Care Quality Commission

The state of health care and adult social care in England

2016/17

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STATE OF CARE

Contents

Foreword

This year's *State of Care* shows that the quality of health and social care has been maintained despite very real challenges. The majority of people are getting good, safe care, and many individual providers have been able to improve. However, future quality is precarious as the system struggles with increasingly complex demand, access and cost. The efforts of staff have largely ensured that quality of care has been maintained – but staff resilience is not inexhaustible, and some services have begun to deteriorate in quality.

With the complexity of demand increasing across all sectors, the entire health and social care system is at full stretch. The impact on people is particularly noticeable where sectors come together – or fail to come together, as the complex patchwork of health and social care strains at the seams: the teenager detained under the Mental Health Act because she's been unable to access the support she needs in the community; the elderly man unable to leave hospital because there's no home care package in place for him; the stroke victim waiting for an ambulance that's delayed because the crew are still waiting to get their previous patient into A&E.

Last year, we said that social care was approaching a 'tipping point' – a point where deterioration in quality would outpace improvement and there would be a substantial increase in people whose needs were not being met. We said this based on five pieces of evidence – on quality, bed numbers, market fragility, unmet need and local authority funding. What this year's report suggests is that while, in some areas of the country, care has moved further away from a tipping point, in other areas it has moved closer to that point.

The additional £2 billion made available by the Chancellor in the Spring budget was a welcome acknowledgement of the pressure the adult social care sector is under. What is now required is a long-term sustainable solution for the future funding and quality of adult social care. The future of care for older people and the adult care system is one of the greatest unresolved public policy issues of our time; the anticipated government green paper on adult social care will provide the opportunities for Parliament, the public and professionals to consider how we should collectively develop an appropriately funded social care system that can meet people's needs now and in the future.

There are other opportunities to address this fragmentation. In children and young people's mental health services, CQC's review is finding that a complex system, where care is planned, funded, commissioned, provided and overseen by many different organisations who do not always work together in a joined-up way, can result in situations where a child's mental health reaches crisis point before they get the help they need. And our report on the state of mental health services highlighted the high number of people isolated in locked mental health rehabilitation wards away from their friends and family. But the Five Year Forward View for Mental Health sets out a compelling vision for the future, and the forthcoming government green paper on child and adolescent mental health services and the review of the Mental Health Act provide a chance for genuinely transformational change to these important services.

The NHS is 70 years old next year. In its first year of existence, Aneurin Bevan voiced concerns about "the increasing demand made on our hospitals by the aged sick". Today, the system faces similar challenges – as it tries to meet the needs not only of older people, but people with increasingly complex conditions: diabetes, obesity, cancer and long-term degenerative conditions. The response to these challenges must be through personalisation of care, achieved through better coordination. We have seen excellent examples of services working together around the needs of people – often harnessing new innovations and technology – with positive results on outcomes, access and people's experience of care.

To deliver good, safe, sustainable care, more providers need to think beyond traditional boundaries to reflect the experience of the people they support. Leadership and support at all levels – system, organisation, service and practice – will be crucial. To truly coordinate care, local system leaders must

ensure there is a golden thread linking vision to delivery, so that everyone involved can not only share the vision but see themselves as part of the team that delivers it. And collaboration must happen not just between sectors but between local agencies and professionals, and be supported and incentivised by the national health and care organisations leading delivery at a regional and local level.

CQC will encourage the move towards coordinated care by increasingly reporting not just on the quality of care of individual providers, but on the quality of care across areas and coordination between these areas, reflecting how people access and experience this care.

Our findings will highlight what is working well and where there are opportunities for improving how the system works, enabling the sharing of good practice and identifying where additional support is needed to secure better outcomes for people using services. And we will continue to celebrate good care, support improvement, and take action to protect people where we need to.

This year's assessment of the quality of health and social care contains much that is encouraging – the fact that quality has been maintained in the toughest climate most can remember is testament to the hard work and dedication of staff and leaders. Many services that were previously rated as inadequate have recognised our inspection findings, made the necessary changes and improved. Safety continues to be a focus of our work, but we have also seen improvements where providers have clear systems and governance in place that enable learning and improvement from safety incidents, and where staff are encouraged to raise concerns.

A great deal has been achieved in exceptionally challenging circumstances. We must now build on this in order to realise a future where people receive a consistently good quality of care and are able to access that care when they need it – whether that's delivered in an acute hospital, a nursing home, a community mental health hospital, a GP surgery or a person's own home. We know that staff and leaders can't work any harder. Everybody's focus must now be on working more collaboratively – looking out, not just in – to create a sustainable and effective health and care system for the third decade of the 21st century.

Peter Wyman
Chair

Sir David Behan
Chief Executive

I am 78 years old.

I have hip and knee problems.

Sometimes I have difficulty remembering things.

I live alone and I want to stay independent as long as possible.

What happens if I have a fall?

UNMET NEED
1.2m
older people with unmet care needs – up from 1m last year

Keeping healthy at home

FALL

Alternatives to A&E
- GP or urgent care centre
- Rapid response team
- Care at home

- GP practices
- Community health care
- Care at home
- Unpaid carers

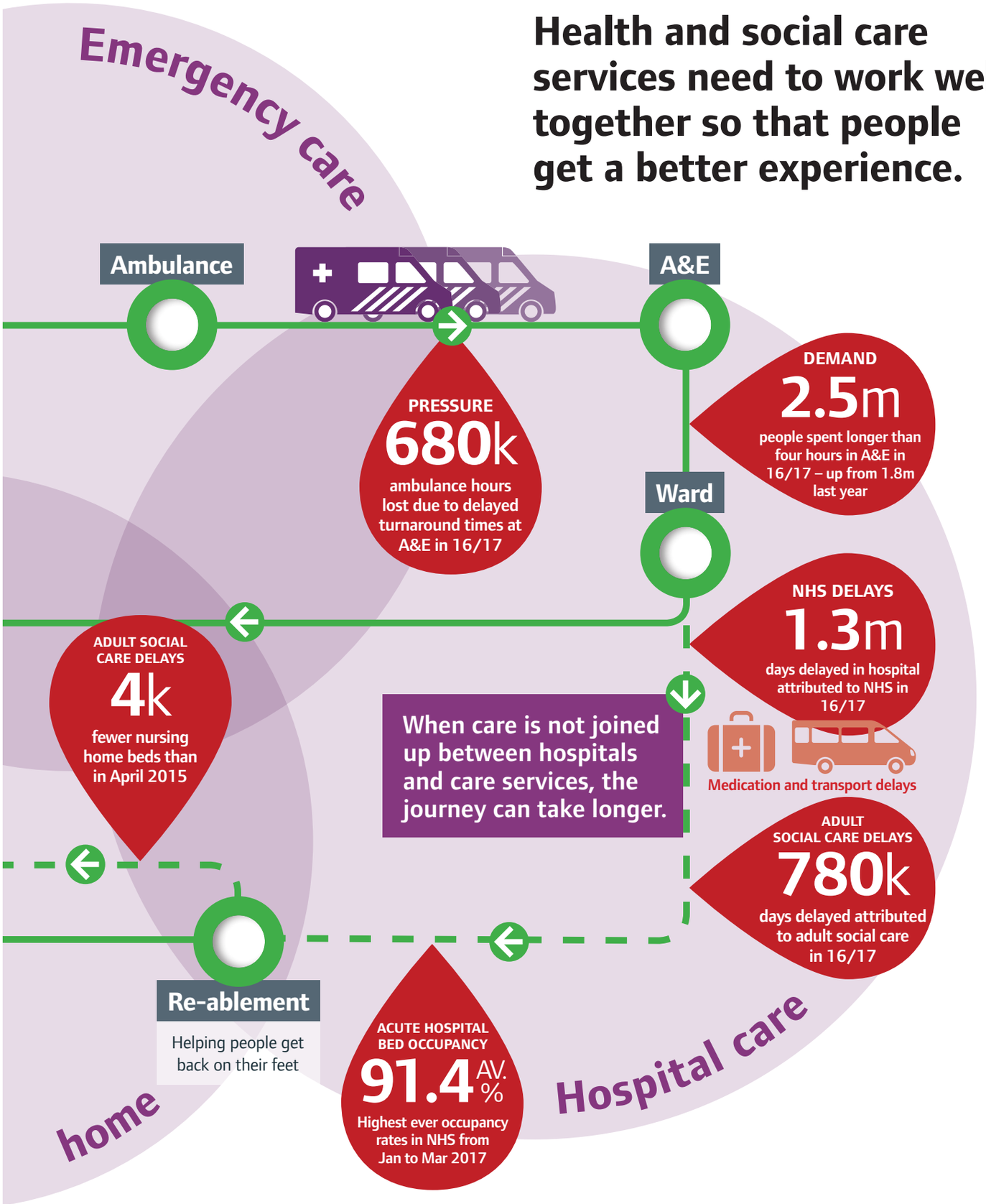
Care home

ADULT SOCAL CARE STAFFING
90k
staff vacancies across adult social care

Returning

- Urgent care centre?
- A&E?
- GP practice?
- Care home?
- NHS 111?
- Re-ablement?

Health and social care services need to work well together so that people get a better experience.



Summary

Health and care services are at full stretch

The complexity of demand for health care and adult social care services in England continues to rise. The number of people with complex, chronic or multiple conditions is increasing, including conditions such as diabetes, cancer, heart disease and dementia. We have an ageing population and we are living longer, and the total number of years people can expect to live in poorer health continues to rise.

These and other factors present different pressures in different parts of the system. Hospitals, for example, have seen substantial rises in the last five years in total attendance at accident and emergency (A&E) departments, in the overall number of emergency admissions to hospital via A&E, and in elective admissions to hospitals.

Within acute hospitals, bed occupancy has remained above the recommended maximum of 85% since at least the start of 2012/13; from January to March 2017, it was the highest ever recorded at an average of 91.4%. Ambulance calls have increased by 20% from 2011/12 to 2016/17.

At least half of adult mental ill-health starts in childhood and at least 10% of children aged five to 16 years have a diagnosable condition. Children and young people today face new emotional demands due to, for example, social media. Some of the experiences and behaviours that are treated as a mental health problem today may not have been considered in the same way two decades ago.

Bed occupancy levels for acute mental health wards remain high, and the total number of detentions under the Mental Health Act has risen by 20% in the last two years.

Delivering adult social care has become more challenging as more and more people need care. The number of people aged 85 or over in England is set to more than double over the next two decades. And there is growing unmet care need – estimates show that 1.2 million people are not receiving the help they need, an increase of 18% on last year.

Primary care workload is growing as a result of people's increasingly complex healthcare needs and the sector is responding by collaborating both across primary care and with other sectors, to ensure that people have the right access to services.

The burden on friends and family carers continues to increase too. Forty per cent of unpaid carers have not had a break in more than a year, while 25% have not received a single day away from caring in five years.

Care providers are under pressure and staff resilience is not inexhaustible

All health and care staff, and the services they work for, are under huge pressure. The combination of greater demand and unfilled vacancies means that staff are working ever harder to deliver the quality of care that people have a right to expect. However, there is a limit to their resilience.

There are fewer available beds in hospitals and people are waiting longer for treatment. Deterioration in the achievement of the four-hour emergency access target is a reflection of the severe pressures that acute hospitals face; it is no longer just a winter problem.

More people are talking openly about their mental health now, and seeking treatment – there has been a steady rise in the number of people in contact with mental health services over the last few years. At the same time, the number of psychiatric nurses has fallen by 12% in seven years.

More GPs are needed, but recruitment is a problem – in a sample of practices, 60% of their vacancies were reported vacant for more than three months from April to September 2016.

While the need for adult social care continues to rise, the number of beds in nursing homes has fallen by 4,000 in two years. There is wide variation in the regional distribution of these numbers, as adult social care providers respond to local pressures.

NHS trust finances remain under severe pressure. Trusts reported a reduced deficit at the end of 2016/17 compared with the previous year, but a recent report into NHS finances suggested that the underlying deficit remains substantial. In adult social care, long-term funding continues to be an obstacle to meeting demand, despite a much needed one-off extra £2 billion from government.

The quality of care across England is mostly good

Through our comprehensive inspection and ratings programme, we now have a baseline picture of the quality of health and adult social care in England. We have inspected and rated all registered health and adult social care services over a three-year period. The majority of the care that people receive is good, and there are providers and services that deliver outstanding care. Among the outstanding providers are 2% of adult social care services, 6% of NHS acute hospital and mental health core services, and 4% of GP practices.

But far too much care needs to improve. We rated 3% of NHS acute hospital core services, 2% of GP practices and 1% of adult social care and NHS mental health core services as inadequate at 31 July 2017. In addition, 37% of NHS acute core services were rated as requires improvement, as were 24% of NHS mental health core services, 19% of adult social care services and 6% of GP practices.

Quality has improved overall, but there is too much variation and some services have deteriorated

Hard work and determination from many providers and their staff has meant people are receiving safer, more effective, and compassionate and high-quality care – services have recognised our inspection findings and made the necessary changes to get better.

When re-inspected, services that were originally rated as inadequate have improved strongly: 82% of adult social care services originally rated as inadequate and re-inspected improved their rating, as did 80% of GP practices. Among NHS acute hospitals, 12 out of the 15 hospitals originally rated as inadequate and re-inspected improved. All of the nine NHS and independent mental health services originally rated as inadequate and re-inspected improved their rating. There was also positive movement, though not as strong, from requires improvement to good.

Throughout the year, CQC has shared examples of improvement in different parts of the system, identifying common factors among those that have succeeded. We often see patient-centred care at its best where there is strong leadership and a positive culture, but we have also pointed to where a shared vision and outward looking approach have been central to improvement. There were improvements for people when providers reached out to local communities and partners, involving patients and the public in shaping services, and collaborating with local groups.

While there has been much improvement, some services have deteriorated in quality. Where we have re-inspected providers originally rated as good overall, the majority have remained good. But 26% of mental health services and 23% of adult social care services dropped at least one rating, as did 18% of acute hospitals. Only 2% of GP practices deteriorated.

There are also substantial variations in the quality of care that people are receiving – within and between services in the same sector, between different sectors, and geographically. The impact on people is particularly felt where sectors should come together – we have seen how disconnections in parts of the system are creating real problems for people.

To put people first, there must be more local collaboration and joined-up care

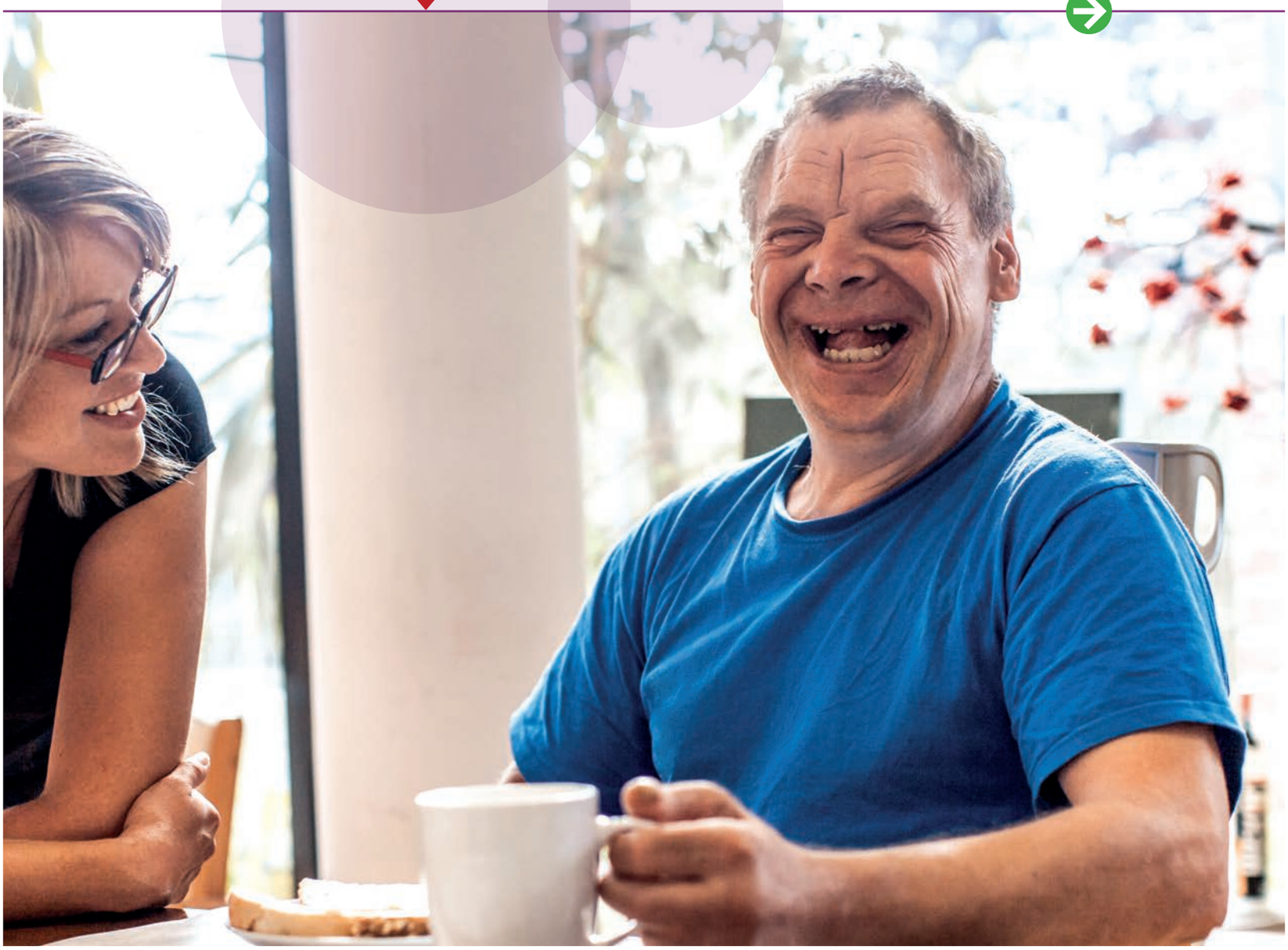
Better care is often where providers are working together to provide a more seamless service, one that is built around the often multiple, or complex, needs of individuals. We have found this where there is joined-up care – local health and care leaders collaborating to engage staff, people who use services and local partners to respond to the challenges they face.

There is wide variation in how health and social care systems join up. Some local systems are working together effectively to ensure people get the right care, while others struggle. Too many people receive fragmented care – care that is built around the priorities or targets of the services, rather than people's needs. To deliver good, safe, well-coordinated care that is sustainable into the future, providers will have to think beyond their traditional boundaries and reflect the experience of the people they support.

Technological innovation offers an opportunity to drive improvement in healthcare services, and to offer more convenient access for patients to advice, treatment and medicines. We actively support new ways of delivering care that are designed to improve the quality of care for people, provided they are implemented safely and responsibly. The challenge and opportunity for innovators is to embed safety in new ways of working and collaborating. Underpinning a culture of safety are good leadership at all levels, strong governance within the service and a culture of openness and transparency.

We found that services that did well had leaders who were enthusiastic and committed to equality, a culture of equality and human rights, and applied 'equality and human rights thinking' to quality improvement. These services worked with people and organisations from outside their own service, to develop both their thinking and their practice.

Working together leaders are finding new ways to deliver care. We can see from our inspections, as well as our work looking at quality of care in a place, that there are challenges for systems. But there are examples of high-quality care where patients are at the centre of care plans involving multiple local services. Innovative care providers are making a real difference for people, reaching out and working in a joined-up way with their local communities.



Introduction

This report sets out the Care Quality Commission's (CQC) assessment of the state of care in England in 2016/17. We use our inspections and ratings data, along with other information including that from people who use services, 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 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

We have now established a full picture of the quality of health and social care in England. We have completed our first programmes of inspections with ratings for all the sectors that we regulate.

