Government Association have highlighted some of the challenges that local authorities are facing. For example, there are challenges not only in responding to new applications for authorisation, but also in re-assessing and (where justified) authorising applications following expiry of existing authorisations, and being able to identify and appoint enough representatives

(such as Relevant Person's Representatives and Independent Mental Capacity Advocates) to support people who may be subject to a DoLS authorisation. Initiatives continue to be put in place to help address this, such as sharing of good practice by local authorities, but significant challenges remain.

This situation affects people who use services. For example, as we reported last year, the backlog may lead to delays in the independent assessments, advocacy and representation provided by local authorities. These are essential to make sure that people are only deprived of their liberty appropriately and that they receive care that meets their needs and is consistent, as much as possible, with their wishes.

The existing scheme has been criticised for its complexity and the sharp questions it raises about sustainability and costs. The Department of Health has asked the Law Commission to carry out a review of how deprivation of liberty for people who lack capacity should be regulated. We hope that their final proposals, due to be published in December 2016, will lead to improvements.

We also found improvement where we have taken enforcement action. When we re-inspected care homes that had previously had enforcement action relating to a breach of the need to seek consent,<sup>g</sup> in relation to DoLS practice, the vast majority had successfully rectified their breaches and were now applying DoLS correctly. In some cases, however, further improvement was needed. Of care homes that had faced enforcement action for breaching the requirement to protect people who use services from abuse and improper treatment,<sup>h</sup> the majority had shown enough improvement when we re-inspected. Where improvements were still needed, most of our inspection reports identified a need to improve staff understanding of DoLS through more training.

It is important to draw learning from good practice to encourage other providers to improve. Where we saw evidence of DoLS and the wider MCA being applied well, the following factors were common.

### **A culture of person-centred care**

Person-centred care is defined, from the point of view of those receiving care, as “I can plan my care with people who work together to understand me and my carer(s), allowing me control and bringing together services to achieve the outcomes that are important to me”.<sup>113</sup>

This principle is central to the MCA. Providers that we considered, during inspection, to be ‘good’ at delivering person-centred care appeared to have a

higher level of understanding of DoLS and the wider MCA than those who were not.

Importantly, staff assessed individuals properly, avoided applying blanket approaches to people’s capacity assessments and took account of individuals’ choices, preferences and needs. While not common, our inspectors also highlighted that some providers were proactive in seeking support where relatives were not able to be involved in best interests decision-making – such as involving independent advocates or representatives appointed by the local authority. All of these factors would have a significantly positive effect on people’s experiences and the quality of care they receive.

### **Robust policies and documentation of DoLS procedures (and the wider MCA)**

In examples of mental health trusts that were applying DoLS and the wider MCA effectively, staff were supported by clear policies and procedures in place. For example, in one mental health trust, staff were provided with clear guidelines and a checklist to make sure that capacity assessments were carried out correctly and escalated for specialist advice where necessary.

Staff were aware of the policies on the MCA and DoLS and could refer to them if needed. In one community mental health provider for people with a learning disability or autism, a multidisciplinary approach was taken to best interests decisions. Treatment records showed evidence of informed consent and, where appropriate, assessment of capacity. In an acute hospital, audits had been carried out in wards. They recognised the importance of full completion of the

Footnote:

g Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

h Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

## **Better training leads to improvements**

One provider had made significant progress in implementing DoLS and the wider MCA since our last inspection. Previously, we had reported staff “not really knowing what it [DoLS] was”. When we re-inspected, we

found that training had been completed, assessments of people’s capacity to consent to necessary arrangements were being made, and authorisation was now appropriately sought from the local authority. The manager

in charge of the service said that the main driver for improvement in their handling of DoLS applications was the increased understanding across the service that they had fostered through training.

DoLS application forms, and a scoring system was used to motivate the team to ensure good practice.

Having clear policies and procedures in place helps to ensure that people consistently receive care that safeguards their rights, that their care is more reflective of their needs and wishes, and that their liberty is restricted only if it is necessary and proportionate.