We now have a baseline from which to draw conclusions about 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 has recently consulted 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.

Our data

To present as contemporary a picture of quality as possible, the data on inspections and ratings in this report are for CQC ratings published as at 31 July 2017. This covers:

- 21,256 adult social care services
- 152 NHS acute hospital trusts
- 197 independent acute hospitals
- 18 NHS community health trusts
- 54 NHS mental health trusts
- 226 independent mental health locations
- 10 NHS ambulance trusts
- 7,028 primary medical care services.

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

- Quantitative analysis of our inspection ratings of almost 29,000 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 15 focus groups with 80 CQC inspectors and inspection managers from across the adult social care, acute hospitals, mental health, and primary medical services directorates. A further three focus groups with 15 specialist CQC staff from the integrated care, corporate provider and registration teams were also analysed, along with several table-based discussions at a meeting of around 25 CQC relationship leads with the NHS Five Year Forward View new care model 'vanguard' providers. This included inspection managers, heads of inspection, strategy managers and other CQC colleagues with a special interest in integrated care. The groups and meetings took place during May and June 2017. Expert evidence was also received from NHS England and Healthwatch England.
- The analytical findings have been corroborated and in some cases supplemented with expert input from our Chief Inspectors, Deputy Chief Inspectors, specialist advisors and analysts 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 2017.

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, including a chapter on equality in health and social care and a chapter on the Deprivation of Liberty Safeguards.

Part 1

THE STATE OF CARE IN ENGLAND

1. A health and care system that is at full stretch

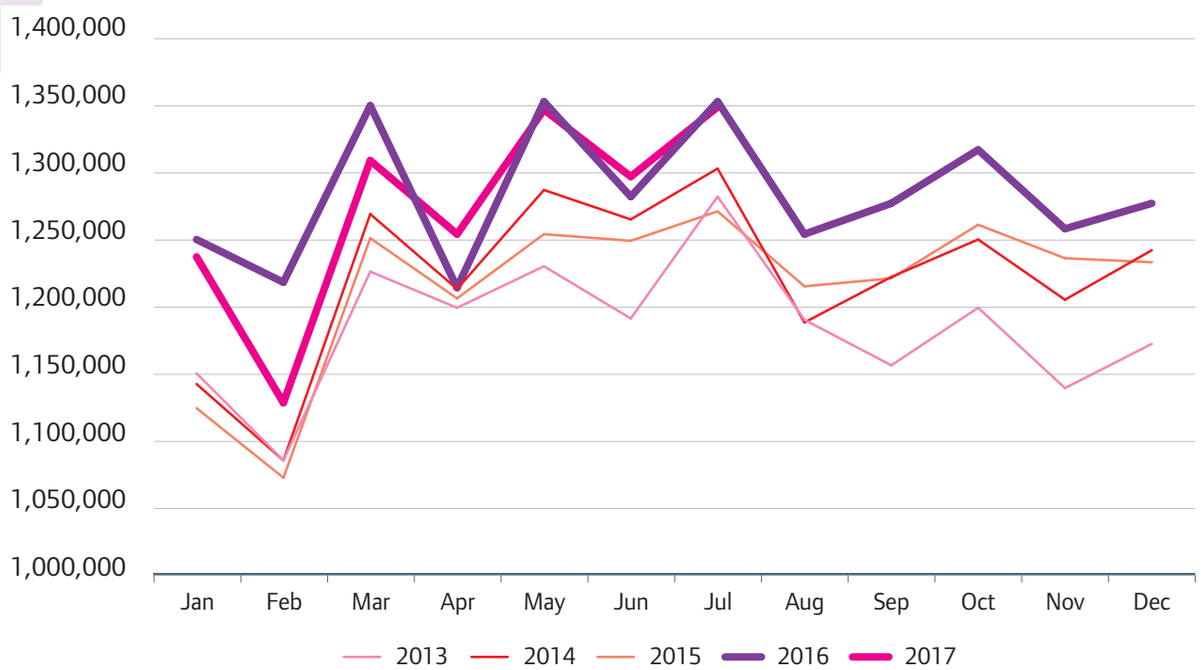
Complexity of demand for health and care services continues to rise

The complexity of demand for health care and adult social care services in England continues its onward rise. England has an ageing population: the number of people aged 65 and over is projected to increase in all regions of England by an average of 20% between mid-2014 and mid-2024.[1]

The number of people with complex, chronic or multiple conditions is increasing, including conditions such as diabetes, cancer, heart disease and dementia, which presents an enormous challenge to all care services. For example the total number of people with dementia in England is projected to reach one million by 2027, and continue rising, reaching 1.75 million by 2050.[2] The demand for care is changing shape: for example, where once operations such as hip replacements may have been straightforward, now they may be complicated by the increasing prevalence of dementia, and talking therapies for people with mental health needs are now much more in demand.

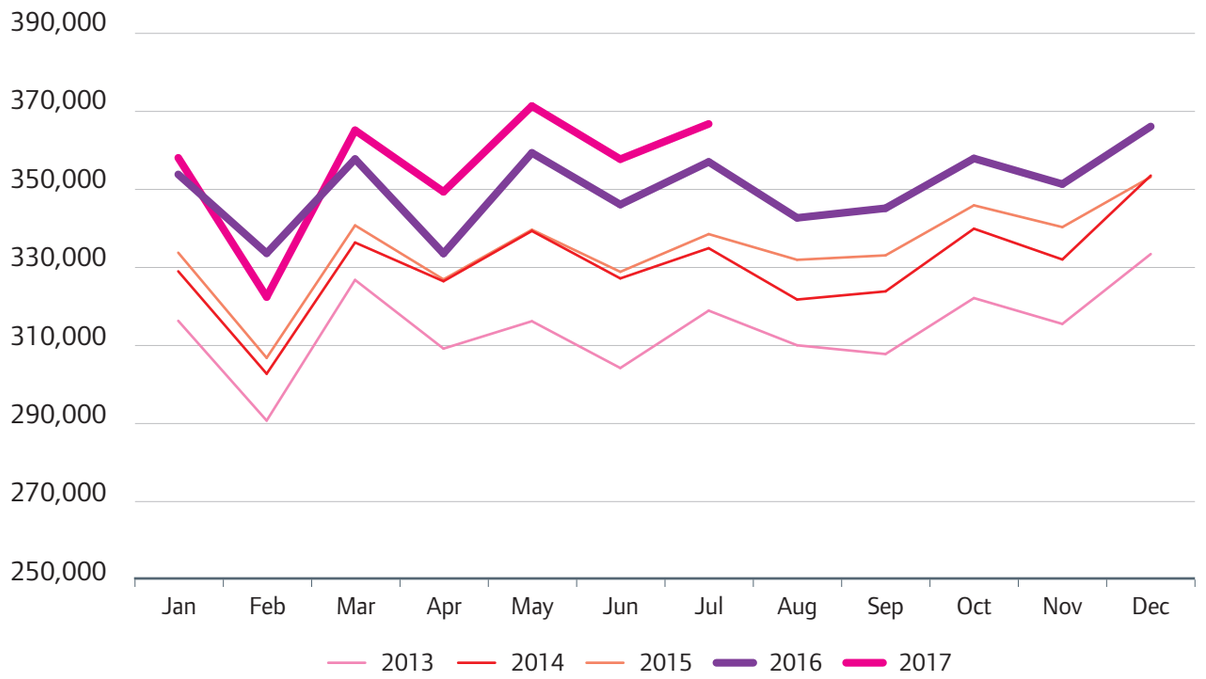
We are living longer lives, with life expectancy at birth having risen between 2009-11 and 2013-15 to 79 years for men and 83 years for women. However, over the same period, the proportion of years we can expect to live in good health has fallen slightly from 79.9% to 79.7% for men and from 77.4% to 77.1% for women. This adds to pressure on health and social care services, because the total number of years that people can expect to live in poorer health continues to rise.[3]

Figure 1.1 Monthly attendances at major A&E departments, 2013 to 2017



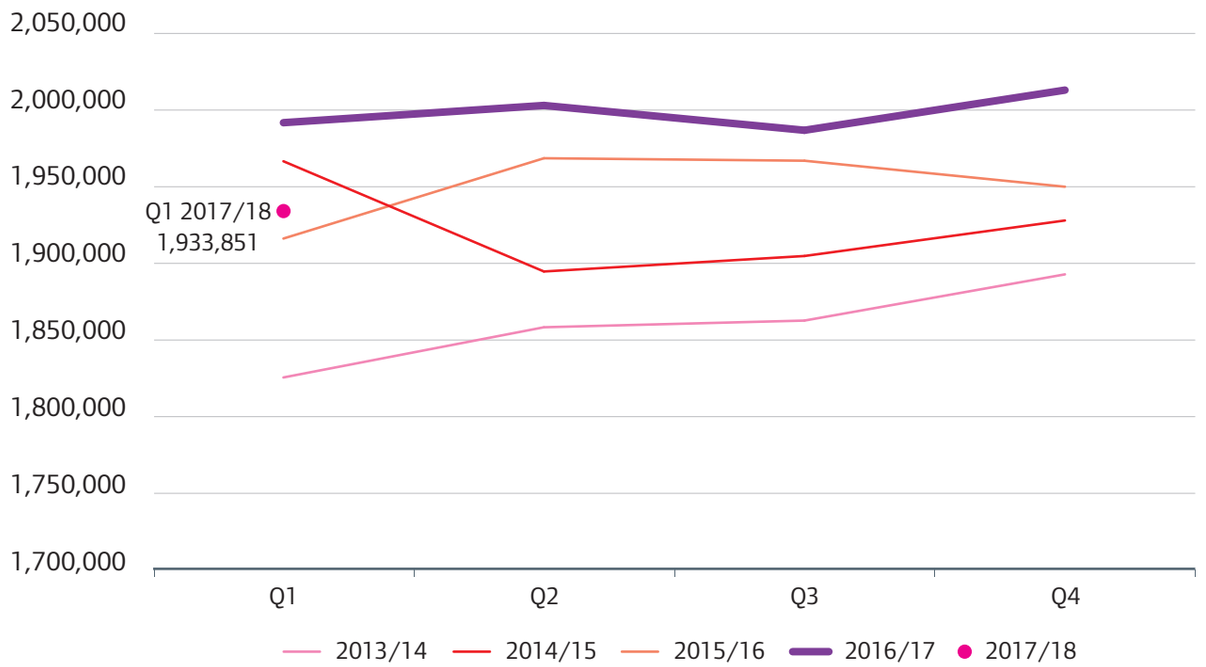
Source: NHS England, A&E attendances and emergency admissions statistics.

Figure 1.2 Monthly emergency admissions via major A&E departments, 2013 to 2017



Source: NHS England, A&E attendances and emergency admissions statistics.

Figure 1.3 Quarterly elective admissions to NHS acute hospitals, 2013/14 to 2017/18



Source: NHS England.

Hospital care

We can see this pressure in the number of people attending hospital. Total attendance at accident and emergency (A&E) departments, the overall number of emergency admissions to hospital via A&E, and elective admissions to hospitals – all have risen substantially in the last five years (figures 1.1 to 1.3). There has been no let-up in 2017, with the numbers in some cases higher than ever. Ambulance calls have also increased substantially, from 8.2 million to 9.8 million from 2011/12 to 2016/17, an increase of 20%.[4]

Mental health care

Mental health has never had a higher profile. The demand for mental health services is widespread and increasing. More people are talking openly about their mental health now and seeking treatment. At any one time, one in six adults will be experiencing a diagnosable mental health condition.[5]

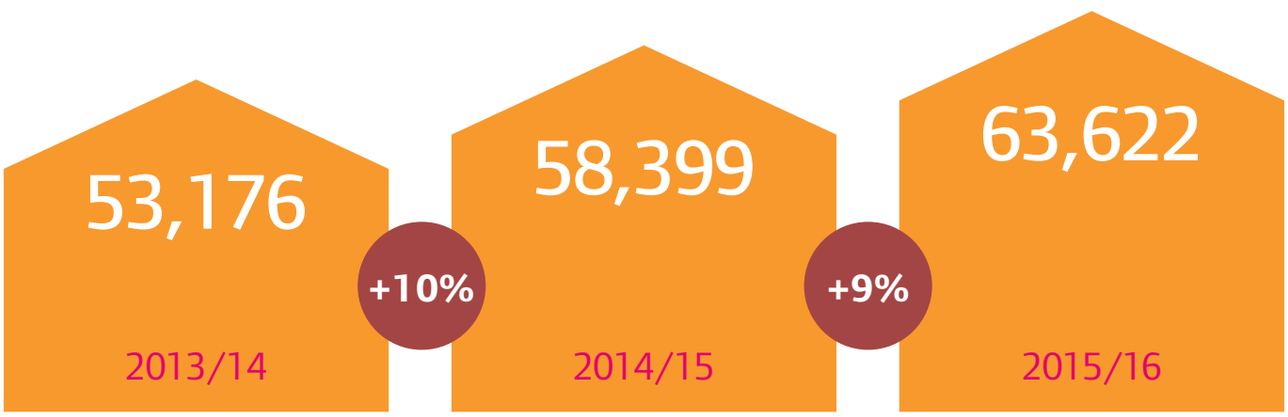
At least half of adult mental ill-health starts in childhood and at least 10% of children aged five to 16 years have a diagnosable condition.[6] Children and young people today face new emotional demands due to, for example, social media.

Some of the experiences and behaviours that are treated as a mental health problem today may not have been considered in the same way two decades ago. Greater awareness of mental health conditions, a reduction in the stigma of mental health, and a growing expectation that positive mental health be viewed as a asset mean that more children, young people, their families and carers seek help for mental health problems.

Although the majority of people with mental health conditions are supported and treated by primary care services or by IAPT (improving access to psychological therapies) services, an estimated 1.8 million people were in contact with adult mental health and learning disability services at some point in 2015/16. This equates to about 3.4% of the adult population in England.[7] As people live longer, so more people will need mental health care – in 2015/16, 13% of those aged 80 to 89 and 20% of those aged 90 and over were in contact with mental health services.

There has been a steady rise in the number of people in contact with mental health services over the last few years. Although the number of people admitted has remained stable, the total number of detentions each year under the Mental Health Act rose by 20% in the last two years, from 53,176 in 2013/14 to 63,622 in 2015/16 (figure 1.4).[8]

Figure 1.4 Number of detentions under the Mental Health Act, 2013/14 to 2015/16



Source: NHS Digital, Inpatients Detained in hospitals under the Mental Health Act 1983.

Adult social care

Delivering adult social care is becoming more challenging, as more and more people need care – for example, the demand for care from older people continues to rise:

- The number of people aged 85 or over in England is set to more than double over the next two decades.[9]
- More than a third of people aged over 85 have difficulties carrying out five or more tasks of daily living without assistance, and are therefore most likely to need health and care services.[10]

Furthermore, there is also a significant amount of unmet care need – estimates suggest that 1.2 million people are not receiving the help they need (one in eight older people). This has increased by 18% since last year and is a 48% increase since 2010.[11] This unmet need clearly has the potential to translate into further pressure on services at a future date, when people's needs become more serious.

Primary care

Primary care workload is continuing to grow. From 2013 to 2016, the population of England rose by 3%.[12] In its report on pressures in general practice, the King's Fund reported that the number of consultations in a sample of practices grew by more than 15% between 2010/11 and 2014/15, and that many GPs are choosing to retire early or work part-time. [13]

It is not just in GP surgeries that demand for health care is growing. People in prisons and other custodial settings are in vulnerable situations and need access to good quality health care. The numbers of prisoners over the age of 50 almost trebled from more than 4,800 in 2002 to almost 12,600 in 2016.[14] An ageing prison population creates increasing pressures on healthcare staff and resources, as older prisoners display higher and earlier rates of chronic illness than in the general population.[15]

The number of adults and young people who use illegal substances in custodial settings is also growing, as is the number of those with mental health conditions. The use of psychoactive substances such as 'spice' in some prisons has a significant impact on the health and wellbeing of prisoners, and potentially staff.

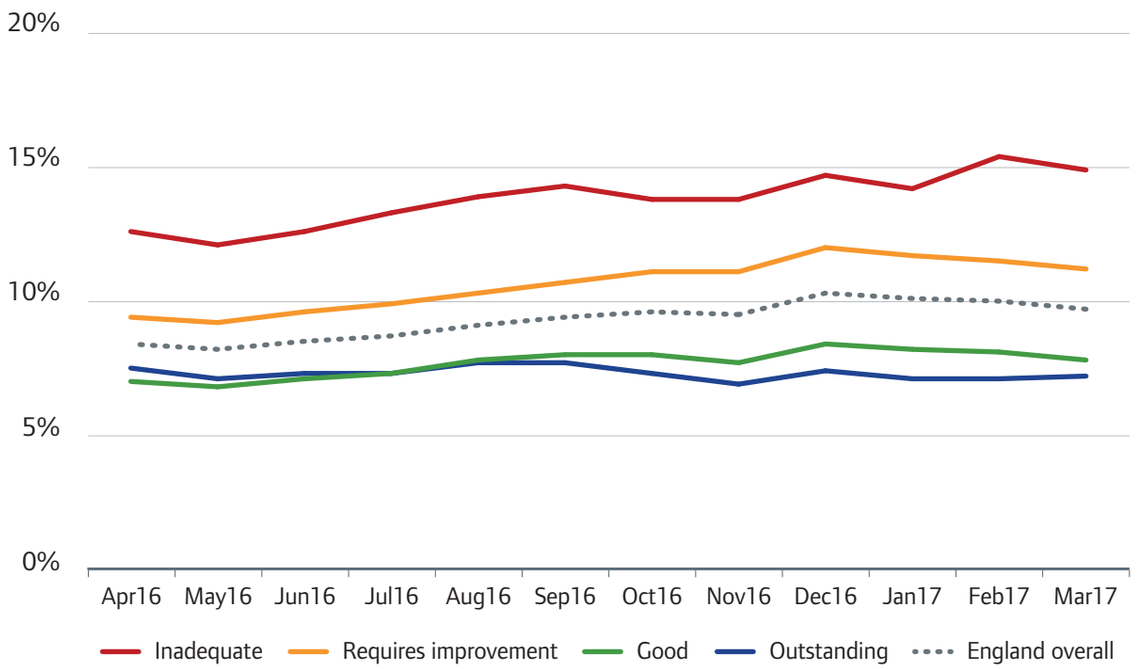
Carers

The burden on carers continues to increase too, and this has the potential to add further demand on health and social care services. In its annual *State of Caring*, Carers UK this year reported that carers who had not had a break in a year or more reported a deterioration in their health, both mentally (73%) and physically (65%).[16]

It said that carers are reaching 'breaking point' as they struggled to take even a day away from care responsibilities. Forty per cent of unpaid carers had not had a break in more than a year, while 25% had not received a single day away from caring in five years.

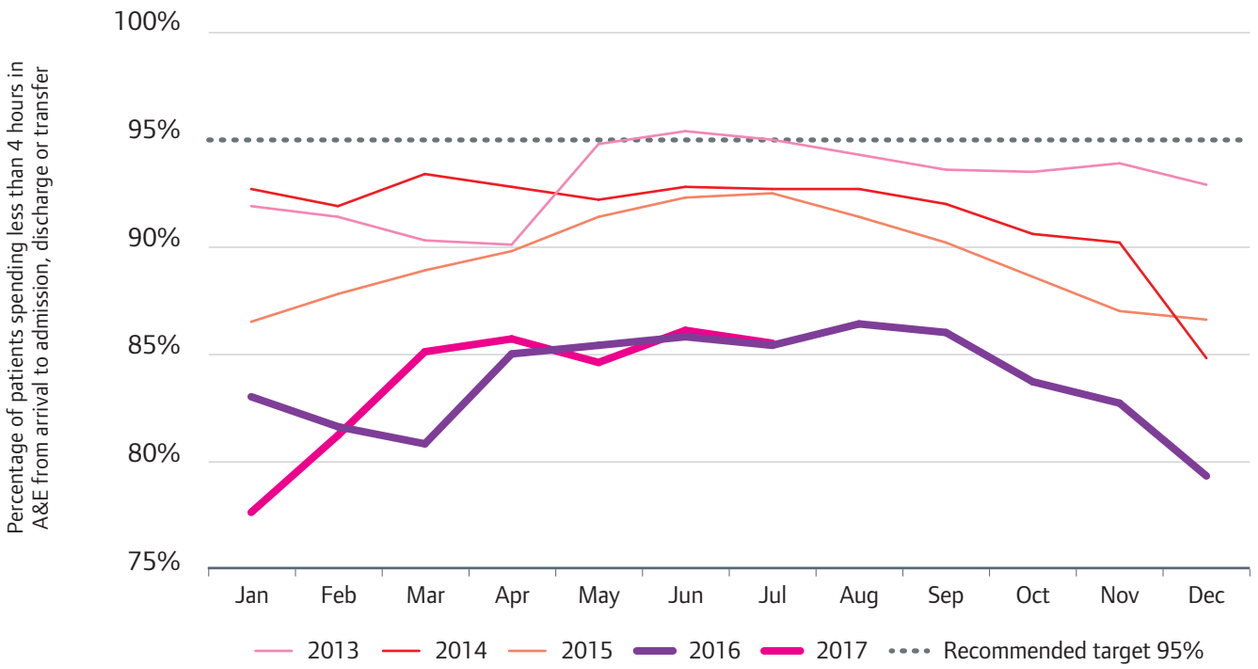
Carers most frequently listed access to breaks as one of three factors that could make a difference in their lives. Yet few were able to take regular breaks, with only 16% of carers currently buying or receiving a break from caring in the form of services such as respite or alternative care provisions.

Figure 1.5 Percentage of patients waiting longer than 18 weeks for treatment from referral by trust overall rating, 2016/17



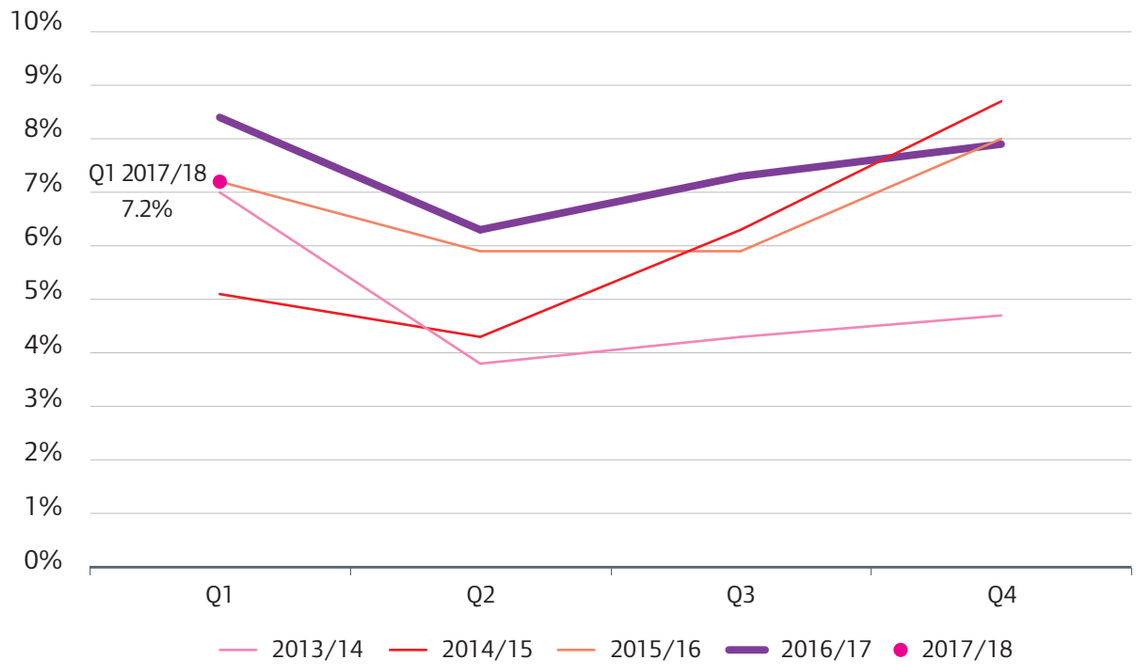
Source: NHS England: monthly referral to treatment times for incomplete pathways, CQC ratings data at 31 July 2017.

Figure 1.6 Performance against the 4 hour A&E target, 2013 to 2017



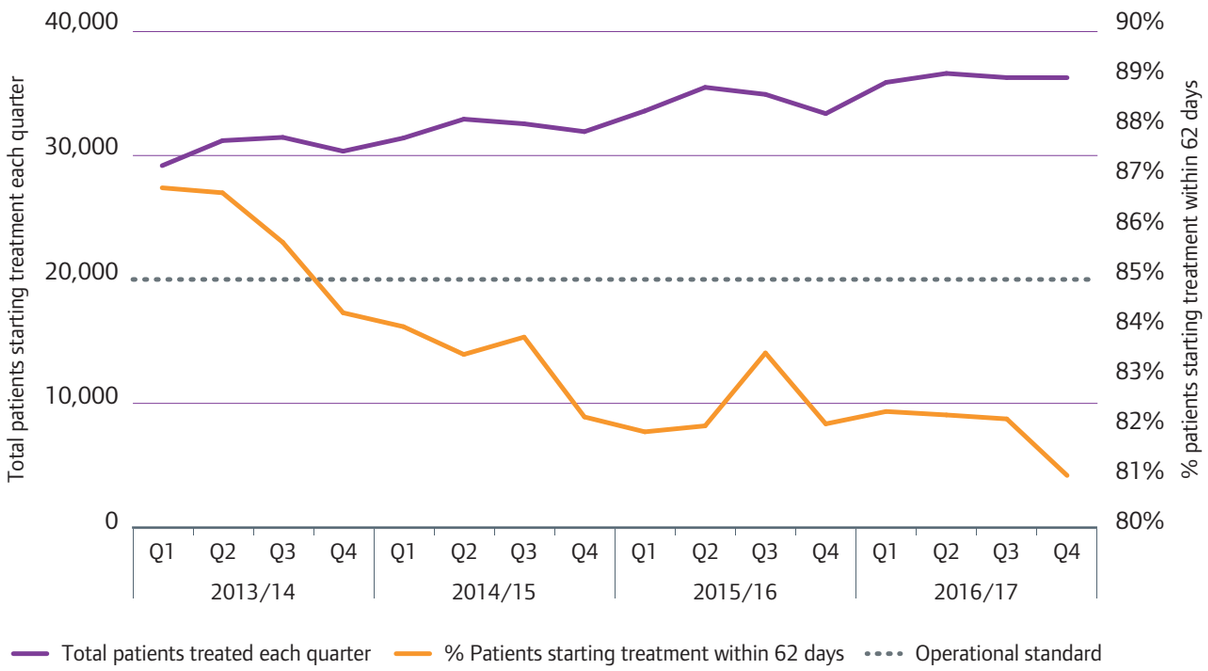
Source: NHS England, A&E attendances and emergency admissions statistics.

Figure 1.7 Percentage of patients not treated within 28 days of a cancellation of an operation, 2013/14 to 2017/18



Source: NHS England, Cancelled elective operations.

Figure 1.8 Wait for first cancer treatment following GP referral, 2013/14 to 2016/17



Source: NHS England, cancer waiting times statistics.

Ability to meet this demand is under severe pressure

Hospital care

While demand for hospital care has been rising so strongly, the number of hospital beds has been gradually reducing. From the last quarter of 2010/11 to the last quarter of 2016/17, decisions to admit rose by 16% while available beds fell by 8%. This balance was achieved by hospitals being able to reduce the length of time that people spent in hospital, but there are signs that this improvement in efficiency has begun to slow down.[17] NHS Digital has suggested that the scope for further reductions in average length of stay may be limited.

In acute hospitals, bed occupancy has remained above the recommended maximum of 85% since at least the start of 2012/13. From January to March 2017, it was the highest ever recorded at an average of 91.4%.[18]

Figure 1.5 shows that those trusts rated as good or outstanding were better able to manage capacity within their hospitals to ensure that as many patients as possible would be seen within the target of 18-weeks between referral from a GP for treatment and the start of that treatment.

In hospitals, the pressures are having a substantial impact on people trying to get treatment – for example, people increasingly wait more than four hours in A&E (figure 1.6); and when planned operations are cancelled (a figure that itself is increasing), people are waiting longer to be treated following the cancellation (figure 1.7).

Deterioration in the achievement of the four-hour emergency access target is a reflection of the severe pressures that acute hospitals face. As figure 1.6 shows, this is no longer just a winter problem. Our inspections have shown that many hospitals could do more to improve the flow of patients through their beds and their four-hour performance, but they must also ensure that the safety and quality of care for patients in their emergency department is protected when it is under pressure. Services that manage these well have high-quality, effective clinical leadership within the department, and strong support from the remainder of the hospital and the wider health and social care system.

In cancer treatment, there has been a fairly steady increase in the total number of people being treated for cancer following a GP referral, but they are having to wait longer for treatment. At the start of 2013/14, around 29,000 people per quarter were being treated for cancer, and 87% of these were getting their first treatment within two months. By the end of 2016/17, the number of people being treated had risen to around 36,000 per quarter, but the proportion of people getting that treatment within two months has dropped to 81% (figure 1.8).

NHS trust finances remain under severe pressure. NHS Improvement reported a total deficit for NHS trusts at the end of 2016/17 of £791 million, down from £2.4 billion at the end of 2015/16.[19] However, a Nuffield Trust report into NHS finances suggested that this was influenced by non-recurrent factors and that the underlying deficit remains substantial, despite trusts making extensive efficiency savings in year.[20]

They calculated the underlying deficit to be £3.7 billion in 2016/17, compared with £4.3 billion in 2015/16. At the time of that analysis, the Department of Health reiterated that the government continues to invest in the NHS and said that the scale of the investment is in line with other European countries.

Mental health care

The government has made mental health care a national priority. The Five Year Forward View for Mental Health, published last year, points the way to a future where people have easy access to high-quality care close to home, and they are able to exercise choice. However, there are a number of significant pressures and challenges on providers of mental health services. Bed occupancy levels for acute admission wards remain high: occupancy in NHS services was 89% in the three months to 31 March 2017.[21]

Because of the high threshold for admission, only those people who need intensive treatment and care are admitted to a mental health ward. And because of high demand, many people referred for specialised mental health treatment in community settings face long waits.

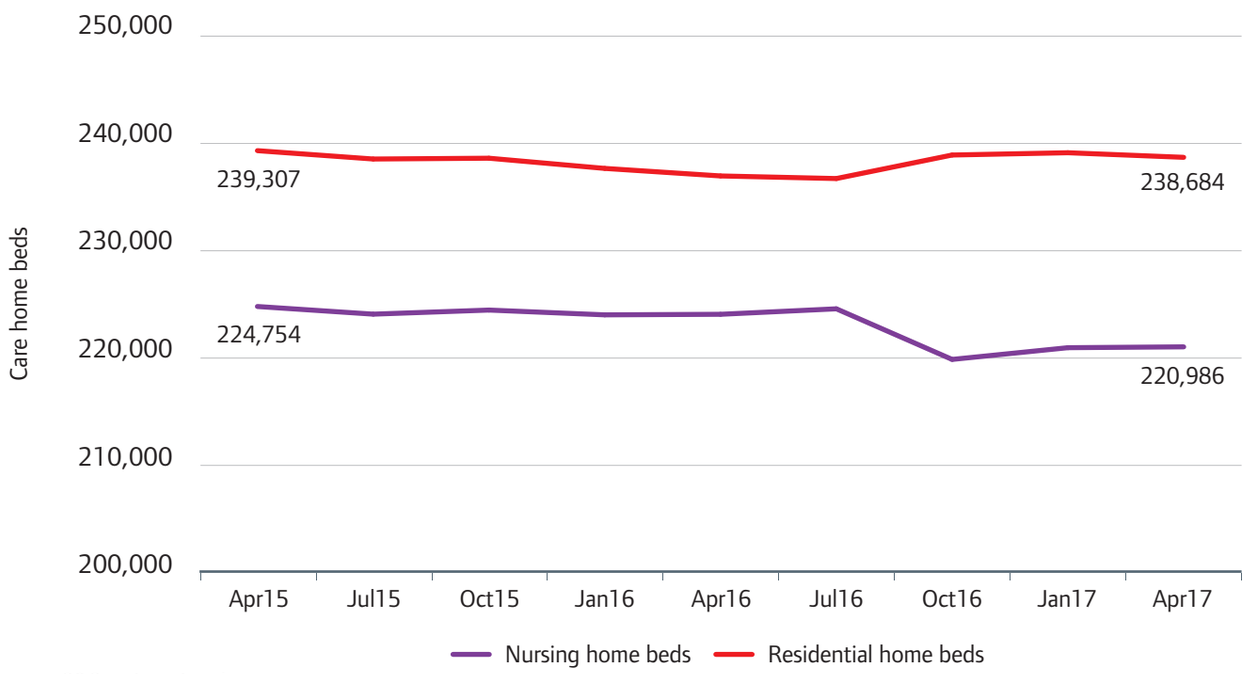
Data from the NHS Benchmarking Network shows there are particularly long waiting times for NHS eating disorder services, with 27% of people waiting 11 weeks or more in 2015/16, and for NHS memory services, with 42% of people waiting for 11 weeks or more for second appointments in that year. In addition, there has been a substantial increase in the maximum waiting times for routine appointments for children's and young people's community services in the NHS. The maximum wait for an appointment has risen from 11 weeks in 2012/13 to 26 weeks in 2015/16.

The high and perhaps growing demand for mental health care has been accompanied by a steady decline in the number of NHS mental health nurses. From January 2010 to January 2017, the number of psychiatry nurses (full-time equivalent) fell by 12% (from 40,719 to 35,845). During this period there has been an increase in the number of full-time equivalent community psychiatry nurses, but this has not been enough to prevent the total number declining.

The pressure on beds, and inability of community services to provide an alternative to admission, mean that too many people with mental health conditions are admitted to acute wards or psychiatric intensive care units some distance from their homes

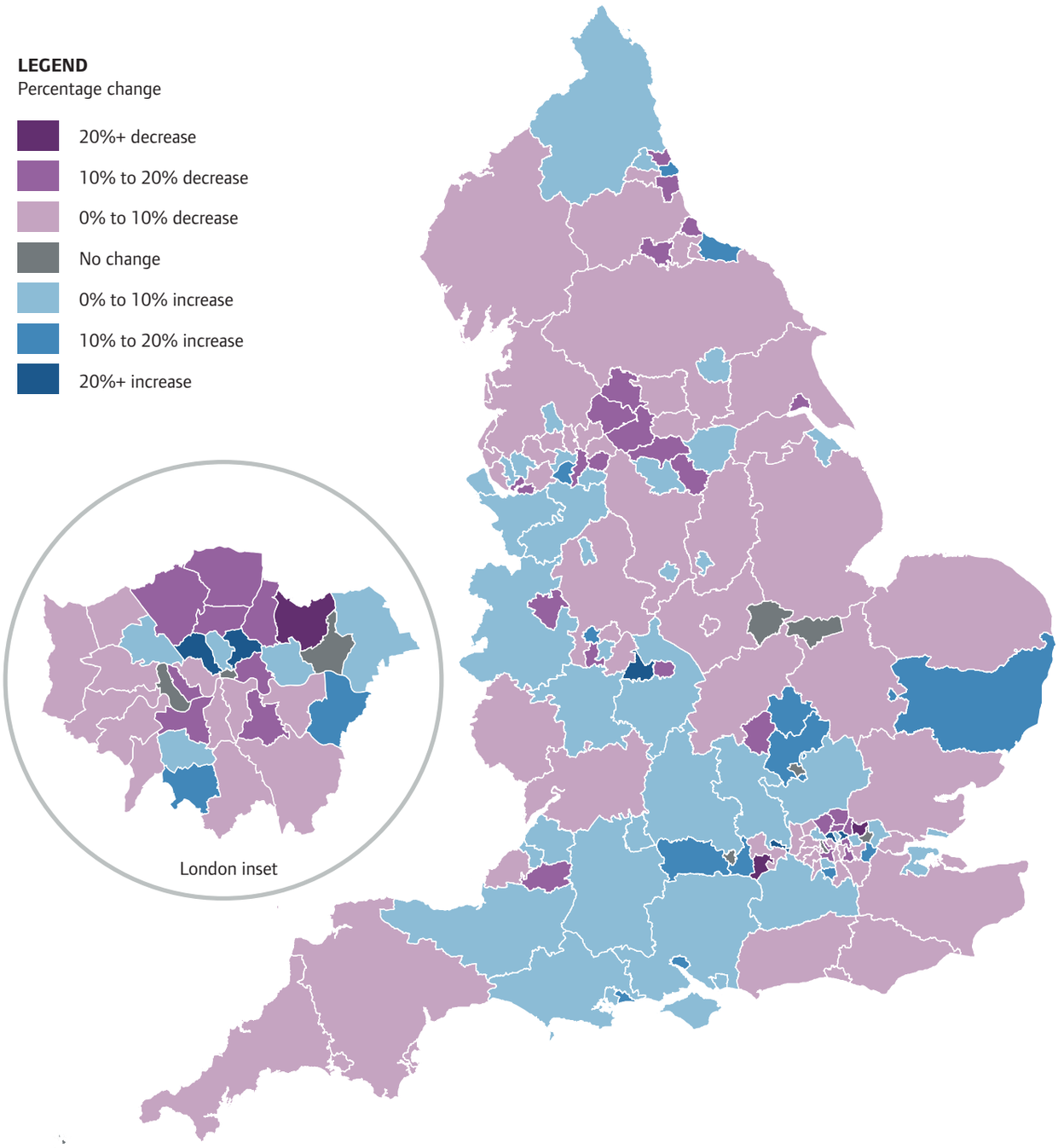
To achieve the vision set out in the Five Year Forward View for Mental Health, the sector must overcome an unprecedented set of challenges – high demand, workforce shortages, unsuitable buildings and poor clinical information systems. Some services remain rooted in the past – providing care that is over-restrictive and that is not tailored to each person's individual needs. But the best services are looking to the future by working in partnership with the people whose care they deliver, empowering their staff and looking for opportunities to work with other parts of the health and care system.

Figure 1.9 Numbers of beds in registered nursing and residential homes, April 2015 to April 2017



Source: CQC registration data

Figure 1.10 Percentage change in number of nursing home beds, April 2015 to April 2017



Source: CQC registration data.