### Good leadership

We found examples of DoLS and the MCA being implemented well where there was specific (often senior) staff with expertise driving change and ensuring staff engagement. Acute hospital trusts that did well tended to identify senior members of staff to lead and provide a focus to staff understanding of DoLS, and to improve its implementation. For example, one inspector highlighted a clinical lead in critical care with a particular interest in DoLS. This person

developed a bespoke management tool for critical care DoLS, in partnership with the trust's legal team and their professional body.

Leadership was often important for establishing good quality training and widespread organisational understanding. Inspectors described these trusts as likely to have a culture that valued staff being actively engaged, and understanding the needs of patients through the delivery of person-centred care.

We also saw some evidence of the importance of leadership in adult social care. In one provider, staff 'champions' received additional training in a range of areas such as mental capacity, and supported other staff to ensure best practice. In contrast, we found that the absence of a registered manager could lead to poor practice. We looked at a sample of services rated as inadequate for effectiveness, and found that many did not have a registered manager in post.

## Continuing variation

While we found examples of good practice in how DoLS and the wider MCA are applied, we also found examples of poor practice.

In acute hospital and mental health trusts, there was variation both between providers and within individual providers across the different core services that we inspect. While some core services showed good practice, others did not, suggesting that oversight across the trust was not consistent. Additionally, analysis indicated that some trusts, particularly large ones, may have variation in their practice across different locations. For example, a main site might

have a good grasp and application of DoLS, while other sites may not be meeting their obligations well.

In adult social care, training and staff understanding and documented use of advocates, were recorded more consistently in residential homes than in nursing homes. In contrast, good practice in best interests decision-making, involvement of family and other professionals in best interests decision-making, and reviews of DoLS assessments taking place when needed, were recorded more consistently in nursing homes than in residential homes.

### Exceptional with applications

Inspectors described one mental health hospital as "exceptionally" good with DoLS applications. The applications were individualised and comprehensive, with each one telling a story about the patient. The number of restrictive interventions had reduced dramatically in recent years, with lots of work having been done around restraints, medicines and seclusion. This was largely down to staff training and support.

### Followed on care journey

In one acute hospital, patients with a learning disability sometimes held a 'care passport'. They brought this into hospital with them to enable staff to have a greater understanding and insight into their choices, preferences and needs. The learning disability nurse would follow the patient through their care journey through the hospital, develop a care plan that included the use of advocacy, and make sure that mental capacity and consent were considered.



Specifically, there was variation in how well DoLS were being applied in the following areas.

### **Variation in levels of staff training and understanding**

There were some services in all sectors where staff showed good understanding of the DoLS and the wider MCA, and were clear about the procedures for applying them appropriately. However, there were many other services where training and staff understanding were not good enough.

In all sectors, we were more likely to see a higher level of training and understanding of DoLS in services rated overall as outstanding, compared with those rated inadequate.

With a small number of exceptions, staff working in the outstanding adult social care services understood DoLS and incorporated it in everyday practice. There was a very small minority of staff with an understanding of DoLS in services rated as inadequate. In adult social care, staff training in DoLS was much more widespread for the outstanding care homes in our sample, compared with the inadequate care homes we looked at.

### **Variable practice in how capacity assessments and best interests decision-making are carried out and documented**

In providers across all sectors, we found variable practice in the implementation of capacity assessments and best interests decision-making. While we have previously highlighted some appropriate practice, we have also found some areas of concern.

In particular, many providers made assumptions that individuals lacked capacity without having carried out or documented assessments, or they assessed individuals as lacking capacity without ensuring this was time and decision-specific. For some providers, the 'blanket' approach to capacity assessments suggested to our inspectors that their focus may be more on managing organisational risk than delivering person-centred care. Some providers also made blanket assumptions that individuals with particular conditions lacked capacity, such as people living with dementia.

There was also variation in the documentation of evidence of family and other professionals being involved in best interests decision-making. Evidence of MCA compliant

decision-making, including the involvement of family or friends, was recorded in a majority of care homes rated as outstanding overall, but only in a very small minority of those rated as inadequate overall.

### **Variable practice in the management of applications for authorisation to deprive a person of their liberty**

We know that many providers are applying for standard authorisations to deprive people of their liberty, and seeking urgent authorisations where needed. However, our inspection reports identified some continuing variable practice in how providers are managing these processes.