Adult social care

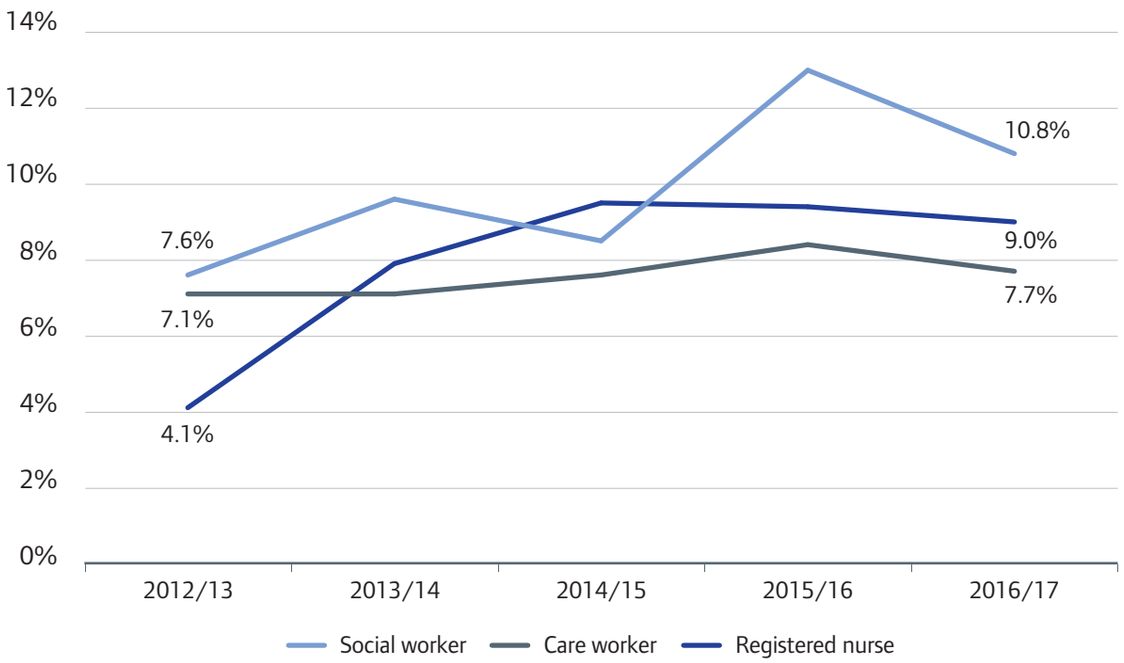
While the need for adult social care continues to rise, there were almost 4,000 fewer beds in nursing homes in March 2017 than there were in March 2015 (figure 1.9) – a reduction of 2%. There is wide variation in the regional distribution of these numbers as adult social care providers respond to local pressures (figure 1.10). In a small number of areas, the number of nursing home beds has fallen by more than 20%; in others, the number of beds has increased.

In domiciliary care, the volume of local authority funded care has decreased, due to ever tightening eligibility criteria.[22] Furthermore, there is substantial churn in the provision of domiciliary care, with around 500 agencies registering with us each quarter and around 400 deregistering. We have found that a rising number of agencies are deregistering with us not long after registering, and before being inspected, which implies that they never provided any care to people during the time they were registered. This not only adds to uncertainty for the sector as a whole, but the lack of continuity of care deeply affects and worries people using the service.

The additional £2 billion funding for adult social care announced in March 2017 was very much welcomed by the sector. However, concerns about the rising cost of adult social care and its funding have continued. Findings from the most recent Association of Directors of Adult Social Services (ADASS) budget survey have estimated that the National Living Wage will cost councils around £151 million plus at least £227.5 million in implementation and associated costs in 2017/18 – around a third of the £1 billion that made up the first tranche of the additional funding (the second £1 billion applies across 2018/19 and 2019/20).[23]

Directors of adult social services said in the survey that pressures from the NHS are increasing and the Better Care Fund (BCF) is not providing the additional resource that social care requires. Although there is an increase in the money provided by the BCF, ADASS argues that it provides no more resources in real terms (79% was spent on preventing cuts

Figure 1.11 Adult social care staff vacancy rates, 2012/13 to 2016/17



Source: Skills for Care, The state of the adult social care sector and workforce in England 2017.

to services) than the NHS transfer to social care in 2014/15. ADASS reports a gross budget for adult social care in 2016/17 of £19.7 billion, up from £19.6 billion in 2015/16.

There is continued uncertainty over extra money the social care sector may need to find to cover 'sleep-in' payments in the home of the person they are caring for. The government is currently considering how to resolve this issue. Meanwhile, providers are also concerned about potential sleep-in back-payments they may need to make, potentially backdated over a number of years. This is affecting provider confidence at a time when the sector requires stability.[24]

In addition, there are now increased costs relating to delayed transfers of care, with fines being applied on some local authorities by NHS trusts and clinical commissioning groups under the Care Act 2014. In their 2017 budget survey, ADASS said that 15.5% of local authority respondents reported that fines were levied for delayed transfers of care, and 7.7% reported that an intention had been expressed. This is introducing tension in the relationship between some local authorities and NHS trusts at a time when the focus should be on working together.

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.[25]

Age UK estimates that an additional £4.8 billion a year is needed to ensure that every older person who currently has one or more unmet needs has access to social care, rising to £5.75 billion by 2020/21.[26]

Primary care

While the number of GPs has continued to rise, we have seen that due to increases in part-time working and rises in the population, there are now fewer GPs per head of the population. After reaching a peak of 69 full-time equivalent GPs per 100,000 people in 2009, it levelled out at around 67 until 2014, after which it fell to 63 in 2015 and 62 in 2016.[27] Without enough GPs to meet the growing demand, there is increasing pressure on general practice to manage patients' expectations about access to a consultation with a GP.

There is a downward trend in the number of partner GPs in the UK, with a 400% increase in the number of salaried GPs from 2003 to 2012.[28] This could be the result of the increasing pressures associated with running a practice – either as an individual or as a partnership model, as well as a desire to control individual workload. It could be a choice by younger GPs who wish to practice medicine without these additional responsibilities.

The pressures on the criminal justice system mean that, for people in prisons, their health outcomes can be affected by limited access to services because of controlled prison regimes and levels of staffing. For example, we have found that where the use of 'spice' in prisons is most prolific, healthcare staff are frequently diverted from delivering routine care and treatment to patients because they are dealing with medical emergencies caused by its use.

In addition, the Prison Reform Trust has reported that overstretched prisons are struggling to meet the needs of the high numbers of people in their care with a mental health condition. They highlight that 25% of women and 15% of men in prison have symptoms indicative of psychosis, compared with 4% of the general population; and 49% of women and 23% of men in prison are identified as suffering from both anxiety and depression, compared with 15% of the general population.[29]

Staffing and recruitment

All health and care sectors are facing great challenges in recruiting and retaining staff. Inevitably this leads to situations where different services are competing with each other to recruit from the same pool of skilled and qualified staff.

In adult social care, vacancy rates remain high but appear to have stabilised or even improved slightly since 2015/16, before which rates had been rising steadily. These patterns are reflected in the vacancy trends of care workers and registered nurses (figure 1.11). Across all roles, Skills for Care estimates that there are currently 90,000 vacancies at any one time. Domiciliary care agencies continue to report higher vacancy rates than care homes.[30]

Skills for Care also highlighted similar patterns in staff turnover rates. In the local authority sector, the turnover rate across adult social care services has increased from 11.7% in 2012/13 to 14.6% in 2016/17. The independent sector has recorded higher levels and increases in turnover rates, rising from 24.6% to 29.0% during the same period.

Experimental data from NHS Digital shows that, for a sample of GP practices, 60% of their vacancies had been vacant for more than three months from April to September 2016, compared with 54% for the same period in 2015.[31]

NHS Jobs vacancy data showed that the number of vacancies across all NHS settings increased by 16% from March 2015 to March 2017 (during a period when the total number of FTE posts went up by 4%). In the same period, the number of nursing and midwifery vacancies rose by 22% and medical and dental vacancies by 40% (while the number of FTE posts in those roles rose by 1% and 3% respectively). [32]

The Five Year Forward View for Mental Health set out an aim to recruit to an additional 21,000 posts by 2020. Health Education England have published figures on current vacancies in mental health trusts that show high levels of vacancies across all staff types and a total vacancy rate of 9%.[33]

The effect of Brexit is as yet unclear but it is likely to impact further on staff recruitment. Skills for Care data shows that 6% of adult social care staff are from the European Economic Area (EEA); this ranges from 1% in the North East to 10% in London and the South East.[34] In September 2016, 5% of GPs in London were from EEA countries.[35] London also has the highest NHS dependency on EU staff, with around 10% of staff. The Health Foundation reported earlier this year that the number of nurses from the EU registering to work in the UK had dropped by 96% between July 2016 and April 2017.[36]

These staff shortages mean that staff have to work under great pressure to deliver the quality of care that people have a right to expect. Despite the challenges they face, our ratings show that the vast majority of health and adult social care services are very caring – this is testament to the dedication, compassion and respect for people that staff bring to their work, day in day out.

In 2017 this was evident to anyone who witnessed the remarkable response of so many health and social care staff in the wake of the fire at Grenfell Tower in London, and the terrorist incidents at Manchester Arena and London Bridge.

Are we nearer to the tipping point?

In last year's *State of Care* report, we said that social care was approaching a tipping point – a point where deterioration in quality would outpace improvement and there would be a significant increase in people whose needs weren't being met. We said this based on five pieces of evidence – on quality, bed numbers, market fragility, unmet need and local authority funding – from our own inspections and external data.

One year on, the overall picture remains precarious, with no long-term solution yet in sight. Demand for care is still increasing through an ageing population with increasingly complex health conditions.

At the same time, the capacity of the adult social care sector continues to shrink, with fewer nursing home beds in particular available. Furthermore, more people are having to go without paid care and support at all.

The additional £2 billion made available through the Better Care Fund has been welcome. How well local areas work together to use this money will be a good indication of whether the people in that area can expect care that is organised around their needs or not. In the 2017 ADASS Budget Survey, 79% of the directors of adult social care that responded believed that providers are facing financial difficulty in 2017/18.[37] This shows the imperative for a sustainable long-term solution to the issue of social care funding.

Overall, care services are continuing to improve their quality of care, as seen in the ratings we award, but services rated as good are beginning to deteriorate in quality as well and this suggests that improvements may be difficult to sustain.

Locally there is variation in how local systems are responding to the challenge of collectively matching capacity to need services, and this in turn impacts on people differently.

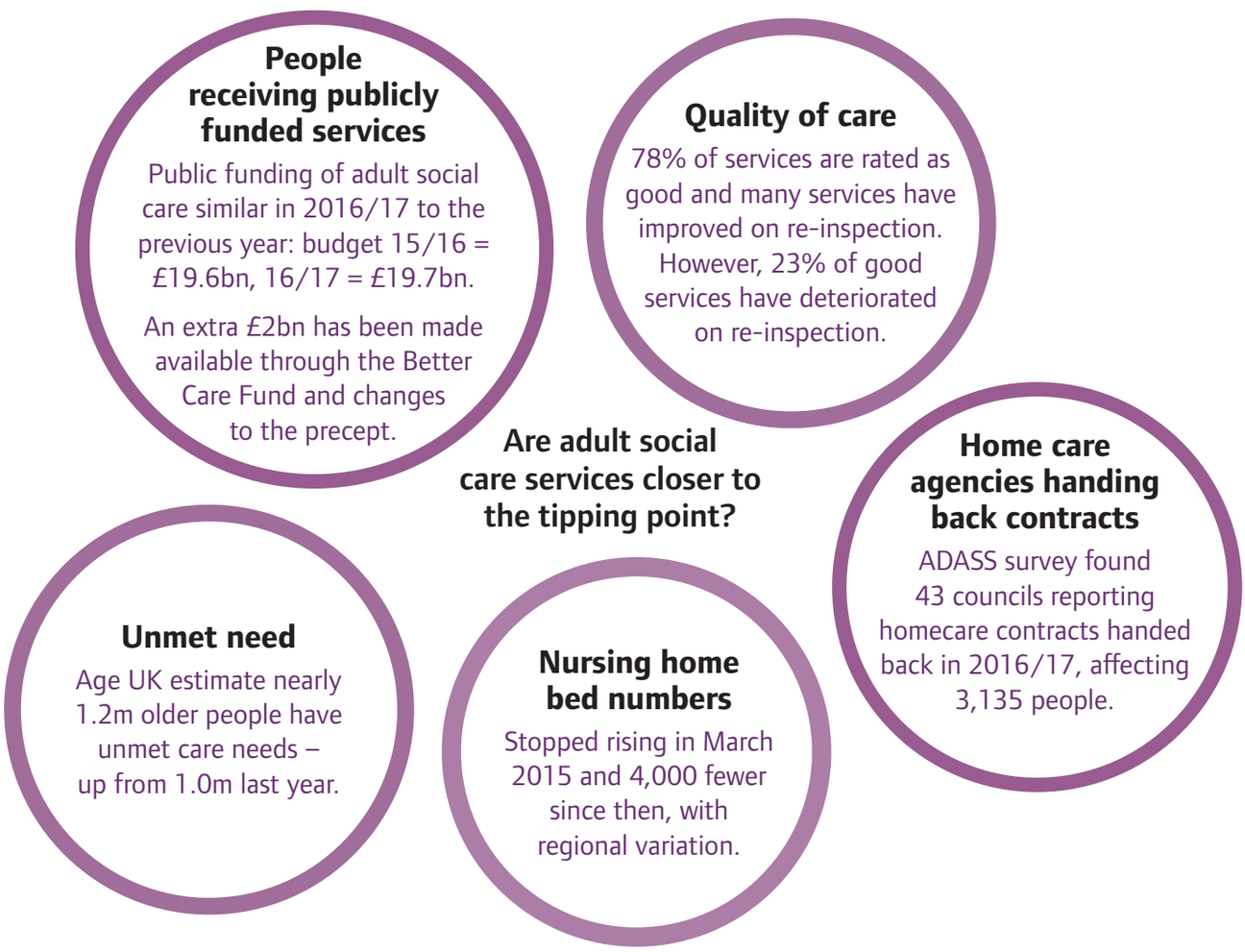
What is clear is that there is not one national picture for adult social care – the pressures are being felt at a local level and to different degrees. There is wide variation across the country in the quality of care. There is variation too in providers' response to market conditions – in some parts of the country, the number of beds is rising; in others, it is falling.

And we believe that the proportion of people paying for their own care, and in effect subsidising those funded by their local authority, varies widely too.[38]

So while in some areas, social care has moved further away from a tipping point, in other areas it has moved closer.

We are also seeing a whole health and care system that is at full stretch, not just social care. Overall, the quality of care remains relatively stable, with the majority of all care rated as good and improvements in some services. But some providers are struggling to improve and some that were previously delivering a good standard of care have slipped backwards. And far too many people are still not able to access the care they need.

Figure 1.12 Are adult social care services closer to the tipping point?



2. The quality of care in the care sectors

Through our comprehensive inspection and ratings programme, we now have a baseline picture of the quality of health and adult social care in England.

CQC has inspected and rated registered health and adult social care services in England over a three-year period. The findings from the individual inspections are all published and we have also reported separately in 2017 on our overall view of different parts of the health and adult social care system.

The majority of the care that people receive is good (figure 1.13). As at 31 July 2017:*

- 78% of adult social care services were rated as good (31 July 2016: 71%).
- 55% of NHS acute hospital core services were rated as good (31 July 2016: 51%).
- 68% of NHS mental health core services were rated as good (31 July 2016: 61%).
- 89% of GP practices were rated as good (31 July 2016: 83%).

In each sector, there are providers and services that deliver truly excellent care and achieved an outstanding rating as a result: 2% of adult social care services, 6% of NHS acute hospital and mental health core services, and 4% of GP practices.

These outstanding services include care homes with the capacity to care for almost 8,000 people, and general practices with a total list size of more than 2.9 million people.

There is still far too much care being provided that needs to improve. As figure 1.13 shows, 19% of adult social care services were rated as requires improvement at 31 July 2017; 37% of NHS acute core services were rated in this way, as were 24% of NHS mental health core services; and 6% of GP practices were rated as requires improvement as at 31 July 2017.

And we are still seeing a very small minority of care that we rate as inadequate: between 1% and 3% across the services we rate. These services rated as inadequate include care homes with the capacity to care for almost 9,500 people, and general practices with a total list size of just under 650,000 people.

Improvement

In each sector, we have seen improvements take place in services – those have been the result of the hard work and determination of many providers and their staff to provide safe, effective, compassionate and high-quality care, and to take on board our inspection findings and make the changes that were necessary.

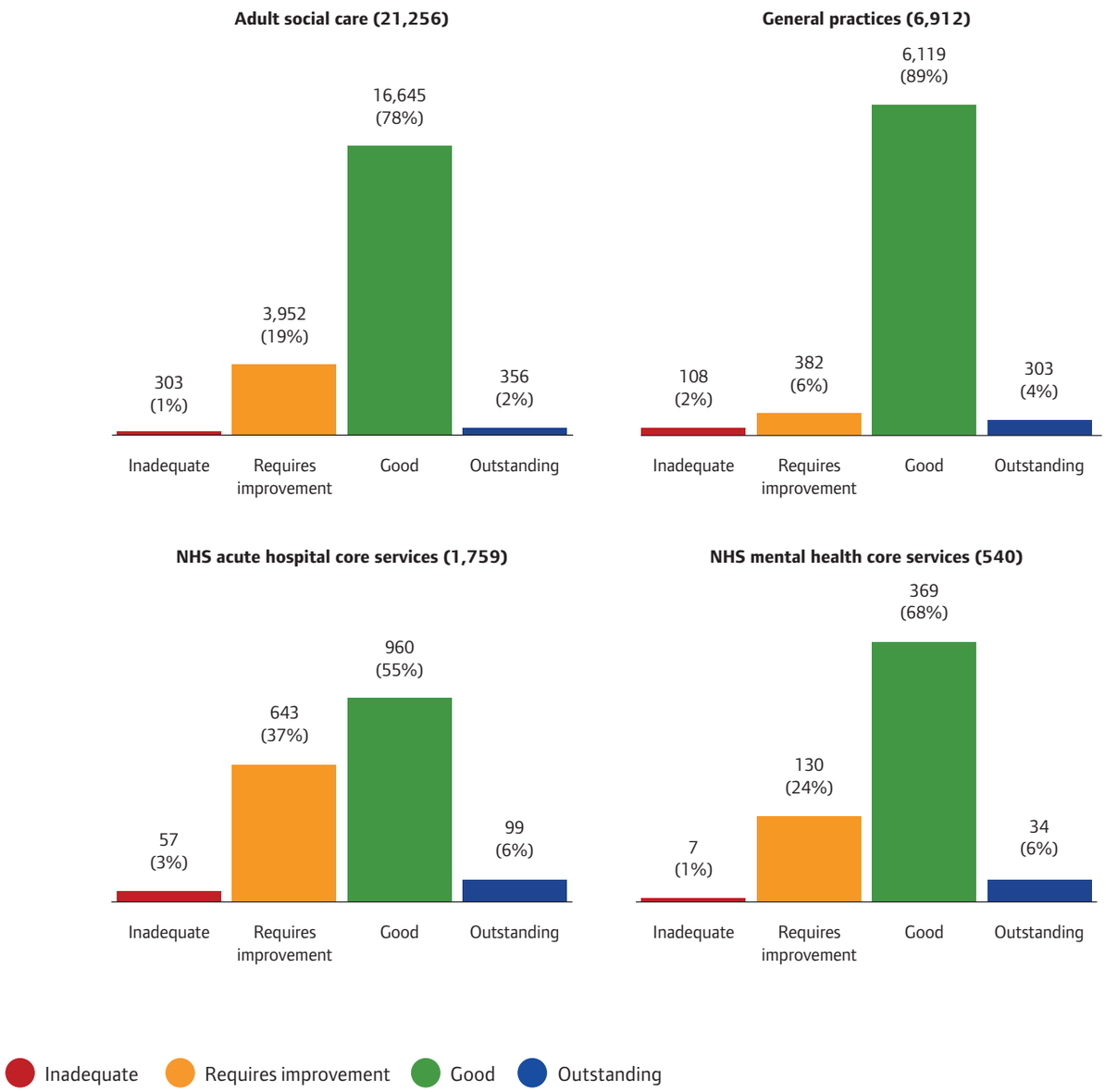
Services that were originally rated as inadequate have improved strongly (figure 1.14).** Up to 31 July 2017:

- 82% of adult social care services originally rated as inadequate and re-inspected (606 out of 740) improved their rating.
- Among NHS acute hospitals, 12 out of the 15 hospitals originally rated as inadequate and re-inspected improved.
- All of the nine mental health services (NHS trusts or independent hospitals) originally rated as inadequate and re-inspected improved their rating.
- 80% of GP practices originally rated as inadequate and re-inspected (156 out of 196) improved their rating.

* The figures for 2017 are not directly comparable with those for 2016, as in most cases we had not completed our comprehensive inspection programme at that point. In the early stages of each programme, we focused our inspection activity on those services where we had most concerns. It was therefore to be expected that we would rate more services as good towards the latter stages of each programme. However, many services in each sector have improved their rating.

** Note that some services will have deregistered before we were able to re-inspect them.

Figure 1.13 Main sector ratings as at 31 July 2017



Source: CQC ratings, 31 July 2017.

For services that were originally rated as requires improvement, there has been positive change, although not as great as for those rated as inadequate (figure 1.15):

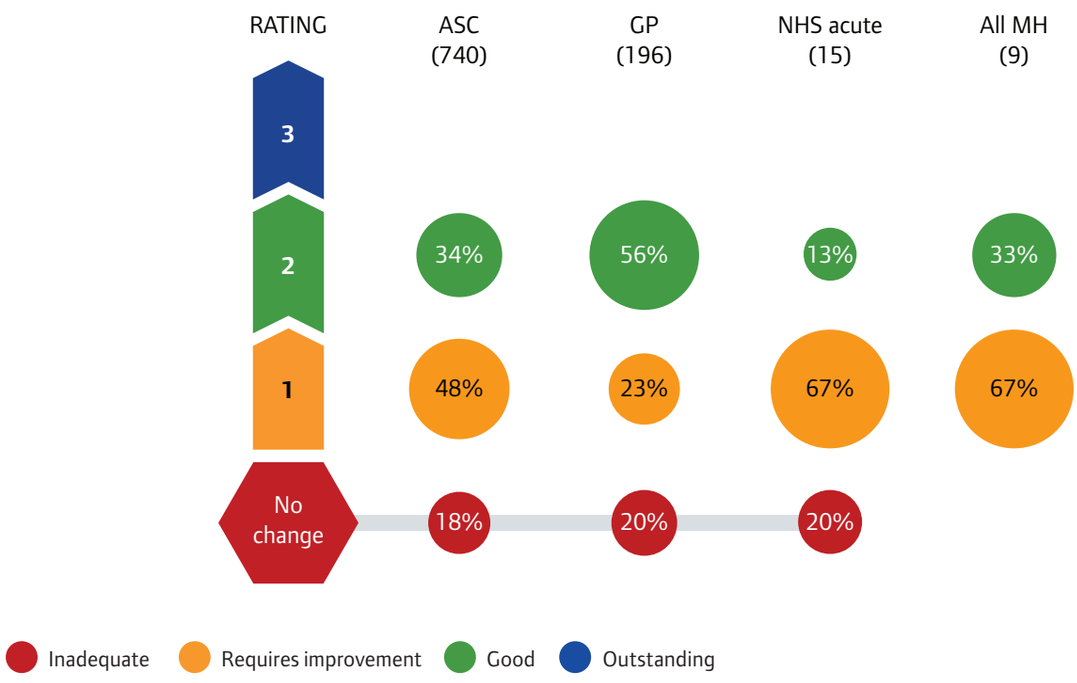
- 58% of adult social care services originally rated as requires improvement and re-inspected (2,653 out of 4,533) improved their rating.
- Of the 64 NHS acute hospitals originally rated as requires improvement and re-inspected, 17 improved.
- Of the 68 mental health services originally rated as requires improvement and re-inspected, 48 improved.
- 85% of GP practices originally rated as requires improvement and re-inspected (519 out of 613) improved their rating.*

* Note that some services will have deregistered before we were able to re-inspect them.

In our report published in June 2017 on improvement in acute hospital trusts, we identified a number of important factors that led to some trusts making substantial improvements in quality.[39] These included:

- strong leadership – leaders being visible and approachable so that staff felt supported to make changes
- cultural change – engaging staff and empowering them to drive improvement, and breaking down barriers between teams so they could work together on solving problems
- shared vision – building a common vision and values among everyone with a stake in the trust's success
- an outward looking approach – reaching out to local communities and partners, involving patient and the public in shaping services, and collaborating with local groups such as local Healthwatch to help drive improvement.

Figure 1.14 Re-inspection of services initially rated as inadequate overall



Source: CQC ratings, re-inspections from start of ratings programme up to 31 July 2017.

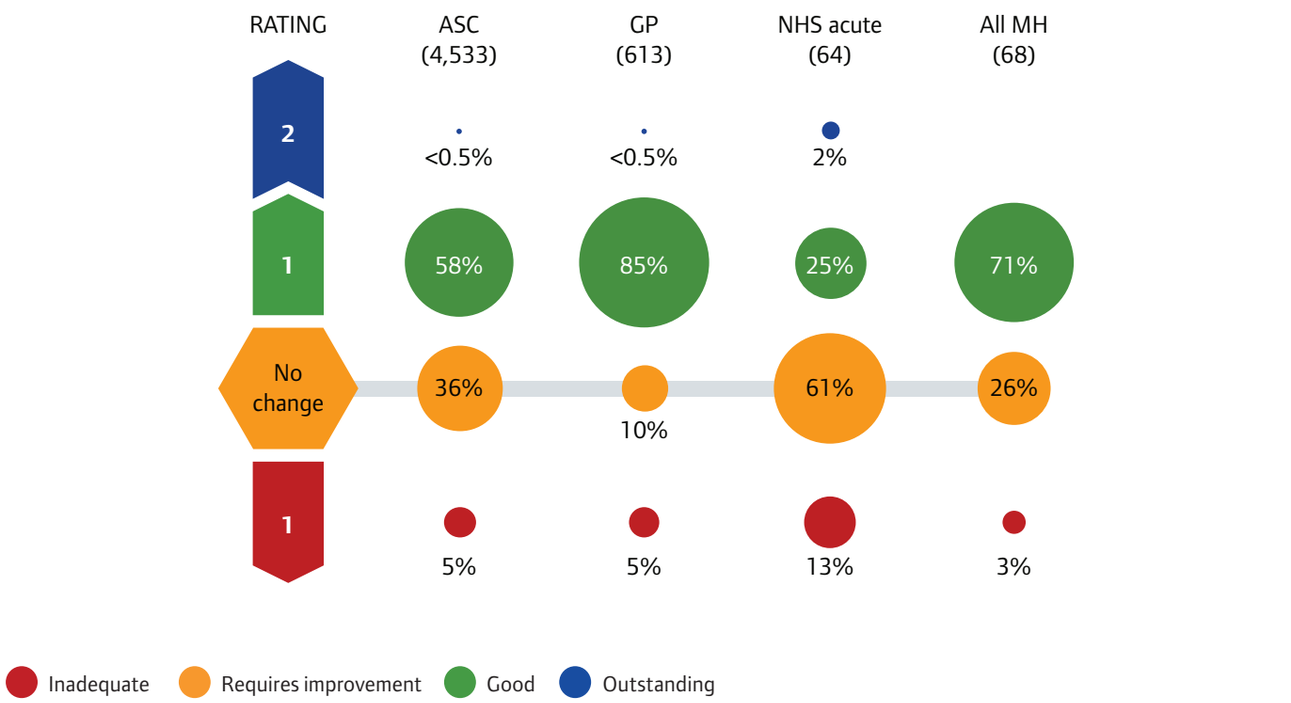
One example was East Lancashire Hospitals NHS Trust, which launched its 'Tell Ellie' campaign (East Lancashire Listens, Involves and Engages) – a significant change that took the trust out to patients for the first time. It was the start of a different approach to engaging with the local community; subsequently, the trust established a stakeholder listening event every quarter. They invite people from a range of interested organisations to come and talk to the board, and what they hear is directly used to inform changes in how they deliver services.

At Frimley Health NHS Foundation Trust, they created an independently chaired quality and oversight committee that had consistent and appropriately senior attendance despite competing demands on people's time. Importantly, senior representatives from five clinical commissioning groups attended meetings, as well as CQC, other partners and senior staff at the trust. Bringing the right people together in one place minimised the need for other meetings and freed up time for staff to get on with making improvements.

Similar themes emerged in our report on the quality of mental health care in England that we published in July 2017, where we examined what underpinned those providers who were rated as good or outstanding for being well-led. Visible leadership was again prominent, as were clear vision and values that permeated the organisation from top to bottom and were reflected in how staff delivered care. In the best cases, the values translated into staff taking a recovery focused approach, working to reduce the stigma related to mental health conditions and adopting a truly holistic approach to care.[40]

Engagement and involvement were also to the fore, with frontline staff and patients both involved in decision making about the management of the organisation. As well as involving their own staff and patients, well-led mental health providers looked outwards and engaged with the range of groups and

Figure 1.15 Re-inspection of services initially rated as requires improvement overall



Source: CQC ratings, re-inspections from start of ratings programme up to 31 July 2017.

organisations that have an interest in the quality of care provided to the community that they serve. For example, they forged strong and constructive relationships with local authorities and with primary care services – to ensure that patients with enduring mental health conditions and complex needs experienced seamless care. They were also willing to learn from other providers that had developed innovative services or that were performing well in some specific aspect of provision.

Likewise, in our report on the quality of adult social care in England, published in July 2017, we reported how leaders in the highest performing services inspired a culture where people are at the centre – treating people as people, as opposed to just recipients of care. One important aspect of this is tailoring activities to individuals' likes and interests – for example using art, music and singing to improve the wellbeing of people living with diagnosed conditions or dementia.[41]

Strong leaders had a pivotal role in bringing about improvement in adult social care. This was characterised by managers with an innovative, outward or forward looking approach who were open to feedback and actively sought out best practice to steer improvement. Good managers truly valued their staff, supporting them to maintain their knowledge of best practice and person-centred care through training and establishing 'champions' in different areas of care.

We identified innovation as one characteristic of outstanding services, with good leaders described as being 'innovative' or 'creative', especially when adopting really person-centred practice and solutions to individual care needs, instead of simply seeing the risks or barriers. The cultures of the services were also highlighted as being open and transparent, with a culture of improvement based on good practice and feedback.

Good leadership that generates a positive and inclusive culture can lead to genuinely person-centred care. In high-quality services, staff really get to know people's likes and dislikes. This supports relationships where staff and people who use services work together to set and achieve meaningful and realistic goals. The way these services engaged with and supported carers and family members also showed an inclusive approach to care.

These themes were echoed in our report on the state of care in general practice, in which we highlighted the particular importance of strong leadership to underpin the delivery of high-quality care.[42] Where there is strong leadership from GPs, nurses and practice management, there is a positive impact on the quality of care. The culture that leaders create within the practice is important: where we saw high-quality general practice there was a non-hierarchical structure and a culture that valued the input of staff, with a balanced team that respected and valued all professionals with mutual respect.

Safety

Since we introduced our new approach to inspection and rating, we have seen a clear improvement overall in safety and also across each of the sectors we regulate and rate.

Despite this progress, there remain many opportunities for further improvement and many providers could and should do more.

We have often found poor systems and processes to manage risk so that safety incidents are less likely to happen again. Poor performance for safety is often due to problems with a provider's overarching systems and governance, which results in safety being a low priority and a culture that does not value ongoing learning from safety incidents. There is still too prevalent a culture where staff feel unable or unwilling to raise safety concerns, and where systems do not respond effectively if they do.

At 31 July 2017, around 5% of acute hospital core services were rated as inadequate for safety, as were 3% of core services in NHS mental health trusts, 2% of adult social care services and 2% of GP practices.

Safety for people using ambulance services is a major concern. As at 31 July 2017, five out of 10 NHS ambulance trusts were rated as requires improvement

for safety, and one was rated as inadequate for their safety. Improvement stories from some ambulance services following our inspections show what can be done to improve quality, but it remains the case that only four out of the 10 trusts are rated as good.

Overall, we find that providers that perform well in this area put safety as a top priority, with good monitoring that gives staff a clear, accurate and current picture so that risks can be looked at on a regular basis. They also have embedded systems and operational processes for keeping people safe and protected. Staff feel empowered to speak out about safety issues and there is a supportive learning culture.

Deterioration in some services

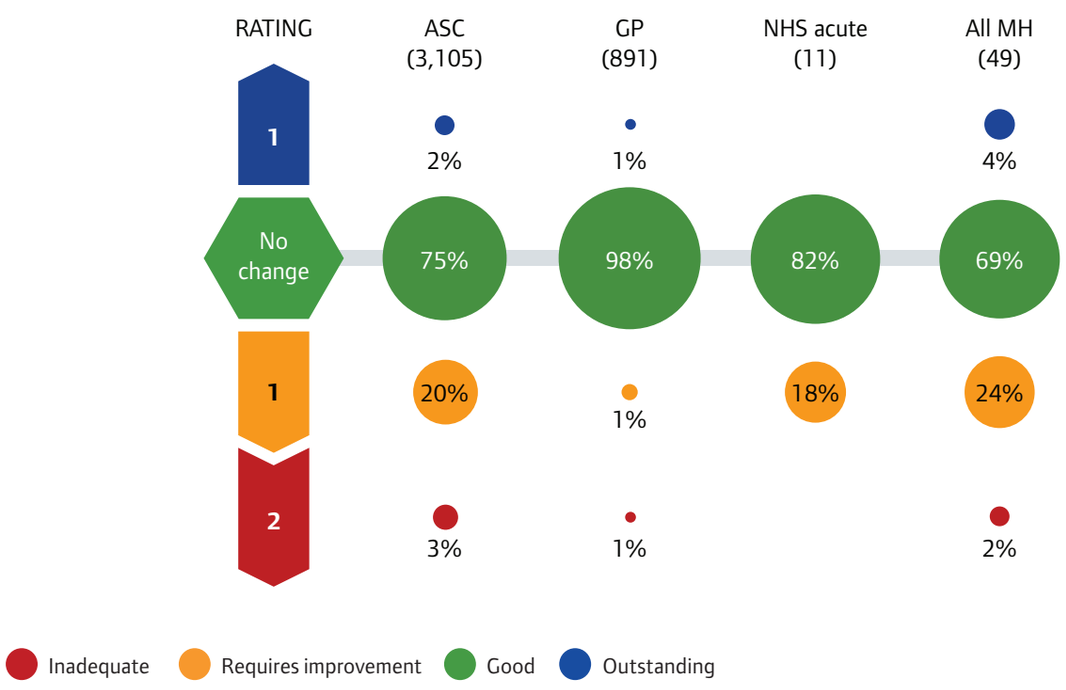
Having completed our initial programmes of comprehensive inspections, we are also now beginning to check the quality, not only of services rated as inadequate or requires improvement (which we check more frequently), but also those that at first inspection we rated as good.

Re-inspections of services that are rated as good can be prompted by concerns from staff, people using services and their families, or notifications from the provider itself, or they can arise when we carry out further checks on a range of core services.

Figure 1.16 shows that we have given a lower rating to the following services, previously rated as good, when we have gone back to re-inspect them:

- 719 out of 3,105 (23%) adult social care services
- 2 out of 11 NHS acute hospitals
- 13 out of 49 mental health services.

Figure 1.16 Re-inspection of services initially rated as good overall



Source: CQC ratings, re-inspections from start of ratings programme up to 31 July 2017.

This early information highlights the importance for providers of maintaining their focus on quality and of continually monitoring the quality of their services. It also suggests that, although on balance there has been more improvement than deterioration, it may be a challenge for the improvement to be sustained.

As we move into a more responsive and targeted phase of our inspections, we will keep this under close review. We will continue to improve the way we listen to and respond to the vital information that alerts us to poor performance, even among those services that have formerly been of good quality.

Variations in care

Everyone has a right to expect consistent and high-quality care – no matter who they are, where they live, and whether that care is delivered in an acute hospital, a care home or nursing home, a community mental health hospital, a GP practice or a person's own home.

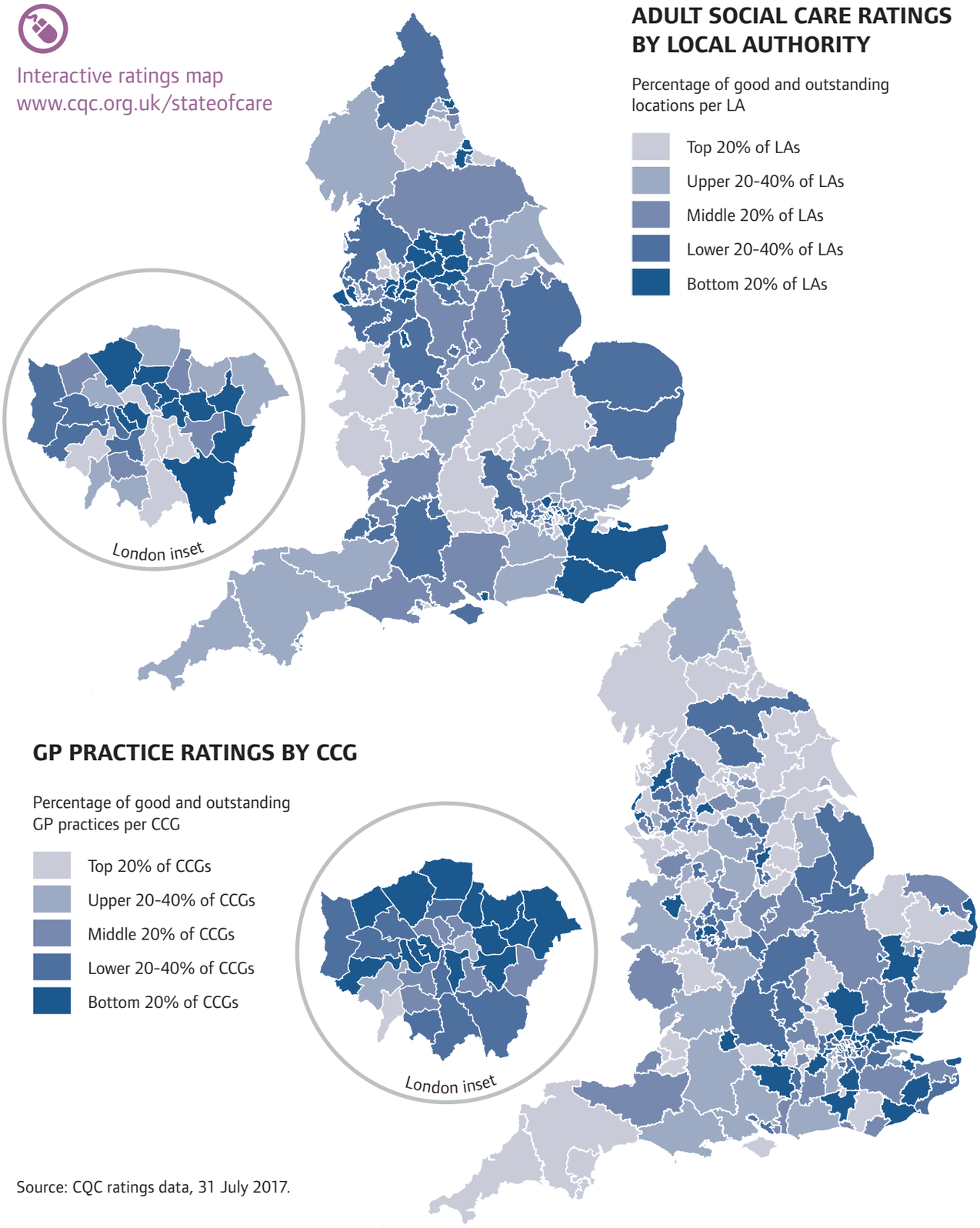
But too often, people are not getting this consistency of care. There are substantial variations in the quality of care that people are receiving – within and between services in the same sector, and between different sectors. There is not a consistent national picture, and the question must be why there is such variation between the care that people are experiencing in different areas.