In some of our inspections, and also through our stakeholder engagement, we found evidence of different issues emerging, including some that we have highlighted in previous years:

- instances where individuals appear to potentially have been deprived of their liberty unlawfully – such as without the provider seeking authorisation to do so or where authorisations had expired
- providers taking a 'blanket approach' to authorisation applications, including submitting applications for individuals with capacity
- decisions about DoLS (including conditions of authorisations) not communicated appropriately (such as recording them in an individual's care plan) and/or complied with
- concerns about the use of urgent deprivation of liberty authorisations, including lack of understanding and continued use beyond their expiration dates
- authorisations not being kept under review.

For example, in one surgery ward of an acute hospital, the safeguarding office was unable to provide the relevant DoLS authorisation information about individual applications. Also, there was no formal way of checking if there were conditions attached to individual applications. This was identified as a significant risk to the organisation and it showed a disconnect between the safeguarding team and clinical staff. In such cases, this would result in the patient receiving poor care. Furthermore, it could mean people being restricted inappropriately and unlawfully.

We recognise that providers are experiencing challenges where the pressures being faced by local authorities delay the outcome of their applications.

However, this does not account for all of the issues noted above. Overall, these issues are concerning as they mean that some individuals may not be receiving care that is a less restrictive option and in their best interests – and, in some cases, that they are missing the opportunity for independent scrutiny and challenge to make sure this is the case.

Staff must always seek less restrictive options for individuals in their care, and be able to recognise where someone may be deprived of their liberty.

Where it is appropriate to deprive someone of their liberty and it is shown that the person does not have capacity for the relevant decision, providers must seek authorisation from the relevant local authority to make sure that there is independent scrutiny to protect people’s interests, and that the care they receive is the least restrictive possible. Information about authorisations and any associated conditions should also be clearly recorded and accessible to staff, to help ensure they treat people with their best interests.

## Learning from good practice to reduce variation

Overall, we saw some examples of good practice in implementing DoLS and the wider MCA in adult social care, mental health trusts and acute hospitals. Some providers that showed poor practice in their use of MCA/DoLS have made the necessary improvements to safeguard the rights and needs of people who use services.

However, there continues to be large variation in practice. There needs to be a greater effort to train staff on DoLS and how to use them effectively, as well as maintaining the right procedures and processes. This is critical for ensuring that people receive good quality care and treatment that is in their best interests, and that they are not deprived of their

liberty unlawfully. It is important that we make sure that everyone, irrespective of their mental capacity, can experience care that considers their needs and preferences. While there are significant challenges in the system, until reform takes place it is important that the current system is complied with to protect people’s interests, and to avoid compromising the quality of the care they receive.

We encourage providers to learn from those that have successfully delivered a person-centred approach. They should ensure there is good leadership that fosters a strong culture of the wider MCA and DoLS, and provides the support that staff need.

### Good management enables faith practice

A woman with strong religious beliefs was admitted to a care home. The home applied to the relevant local authority to deprive her of her liberty, in her best interests. This was authorised under DoLS.

While being deprived of her liberty, the woman had a strong desire to continue to practise her faith. The care home tried different options, consulting with a family member (who was also her Lasting Power of Attorney for health and welfare) to minimise the possible restrictions on her human rights,

despite the need for authorisation. However, the lady concerned was distressed by each option and did not find them suitable.

A best interests meeting was held to find a solution. A decision was made that attempted to minimise her anxiety about “strangers” taking her to church and that also gave her more freedom to live as she wished. The care home and the woman’s daughter involved the church community, and the lady is now picked up by the minister at the care home and taken to church for a communion service. She is

accompanied by a carer, who does not wear a uniform, reducing the likelihood of her being singled out among the congregation.

To minimise as far as possible restrictions on her human rights, the provider, together with her Lasting Power of Attorney for health and welfare, sought ways to enable her to attend her church as she wished to do. This has enabled her to continue to practise her faith as she wishes, has increased her happiness and has had a positive effect on her wellbeing.

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