There are also differences in the overall quality of services depending on where in the country people live. Figure 1.17 shows how ratings profiles for local areas vary in both adult social care and GP practices. Some parts of the country are in the top 20% of areas for the quality of adult social services, but not GP practices; in other areas, it is GP practice care that is in the top 20% for quality, not the adult social care. Overall, there is no consistent pattern.

The impact on people is particularly felt where sectors should come together. We have seen how the disconnect between different parts of the system is creating real problems for people.

Figure 1.17 Geographical variation of ratings in both adult social care services (by local authority area) and GP practices (by clinical commissioning group (CCG) area)

Interactive ratings map
www.cqc.org.uk/stateofcare



Source: CQC ratings data, 31 July 2017.

3. Working together to provide joined-up, person-centred care

People should be able to expect good, safe care when they need it, regardless of how this care is delivered. At a time when more and more people have complex or multiple conditions – as we set out in chapter 1 – they increasingly need help from a number of different care services and professionals.

Care needs to be joined-up, personalised and centred on people's individual needs. And yet we know there is wide variation in how health and social care systems work together, with some collaborating effectively to ensure people get the right care, while others struggle to do so. Many people receive fragmented care – care that is built around the priorities of the services, rather than the needs of the people receiving the care.

Where we see joined-up care, we see more local health and care leaders collaborating to engage staff, people who use services and local partners to respond to the challenges they face. It's clear that where care providers, professionals and local stakeholders have been able to do this – where they have stopped thinking in terms of 'health care' and 'social care' (or specialities within these) and instead focused their combined efforts around the needs of people – there is improvement in the quality of care that people receive.

To deliver good, safe care that is sustainable into the future, providers will have to think beyond their traditional boundaries to reflect the experience of the people they support. Collaboration needs to happen not just between sectors, but between local agencies and care professionals too. This needs to happen with more consistency and urgency, and national leaders need to support this.

Putting people first

The goal is care that puts people first. This is often where providers are working together to provide more seamless care that is built around the often multiple, or complex, needs of individuals.

In one care home, a 'hospital passport' was completed for each person. If they needed to go into hospital, other professionals would be made aware of their preferences for their care, support needs and their current treatments that were best for them.

In a GP practice, we saw personalised care plans that had been agreed between the patient, GP, community matron and other professionals. We reported how, in one case, this process had improved a patient's quality of life by better controlling their diabetes and being less dependent on steroid medication.

Another care home offered 'continuing healthcare assessments' that were very person-centred and helpful to any other services involved in a person's care. For one 17-year-old, his support needs were clearly outlined – recorded in simple language and using his own words. There was a strong focus on his likes, dislikes and wishes. His father told our inspectors, "The team has worked creatively to expand and enrich his social and practical skills. His ability to join in and socialise with his siblings and peers has grown significantly."

A general practice was recognised by CQC inspectors for the way it worked with a range of local organisations to manage the range and complexity of patients' needs. It is involved in a community hub, bringing together a team from different disciplines such as mental health, social care, community nursing, voluntary organisations and general practice, to help make sure people have joined-up care plans that focus on keeping them well at home.

Inspectors have seen a domiciliary care agency that developed dementia care training for local staff such as GP and dental receptionists. One agency applied for clinical commissioning group funding to develop a foot care clinic for people with diabetes.

A personal story of health and care

Jennifer is an Expert by Experience with a physical disability who has used A&E and acute services, specialist hospitals and domiciliary care. Her personal story is one of ups and downs, where at times she has had to navigate her own way through the health and care system.

The downs…

- "In April 2012, out of blue, I could not lift my legs out of the bath before work. I went to see my GP and that day I ended up in A&E."
- "With support from the Back Up Trust (a national charity dedicated to helping people with spinal injuries), I insisted on being referred to a spinal unit. My neurologist was reluctant to do this, so I made a huge fuss and eventually got an appointment at the spinal unit."
- "I returned to work very part-time, struggling emotionally to cope with changes to my life."
- "Peer support can make all the difference. For instance, one of the Back Up Trust's course leaders saw that the spasms in my legs were really bad. He recognised I needed a different pump and catheter to deliver my medication and a new wheelchair. Once I saw the rehabilitation consultant, I eventually got all those things sorted out."
- "Having the wrong foot plates on my wheelchair resulted in me breaking my ankle. Then, while waiting for the necessary assessment, I broke my other ankle. Only when I threatened to sue did they come out and sort out a different solution for me."

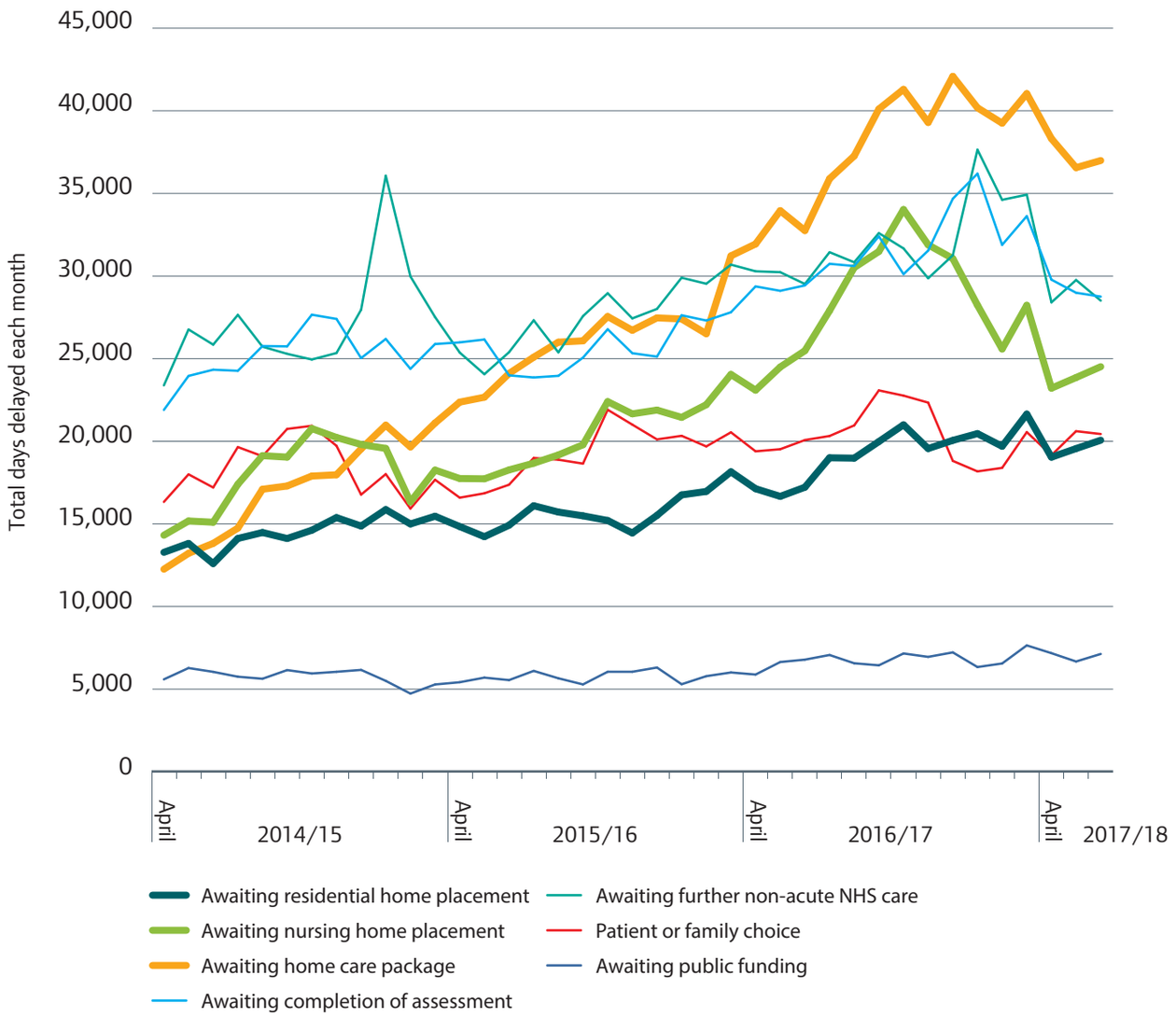
The ups…

- "I have been on two courses with the Back Up Trust. On the first, the volunteer physio set me goals to go upstairs and walk outside to a restaurant. By the end of the long weekend I was able to go upstairs, and walk to the car with a Zimmer frame. On the second, I went on a train journey on my own, and I made numerous phone calls to the charity. The person I spoke to who was also a wheelchair user reassured me it was possible. The course leader encouraged me to use my manual chair and showed me how to get in a car."
- "I asked my occupational therapist to put stair rails in my house and sort my bed upstairs, so that I could sleep in the same bed as my husband."
- "I find the liaison nurses incredibly helpful. They are always at the end of the phone and are specialists in spinal cord injury."
- "Despite my health being uncertain and requiring numerous hospital appointments and various scans, I have somehow managed to have some fun again and get my life back on track. I love all the activities I have been able to do – from driving a sports car with hand controls around Silverstone to canoeing, abseiling and flying aeroplanes."

In Somerset, Yeovil District Hospital NHS Foundation Trust works with patients, carers, health and social care staff and voluntary organisations as part of an integrated care model called the Symphony Care Hub. This aims to provide a better way of supporting people living with three or more specific long-term conditions; the care model helped reduce hospital admissions by 30% in its first year.

Where the system is fragmented, problems at one provider can have significant impacts on other providers, with potentially serious consequences for people. On an unannounced inspection of one NHS acute hospital trust, there were 195 people waiting to be discharged to physiotherapy, or placement into nursing homes or rehabilitation wards. Of these, 88 were listed for discharge but with no indication of what their next step might be, and there was no overall monitoring of planned discharge dates to help prevent extended and unnecessary hospital stays.

Figure 1.18 Total monthly delayed transfers of care (days delayed), 2014/15 to 2017/18



Source: NHS England, Delayed Transfers of Care.

This trust's failure to manage its discharges also caused a serious knock-on impact for an ambulance service, which had queuing vehicles at the hospital's accident and emergency department.

The biggest challenge that hospital trusts face is maintaining a consistent flow of patients through the acute medical and surgical pathways. Without adequate flow, they are unable to respond effectively to the rising number of urgent patients and to admit elective patients in a timely manner. Poor flow leads to too many ambulances delayed at the hospital front door, too many patients suffering long waits in emergency departments for admission, too many patients being admitted to an inappropriate ward, too many patients suffering multiple moves between wards, delaying and disrupting their care, and too many patients having operations cancelled at short notice.

Follow-on care for people leaving hospital is often not there. With a reduction of long-term care beds in some areas and a lack of these beds in other areas, care homes in high demand have waiting lists or may have several people who could use an available place. As a result, people remain in hospital beds unnecessarily while others need hospital services and beds.

Over the past three years, delays in transfers of care have all increased substantially. The majority of days delayed are still attributed to the NHS (55% in March 2017).[44] However, the sharpest increases have been in certain adult social care attributed delays. Delays for people waiting for home care packages have seen the largest increase (figure 1.18) – from April 2014, days delayed due to awaiting a home care package more than tripled to more than 42,000 in December 2016, although since then there have been signs of an improvement, with monthly days delayed falling to 37,000 in June 2017.

Overall, keeping patients in hospital longer than required can have a number of detrimental effects. Long stays can affect patient morale, mobility, and increase the risk of hospital-acquired infections. There can be a damaging effect on people delayed in hospital: research suggests a wait of seven days is associated with a 10% decline in muscle strength.[45]

To investigate these issues further, CQC has been asked by the Secretaries of State for Health and for Communities and Local Government to carry out a programme, in the second half of 2017/18, of local system reviews of health and social care in 12 local authority areas. A further eight sites will be identified in the coming months. Once we have completed all 20 reviews, we will publish a national report of our key findings and recommendations in 2018.

We are looking specifically at how people move between health and social care, including delayed transfers of care, with a particular focus on people aged 65 and over. The review does not include mental health services or specialist commissioning but, through case tracking, will look at the experiences of people living with dementia as they move through the system.

Our findings will highlight what is working well and where there are opportunities for improving how the system works, enabling the sharing of good practice and identifying where additional support is needed to secure better outcomes for people using services.

So far, we have seen that the multi-agency response required from commissioners and providers is in its early stages. Cross-sector work is essential to deliver transformational change, but we can see that the processes for this are not yet well developed.

In addition to these ongoing local system reviews, we have in 2017 published two assessments of quality of care in a place (in the London Borough of Sutton and in Cornwall), focusing on how local services respond to risks or priorities in an area.[47,48]

We can see that relationships and leadership commitment to joined-up working are important to support frontline staff to work together which is essential to securing better outcomes for people. What is crucial is a focus on the delivery of personalised, joined-up care.

How are health and social care working together to meet the needs of people?

The NHS Five Year Forward View set out how services need to develop and change if the needs of the population are to be met now and in the future. We now see a range of health and social care providers that are beginning to reassess the way they provide care services to their local communities. We are seeing new models of care emerging, such as hubs, GP federations and 'super-practices', specialist teams providing support in people's homes and in adult social care services, and digital services and telemedicine that are designed to take pressure off GPs and other medical professionals by reducing the need for in-person appointments.

However, there is wide variation on progress. The pace and scale of change varies from place to place, by sector, and by population groups. Some groups are being better served than others by the changes – for example, health care for older people is a particular focus for vanguards.

Changes in provision

Acute hospital care and primary care appear to be experiencing the most change to date. We have seen some changes on the ground in the acute hospital sector. These changes have often been instigated by the Sustainability and Transformation Partnerships, with providers realigning their resources to ensure timely discharge of patients into other kinds of care.

We have seen that where there is better quality of care for people, providers are aware of the importance of the relationship between hospitals and community services. NHS England points to 'hub-based care' as a significant development – a common feature of the new 'primary and acute care system' and 'multispecialty community provider' models. These hubs aim to better coordinate care from multiple services and professionals around the needs of the individual.

In Salford, for example, the 'Call for Contact' integrated hub coordinates care between professionals working in social care and community health services to prevent and manage crises in the community. They do this by providing a single point of access to district nursing, social care, community equipment and out-of-hours services.

Among mental health services, our inspectors have seen a few examples of providers combining their services – with a common theme of bringing better physical health to those with mental health conditions. For example, at the acute adult inpatient and the psychiatric intensive care unit wards at one trust, a registered nurse was recruited to focus on the physical health of patients. This initiative had come from learning from incidents and reflective practice as there had been instances where they recognised that they could do better. This had a positive impact; the physical health care of patients was better monitored and deterioration was spotted quicker. This had been recognised by ambulance services and A&E, who had noticed that notes accompanying the patient were of better quality and, as a result, they had a better understanding of the person's presentation and what the consistent concerns were.

We have seen some GP practices joining together as new 'hubs' of care, providing greater access and enabling practices to combine their different strengths to deliver services that would typically take place in hospitals. Many smaller providers are becoming parts of a larger organisations or federations – and there is closer, more integrated working with other primary healthcare teams and practices, which follows the recommendations of the RCGP's Roadmap for General Practice.[49]

A research study from the Nuffield Trust found that almost three-quarters of surveyed GP practices are now in some form of collaboration with other practices, to deliver services at a larger scale, almost half of which formed during 2014/15.[50]

In addition, the care coordinator role in primary care seems to be having a positive impact for certain groups of people. These roles, funded either by clinical commissioning groups or GP federations, often work across several GP practices and act as a

communication link for patients who may otherwise be isolated, signposting them to services that they may not be aware of (including mental health services) and helping to identify deterioration in people's conditions at an earlier stage. There is a focus on supporting people to access care at home or in the community, rather than being transferred to secondary care.

In general, the findings from our programme of GP practice inspections pointed to a number of practices using roles such as advanced nurse practitioners, care coordinators and healthcare assistants to support their GPs and help with the workload, and to help reduce referrals to secondary care or avoidable hospital admissions. This reflects the importance of having a multidisciplinary team and mix of skills in general practice.

There is some innovation taking place in adult social care, even though new models of care involving social care provision are not widespread. Examples include visiting healthcare professionals (for example advanced nurse practitioners and community matrons visiting care homes, to reduce the need for residents to go to hospital for appointments), initiatives such as step-down units to support discharge from hospital back to social care, and social care providers offering collaborative training to other providers on topics such as dementia and end of life care.

Person-centred care in Sutton [43]

In a recent piece of work, we used our unique capability to look across health and adult social care to see where there is emerging good practice that could be shared more widely. The focus was on how services and local agencies in the London Borough of Sutton – an area that was part of the 'enhanced health in care homes' vanguard scheme pioneered by NHS England – work together to support joined-up care for people in care homes.

The area was selected because local inspection teams identified it as an area of good practice where integrated and partnership working was having a positive impact on people. It had improved care for older people in care homes in order to both reduce hospital admissions and to enable rapid and safe discharge from hospital.

From 2015/16 to 2016/17, even though the number of beds for care homes supported by GPs in Sutton clinical commissioning group (CCG) increased by 14%, there was an overall reduction in care home residents attending A&E – believed to be the result of better coordination of care, enhanced training of care staff, and better health care support for older people in care homes. In addition, resource packs used by care staff to assess people have led to overall reductions in urinary tract infections, pressure ulcers and falls.

One initiative was the 'Red Bag', used to transfer paperwork, medication and personal belongings of a care home resident when they have to go to hospital. The bag stays with them while they are in hospital and then returns with them, with updated information as necessary, back to the care home. It enables everyone involved in that person's care to understand their personal needs and medical history.

Overall, we found that there is a clear framework and strategic approach to collaborative working in Sutton, overseen by the vanguard steering group, the Sutton CCG and the South West London sustainability and transformation partnership team. There is clear leadership, investment and support from the Sutton CCG to implement change and progress partnership working, and a strong commitment to partnership working across the majority of organisations and stakeholders in Sutton. All stakeholders, staff and people using services that we spoke to said that they felt included, valued and listened to.

CQC inspectors have seen an example of a tissue viability service that goes into care homes, and another of an adult social care provider delivering a centrally-managed and nationwide 'technical nursing function' in people's homes.

Enablers and challenges: Shared vision, good leadership and a collaborative mind-set

Our work has emphasised the importance of trusting relationships that share a common goal as the basis for successful integrated care. A shared vision, good leadership and a collaborative mind-set are key to overcoming barriers to change. The Sutton vanguard is one example where this is working well.

NHS England highlights the Morecambe Bay Better Care Together vanguard, where the local community in Millom have become full and equal partners in the first multispeciality 'Alliance' practice in Cumbria – a partnership between GPs, the community trust, acute trust, social care, ambulance trust and the community. Representatives from the local community attend key Alliance group meetings along with the NHS and other partners. This has enabled the local population to take responsibility for their own health care, while supporting the improvement of services locally.

However, strong systems need to be in place to support these relationships, not just individuals' personal connections. In Cornwall, for example, CQC has reported on a lack of integration and the impact this has had for people who need health and adult social care.

Another challenge is recruitment and retention of the right staff. CQC staff in focus groups described this as a 'major barrier' and it is widely acknowledged that all care sectors are facing major difficulties in this area. In areas where there are

The impact of fragmented care [46]

"I have had lots of falls and fractures and no follow up. I only get treatment for the fracture. There may be other issues for me as I was weak and there was no plan in place to help this."
(Older person)

"Telling the same story again and again becomes draining and you end up just wanting to get out ASAP. How can a professional come to an appointment without some information?"
(Older person)

"I didn't even know he was going to be going home so I hadn't brought his clothes for him to go home in."
(Carer)

"Professionals should sit around a table to discuss a patient's care plan and have a key document that is available to everyone. This is about health talking to social care but also about health talking to health."
(Older person)

staff shortages, organisations can find themselves competing against each other for the same pool of skilled staff. Local workforce strategies may be needed to support greater collaboration between services.

Strong support from commissioners is vital in creating services that collaborate to meet the specific needs of people. In our focus groups, CQC colleagues reported mixed views on how well local commissioners and planners were ensuring that the health and care services they delivered were built around the needs of the population.

There were some positive examples where commissioners are supporting providers to take a population-focused approach – for example, in Sunderland where there are longer-term relationships based on trust and cooperation, and analysis shows that they are one of the best performing local authorities on delayed transfers of care.[51]

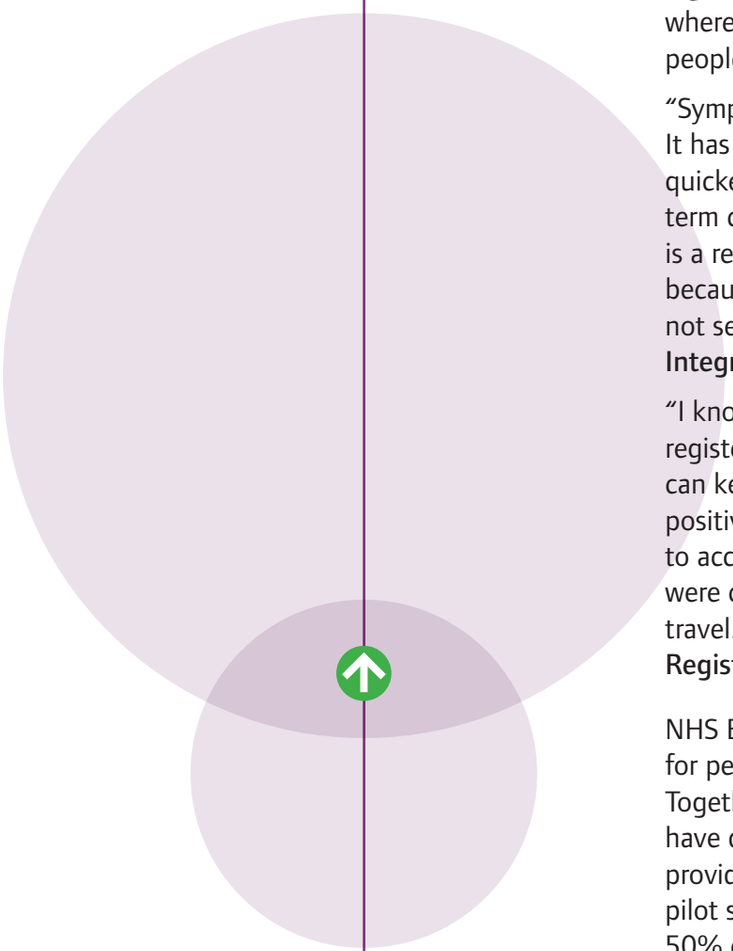
"In Sunderland their starting point is population health, from a commissioning perspective, and that translates into risk stratification… and from the bottom up you can see how the focus is preventative care rather than a reactive model. Whether that's self-management, GPs working differently, community nurses working differently, community matrons managing long-term conditions – you can see how it all works together…"

NHSE highlighted multispecialty community provider Encompass, which is working with Red Zebra, a local infrastructure charity. They provide a platform that reportedly connects 144 voluntary sector organisations through a single point of access, to better coordinate care and community services around a person's needs.

Outcomes for people

People who use health and care services want personalised care with continuity and no gaps. More people are starting to benefit from integration, but integrated care works best when there is active consultation with those who use health and social care services.

In focus groups, some colleagues raised concerns about gaps between what people need and what is being provided.



CQC's integrated care team gave some examples where the impact of initiatives may have been felt by people using services:

"Symphony is in one of the vanguards in the south. It has introduced care navigators who are responding quicker [and dealing with] maintenance of long-term conditions, such as the onset of diabetes. There is a real sense of the community coming together because of the care navigators. It's an example we've not seen before."
Integrated care team

"I know from the two GP federations that I've registered, they've federated themselves so that they can keep business in the local surgery. So that has a positive impact for local people, they can continue to access services at their local surgery – if they were commissioned somewhere else, they'd have to travel."
Registration NCM lead

NHS England cites examples of improvements for people, including one at the Tower Hamlets Together vanguard, in East London, where they have developed a community kidney service that provides a weekly consultant-led e-clinic. Since the pilot started in December 2015, it is reported that 50% of referrals are managed without the need for a hospital appointment. In 2015, the average wait for a renal clinic appointment was reported at 64 days, but using the new e-clinic, the average wait is said to have dropped to five days.

In North East Hants and Farnham, the first Crisis Café has been established to provide a calm and safe atmosphere where people can access the mental health support they need in a friendly and non-clinical setting. This has reduced the impact on A&E, with 48 people out of 252 who attended the café in a one month period saying it was a direct alternative to A&E. The model has now been more widely adopted across the vanguard, with four other crisis cafés and one café specifically for young people established in North East Hants and Farnham.

Evaluation work carried out by NHS England includes data for 2016/17 that shows:

- Growth in emergency admissions per capita since 2014/15 was lower in the primary and acute care system and multispecialty provider vanguards than the rest of England (0.7% and 2.7% lower respectively).
- Vanguards such as Morecambe Bay, Northumberland, Connected Care Partnership in the West Midlands, and Rushcliffe reported absolute reductions in emergency admissions per capita.
- MCP/PACS vanguards saw a slower rate of growth in emergency bed days compared with the rest of England.
- The EHCH vanguards outperformed the national care homes trend for emergency admissions (data up to end of quarter 3 2016/17).

Equality and inclusion

Nobody with care needs should be left behind when services innovate and change. In times of change, with new models and new approaches to care being developed, it is important that services are designed to meet the needs of all those who need them.

In *Equally Outstanding*, our equality and human rights good practice resource, we laid out the ethical, business and economic reasons for services to pay attention to equality and human rights – as well as the legal requirements.[52] We also learned from outstanding health and social care services that have focused on equality and human rights to improve care.

We found that services that did well had leaders who were enthusiastic and committed to equality, a culture of equality and human rights, and applied 'equality and human rights thinking' to quality improvement. These services worked with people and organisations from outside to develop both their thinking and their practice.

It is a fundamental principle that creating an open, fair and inclusive culture for staff will bring benefits to people using health and social care services. A common factor that we found in outstanding services that used equality and human rights approaches in their development, was that they had a focus on equality for staff as well as for people who used their services. For this reason, we have extended our equality objectives to include workforce equality in our assessments of the well-led key question in all our inspections.

It is not only outstanding providers that are paying attention to equality to improve care. In our report *Driving improvement*, we highlighted improving NHS trusts that have focused on equality for staff and patients, including Cambridge University Hospitals NHS Trust and Leeds Teaching Hospitals NHS Trust.[53]

Many providers could learn from the best providers in using equality and human rights to improve the quality of care. Outstanding care providers built on strong person-centred care and inclusive leadership. Attention to equality and human rights at a service level was also needed to tackle specific quality improvement issues. None of the common 'success factors' in the best providers took a large amount of resources. Their success was based on changing behaviours and thinking about issues. In particular:

- leadership committed to equality and human rights
- putting equality and human rights principles into action
- developing a culture of staff equality
- applying equality and human rights thinking to improvement issues
- putting people who use services at the centre
- using external help and demonstrating courage and curiosity.

Providers and the health and social care system as a whole need to work to improve equality of outcome for particular groups of people, including through commissioning and joint working such as, for example, sustainability and transformation partnerships.

In part 2 of this report, we highlight the example of the Greater Manchester Transformation Unit, an NHS improvement agency that specialises in transforming health and care services. The unit has carried out a

Embedding equality in a service

First Community Health and Care CIC is a not-for-profit social enterprise that provides community health care to people in Surrey and Sussex. In a recent inspection, in which we rated them as outstanding, we saw an exceptionally strong commitment to equality and diversity across the organisation, modelled by a part-time chief executive officer and two administrative staff with learning disabilities who were employed on the same terms and conditions as other staff but given high levels of support to fulfil their roles. They told us these "had transformed their lives and was the best job ever". We met with Black and minority ethnic (BME) staff who said they were simply members of staff doing their jobs in a supportive organisation.

The organisation had considered the Workforce Race Equality Standard (WRES); it was monitoring and considering how best to meet the needs of BME staff, but also felt it was more about meeting each member of staff's individual needs. A BME Deputy Chief Nurse had been supported to join a BME Aspiring Director of Nursing Network to enhance their development opportunities. A WRES audit had been carried out and there was an action place to address areas where improvements could be made. The organisation showed outstanding practice in embedding equality in all of their work, particularly with harder to reach communities, including the local Gypsy, Roma and Traveller communities.

pilot to test how to build equality considerations into service re-commissioning. It engaged with local equality groups to find key equality issues, and used these as a factor in option appraisal for the new services. In addition, it developed a process to find out the best practice between providers in the area, for example best practice in giving disabled people access to a service. This best practice was then used as a contractual requirement for providers in the re-commissioned services, to bring all services up to the same standard as the best services.

Also important is empowering people and communities. To do this, local health and social care leaders need to look beyond provider boundaries, and involve local people in developing broader, more holistic services that meet the needs of their communities.

Keeping people safe in a time of change and innovation

We have shown how, for the health and care system to sustain quality and continue to improve, it needs to change by coming together in different ways, and using new models.

Changing and innovating while continuing to provide good quality care is challenging, and organisations need to focus on both despite the inevitable disruptions to staff and to people using services. We actively support new ways of delivering care that are designed to improve the quality of care for people, provided they are implemented safely and responsibly.

Our focus groups shared positive examples of telemedicine services. Examples included Airedale Hospital's telecare hub, which they were extending to people in their own homes and in care homes, with the aim of not needing to have on-site nurses.

Some initiatives help reduce the number of admissions of older people to hospitals, especially though A&E. Some providers have used the TeleMed system, which links care homes to hospitals via a webcam, so appointments can be carried out virtually. A doctor at a hospital can advise on treatment and any suggested medication, and information is then shared with the patient's GP for prescription. Early results seem to show a reduced number of older people admitted to hospital.

Technological innovation offers an opportunity to drive improvement in healthcare services, and to offer more convenient access for patients to advice, treatment and medicines. We have seen a year-on-year increase in companies registering to provide online primary care services, including remote consultation with clinicians over the internet by text-based platforms or video link.

We have seen that these can improve people's access to care. However, we found that we also had to take action on initial concerns around insufficient safety measures and inappropriate precautions to safeguard patients. We have since seen some improvement when we have gone back to re-inspect.

There are implications for safety with innovation, as well as for other aspects of the quality of care that people receive. The challenge and opportunity for innovators is to embed safety in new ways of working and collaborating.

Underpinning a culture of safety are good leadership at all levels, strong governance within the service and a culture of openness and transparency. We saw one NHS trust where there was a good culture of instant reporting, and ensuring lessons were learnt from incidents. Importantly, efforts were made to share the learning among staff on the ward and not just among senior staff. We have also seen an example of where the new leadership of an NHS trust had encouraged staff to not feel scared to report incidents or safety concerns.

We also sometimes see a generic approach to risk, for example adult social care services becoming more risk averse and in doing so applying blanket restrictions on people – contrary to the principles of the Mental Capacity Act – rather than thinking about their different needs.

In one example, the front door of a care home was routinely locked because of the risk of some of the residents leaving unnoticed. In another, table cloths were removed from dining room tables as it was anticipated that people with dementia would pull them off. These blanket approaches resulted in restrictions being indiscriminately placed on everyone who used the service.

In our inspectors' view, such blanket policies may be caused, in part, by low staffing levels. If there are not enough staff to accommodate the needs of all the people using the service, especially those with behaviours that challenged, policies and processes can be applied indiscriminately and thus reduce the service's ability to provide person-centred care.

Our inspectors in all sectors had significant concerns that any staffing shortages affect safe practices. High vacancy rates and a reliance on agency staff to cover vacancies can be a significant safety concern. For example, in mental health services, inspectors have seen more 'rookie' medication errors made by staff who were not familiar with the service and who may not have had enough training or a proper induction to a ward. Even the basics, such as putting notes on care plans, had not always been completed by agency staff due to a lack of training. However, it is not just about numbers – staff need to be capable and deployed effectively to ensure the safety of people at a service.

In designing new services, new technology can play a major role in making sure people are cared for safely, and in maintaining their independence. At one adult social care provider, staff rolled out an app for smart phones. It contains personally relevant information about people's daily schedules and coping strategies for certain situations, to support the people from day to day. The use of this app has been shown to reduce anxiety and support the independence of the users.

However, new technology needs to be well thought through and implemented. Our inspectors have voiced their concerns about the lack of integration sometimes between the IT systems of different services. In one example in a dialysis unit, patient information was not being accurately transferred across the system. This had resulted in patients not getting the correct medication, and patients with DNACPR (do not attempt CPR) orders not having their wishes met, as these orders were not attached to their case notes.

The challenge for leaders is to understand the risks of change, be open about them to staff and people, and work to mitigate them. All partners – services, innovators and national stakeholders – will need to have an open conversation with the public about both the benefits but also the risks from change and innovation, and what it means for people.

Innovative use of new technology in adult social care

Some care providers are successfully harnessing technology to improve care for people. In agreement with individuals, some care homes are using a new system called acoustic monitoring.

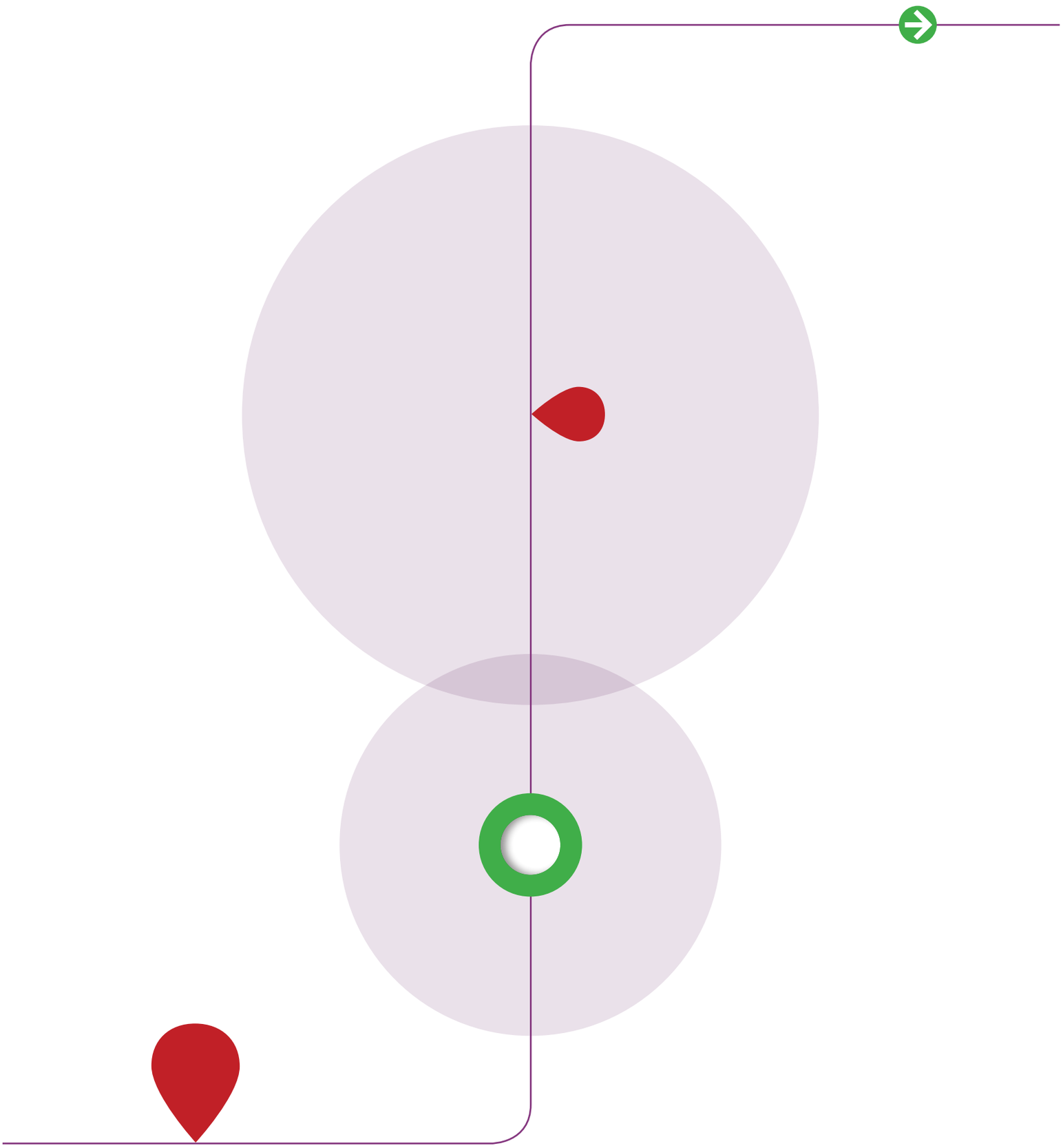
At Drovers House in Rugby, for example, inspectors reported that its acoustic monitoring system enabled staff to respond more promptly and appropriately to people's support needs during the night. Drovers House, which was rated outstanding overall by CQC and outstanding for its responsiveness, is a purpose-built specialist care home with places for up to 75 older people with Alzheimer's and other forms of dementia.

Inspectors said the system has a listening device that is switched on at night and "pre-set to ignore the individual's normal noise level, but to trigger an alarm for unusual noise".

The provider consulted with people and their relatives to explain the benefits of the system. One of these is that people can have undisturbed sleep because staff no longer needed to check people at night by opening their bedroom doors. Instead, people sleep undisturbed unless they need support.

At Drovers House, the night staff takes turns to monitor the system. This means the remaining night staff can run a 'wide-awake' club for people who do not sleep well.

Inspectors said Drovers House employees are enthusiastic about the benefits of the listening system. One member of staff said, "People slept better and staff could go straight to a person's room when needed." Staff had identified some previously 'unpredictable' falls and people had a better quality of life and more one-to-one time at night.



Adult social care

Hospitals, community health services and ambulance services

Mental health

Primary medical services

Equality in health and social care

The Deprivation of Liberty Safeguards

Part 2

THE SECTORS WE REGULATE

Adult social care

Key points

- Over three-quarters (78%) of adult social care services were rated as good. However, 19% were rated as requires improvement and 1% (303 locations) were rated as inadequate.
- Of the five key questions that we asked all services, caring was the best rated – more than nine out of 10 services were rated as good (92%) or outstanding (3%). Safe and well-led had the poorest ratings, both with 22% rated as requires improvement and 2% rated as inadequate.
- Strong leaders had a pivotal role in high-performing services. Registered managers that took an innovative approach, that were known to staff, people using the service, carers and families, and that were open to their feedback had a positive impact.
- A clear focus on person-centred care was another key theme that shone through in high-quality services. In these services, staff were supported to really get to know people as people, understanding their interests, likes and dislikes.
- When we find poor care, we take action to make sure providers and managers tackle problems and put things right for the benefit of people using services, their families and carers. We have taken the most enforcement actions in the regulations relating to a lack of good governance, and issues with safe care and treatment, staffing and person-centred care.
- The *Quality matters* joint commitment has been developed to ensure that staff, providers, commissioners and funders, regulators and other national bodies all play their part in listening to and acting on the voice of people using services, their families and carers.

Introduction and context

This year we published *The state of adult social care services 2014 to 2017*, which gave detailed findings from CQC's initial programme of comprehensive inspections in adult social care.[54]

The adult social care sector has a large number and range of providers, a strong private and voluntary sector, and wide differences in the size and types of services and care provided. The sector covers:

- accommodation and personal care provided in residential care homes, nursing homes and specialist colleges (around 16,000 locations, with the capacity to provide care for around 460,000 people)
- personal care provided in the community for more than half a million people, of which the majority is care provided in people's homes through domiciliary care services (around 8,500 services), as well as extra care housing, Shared Lives schemes and supported living services.

Adult social care is estimated to contribute nearly £42 billion to the economy. It employs around 1.45 million people, the majority of jobs being split between residential and domiciliary care employers (just over 40% each).[55] Adult social care can help individuals, and the families of people who need care and support to carry on working.

Adult social care services are facing a number of challenges. These include:

- A growing number of people with increasing needs.
  - The number of people aged 85 or over in England is set to more than double over the next two decades.[56]
  - The number of working-age adults with long-term needs has also increased.[57]
  - It is estimated that nearly 1.2 million older people have unmet care needs – up 18% from last year.[58]
- Difficulties in recruiting and retaining staff to care for people.
  - In 2016/17 the overall staff vacancy rate across the whole of the adult social care sector was 6.6%, rising to 10.4% for domiciliary care staff. The staff turnover rate in 2016/17 was 27.8% (having risen by 4.7 percentage points since 2012/13).[59]
- Rising costs of adult social care and concerns about funding.
  - Age UK estimates that an additional £4.8 billion a year is needed to ensure that every older person who currently has one or more unmet need has access to social care, rising to £5.75 billion by 2020/21.
  - In the Association of Directors of Adult Social Services survey, 43 councils reported that domiciliary care contracts had been handed back in 2016/17, which was predicted to affect 3,135 people.[60]

On 12 July 2017, CQC joined more than 100 people, organisations and national bodies with an interest in adult social care to officially mark the launch of the *Quality matters* commitment. *Quality matters* sets out a determined and shared vision on how quality care and support can be achieved and person-centred care becomes the norm for all.[61] This initiative has been jointly developed to ensure that staff, providers, commissioners and funders, regulators and other national bodies all play their part in listening to and acting on the voice of people using services, their families and carers.

Overview of quality

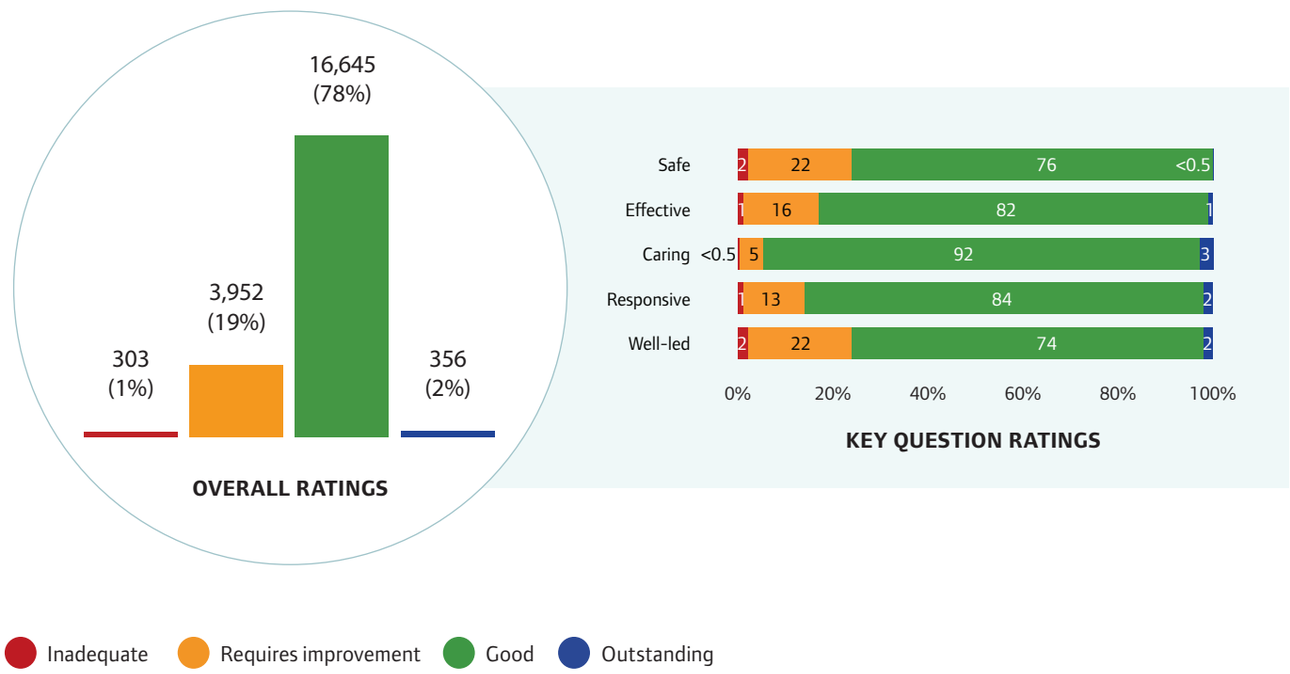
Overall and key question ratings

At the end of July 2017, four-fifths of adult social care services in England were rated as good (78%) or outstanding (2%) overall (figure 2.1). These are higher figures than those reported last year – 71% and 1% respectively; and they give a more comprehensive picture of adult social care performance, based on almost 36,000 inspections.

Nearly a fifth of services were rated as requires improvement, however, and this proportion is too high. We are particularly concerned about the 303 locations (1%) that were rated as inadequate. We estimate that these services may collectively have the capacity to care for about 16,000 people. Since poor care can have such a big impact on people's day-to-day lives, it has to be everyone's responsibility to make sure that people's care is safe, compassionate and of high quality. CQC will work with providers and commissioners to ensure the necessary changes to improve care are made.

Of the five key questions that we asked all services, safe and well-led had the poorest ratings, both with 22% rated as requires improvement and 2% as inadequate. In the majority of cases, our inspectors have seen and heard that staff involve people in their care and treat them with compassion, kindness, dignity and respect, leading to 'caring' being the most highly rated of all the questions we ask services. More than nine out of 10 services were rated as good (92%) or outstanding (3%) for caring.

Figure 2.1 Adult social care ratings – overall and by key question



Source: CQC ratings data, 31 July 2017, total 21,256 locations.

Overall ratings – regional breakdown

Region-by-region analysis of the overall ratings shows that there is variation in quality by area. Figure 1.17 in part 1 maps regional performance across local authority areas in England. The lighter areas on the map show where, on average, we found the highest rated adult social care services, and the darker areas show where the lowest rated services were.

Types of services

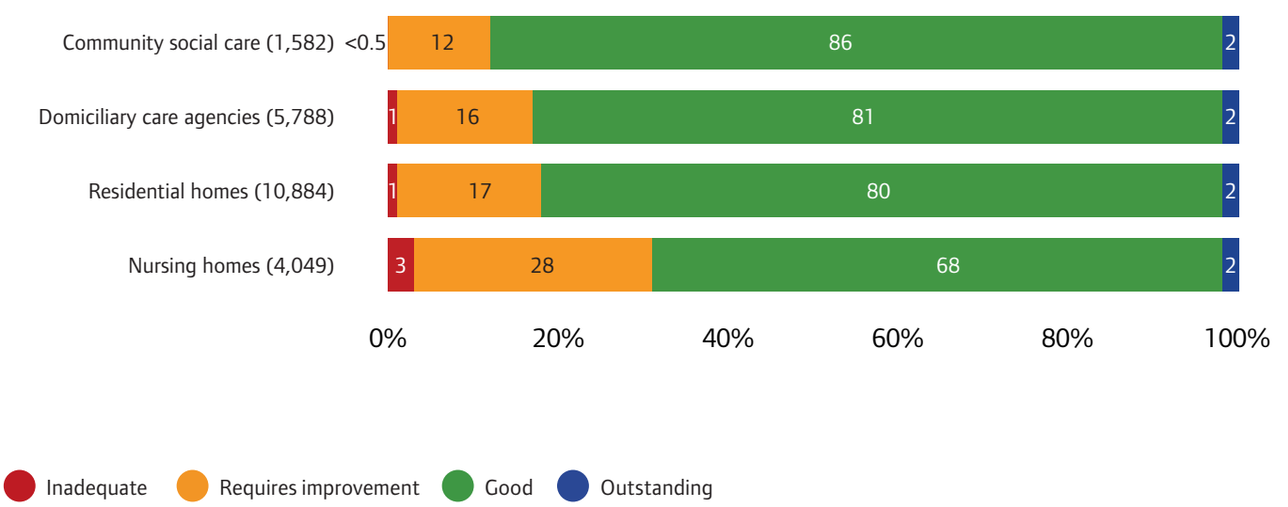
There is considerable variation if we look at the ratings across different types of services. Community social care services (for example supported living and Shared Lives) were rated the best overall when compared with other services (figure 2.2). Domiciliary care services and residential homes received similar ratings, with four out of five services rated as good. It is nursing homes that remain the biggest concern – 68% were rated as good and 2% as outstanding, with 28% rated as requires improvement and 3% as inadequate. To give an idea of the numbers of people experiencing these levels of care, the 3% of nursing homes rated as inadequate can provide services for around 6,300 people.

Size of services and providers

Analysis of our inspections shows that there is variation in performance depending on the size of services. In both nursing and residential homes, there is a trend that smaller homes (one to 10 beds) are rated better than larger homes (above 49 beds), with 92% of small nursing homes and 89% of small residential homes rated as good, compared with just 63% of large nursing homes and 72% of large residential homes. This pattern may be in part because many smaller homes are for people with a learning disability, and these services tend to perform well – they have around half the proportion of inadequate or requires improvement overall ratings compared with services without a learning disability specialism. The caring and responsive key questions were particularly strong for learning disability services, showing that providers are organising their services to meet people's needs, and staff are involving people in their care and treating them with compassion, kindness, dignity and respect.

When looking at domiciliary care, our data shows that services providing care to a smaller number of people were also performing better than larger

Figure 2.2 Adult social care overall ratings by type of service



Source: CQC ratings data, 31 July 2017.

services. Our ratings data shows that 84% of small services (for one to 50 people) were rated as good, whereas only 73% of larger services (for more than 100 people) achieved the same quality.

We have found that services that care for smaller numbers of people often found it easier to demonstrate a good level of responsiveness – for example, by being able to offer activities that are based on people's individual interests.

It is interesting to note, however, that corporate providers (with 20 or more locations) have been better at improving. As reported in *The state of adult social care services 2014 to 2017*, only 15% of locations owned by corporate providers remained inadequate at their last rating, compared with 22% of non-corporate locations. This might suggest that corporate providers are more equipped to step in to support any of their locations that are performing poorly, and we are aware of larger corporate providers establishing quality turn-around teams to address problems at individual locations.

High-quality care

All providers can learn from high-quality services – especially those that are rated as inadequate or requires improvement. Good and outstanding providers can also learn from the best practice since continuous improvement is vital to maintain quality care for people. Leadership and person-centred care are two main themes that characterised high-quality adult social care.

Leadership

Strong leadership has a pivotal role in both high-performing services and bringing about improvement in adult social care. At registered manager level, strong leadership was characterised by individuals with an innovative approach who were open to feedback and actively sought out best practice to steer improvement – for example, through involving people who use services in training. Managers were visible in the service, and known to staff, people using the service, carers and families. They also genuinely appreciated equality and diversity and sought ways to meet people's human rights.

Good managers truly valued their staff, supporting them to maintain their knowledge of best practice and person-centred care through training and establishing 'champions' in different areas of care.

Strong leadership was not restricted to registered manager level. Managers were supported by providers to communicate a strong vision and values to all staff, encouraging a culture of openness and transparency.

Person-centred care

Good leadership that generates a positive and inclusive culture leads to genuinely person-centred care. In high-quality services, staff really get to know people as people, understanding their interests, likes and dislikes. This supports relationships where staff and people who use services work together to set and achieve meaningful and realistic goals.

Practical examples of how services delivered person-centred care included:

- Tailoring activities to individuals' likes and interests. This often involved using the arts to find creative ways of enhancing people's quality of life. For example, there is building evidence that music and singing activities improve the wellbeing of adults living with diagnosed conditions or dementia.[62]
- Staff actively supporting links with the wider community and involving volunteers in day-to-day activities.
- Arranging the environment so it provides positive living, learning and social experiences – for example placing objects around the home that were meaningful for people and that they could interact with.

In part 1 of this report, we highlight that the best services collaborate at a local level. In adult social care, this has a key role in making sure that people receive person-centred care. Our inspections are beginning to see pockets of evidence of integration, but localised initiatives are only at an early stage of development.

Examples included:

- A step-down unit in a care service, which provided care for people who no longer needed an acute bed but were waiting for a residential or nursing home.
- A system that links a care home to a hospital via a web cam so that appointments can be carried out virtually. It enables a hospital doctor to advise on treatment and any suggested medication can be forwarded to the person's GP for prescription. This approach has been seen to reduce admissions of older people to acute settings.
- A domiciliary care agency that had been involved in developing training for support staff, such as GP and dental receptionists, to help them recognise the signs of dementia and better understand any behavioural symptoms that people may have.

Shared Lives

CQC ratings data shows that Shared Lives services, which match adults who have care needs with approved carers, perform very well; over 90% were rated as good or outstanding. The key questions of caring and responsive are rated particularly highly compared with all adult social care services. This reflects the personalised approach of Shared Lives services that can bring positive results for people using them. The example below shows some of the characteristics that have led to high ratings and remarkable support for people using services:

- Strong leadership, with managers who maintained strong relationships with other local health and local authority services, who were forward looking and focused on solutions to maintain placements.
- Positivity of staff reflected this strong leadership and careful recruitment. Staff were dedicated, enthusiastic and motivated by achieving positive outcomes for people using the service.
- There was a robust process for matching a carer with a person to ensure that their needs were catered for.

Person-centred care in a high-performing service

Mary and Joseph House is a care home in Manchester, providing accommodation and personal care to adult men with enduring mental health needs.

A person who used the service said:

> "The staff here know what they are doing. They have supported me so well, I was close to death when I first arrived, now I am strong and feel great."

Mary and Joseph House check that people have realistic aims and objectives. They want to make sure that, if people are moving out, they have their finances sorted out correctly. There was an example of a person who was due to move back into his family home. The service was supporting him over a number of months, to visit his home regularly, to try and build up links with the community, to find new volunteering opportunities, and to know that he can still come back to Mary and Joseph House for a cup of tea or to have a meal.

Arts and creativity were an integral part of the service provided at Mary and Joseph House:

- The service had a choir and an instrumental band that had been organised by the staff and people.
- A therapeutic gardener and art teacher were employed. The gardening team have worked with the art group to achieve Gold Awards in various Royal Horticultural Society competitions.

Improvement

Re-inspections

Throughout our initial programme of comprehensive inspections in adult social care, we have seen improvements across all types of services. Figure 2.3 shows what has happened to all services that have been re-inspected.

Improvement is most evident in services that originally had the poorest quality, and were rated as inadequate. These services may not have been keeping people safe – there may have been widespread and significant shortfalls in the care, support and outcomes that people experienced; staff may not have treated people with respect and sometimes been unkind and lacked compassion; people may not have been involved in the development of their care; and these things may have stemmed from a lack of good leadership.

Eighty-two per cent improved their overall rating of inadequate following re-inspection; 48% moved to requires improvement and 34% moved two ratings to good. We will continue to focus on those services that continue to be rated as inadequate (18%).

We have not seen the same rate of improvement in services that have been rated as requires improvement. We are clear that providers and commissioners need to work together to improve services rated as requires improvement to achieve a rating of good or outstanding. Of the 4,533 locations originally rated as requires improvement that were re-inspected, 58% had improved to a rating of good. However, in 36% of cases, there had been no change, and in 5% of cases, quality had deteriorated, resulting in a rating of inadequate.

Having completed our initial programme of comprehensive inspections, we are now looking at the movement in quality, not only of services rated as inadequate or requires improvement (which we check more frequently), but also those that at first inspection we rated as good or outstanding. Of the 3,105 locations originally rated as good that we have re-inspected (some planned as part of our timetable for return inspections but most prompted by concerns or notifications), 2% had improved to outstanding. In 75% of cases, there had been no change, but in 23% of cases, quality had deteriorated, resulting in a rating of requires improvement (20%) or inadequate (3%).

A high-performing Shared Lives service

The Shared Lives Service in Lancashire provides long-term placements, short breaks, respite care, day care and emergency care for adults with a range of needs, within carers' own homes.

A person who used the service said:

> "Shared Lives are amazing. This is my home and I am made to feel part of the family. Staff are really nice and friendly."

One carer said:

> "We wanted to see what [the person's] potential could be. They have gone from doing almost nothing to being outgoing and making decisions for themselves, including where they want to go and who they want to see. It's been amazing to see the transformation."

One person showed us photographs of themselves when they had moved into their Shared Lives home a few years ago, to show us they had lost a significant amount of weight. They were proud of this achievement and it was obvious they had been given a lot of support from their carer and support officer to eat well and lead a healthy and active life.

Even people who use outstanding services can experience a decline in their care – of the 12 services originally rated as outstanding that we have re-inspected, five of these have deteriorated by two ratings to a rating of requires improvement.

How services improve

Good leaders have a big influence on the quality of care that people receive. This applies not only to high-quality services but also to services that have improved between inspections.

We have seen improvement achieved by consistent managers who are supported by the provider to bring about fundamental change. We have also seen improvement brought about through recruiting new registered managers. This is typified in the example below, where the new manager and provider:

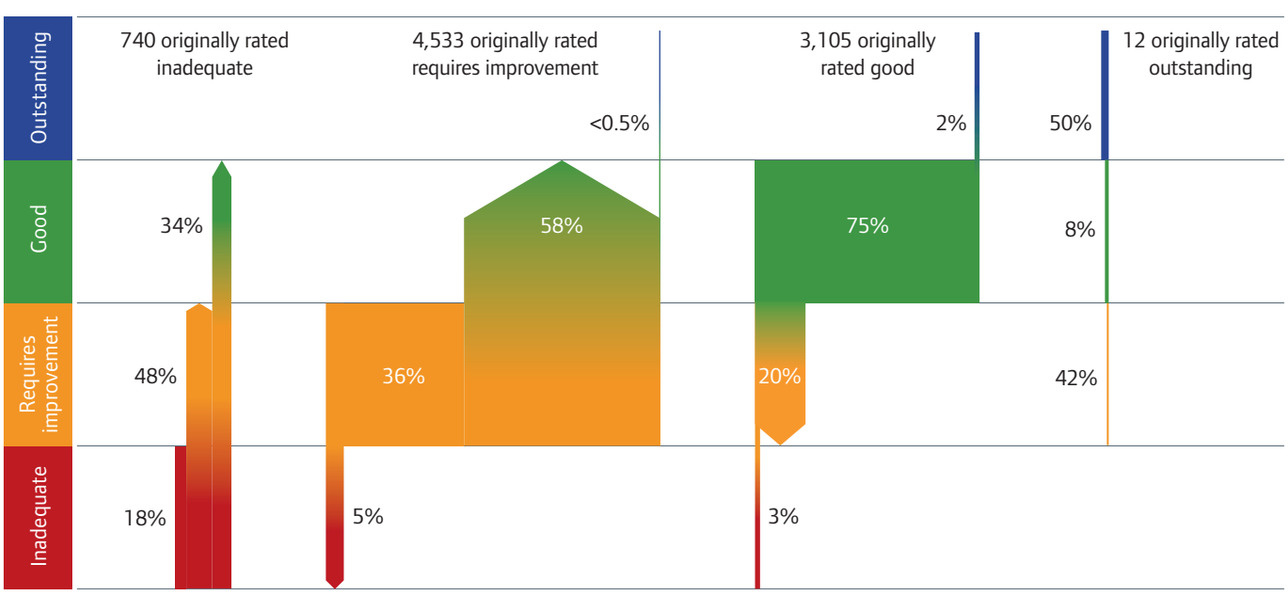
- addressed staff issues by providing training to help them understand the needs of the people in their care
- accepted and owned the issues raised by CQC
- moved to a more person-centred approach and culture, for example by involving people more in their care.

Enforcement

CQC understands there are financial pressures facing the adult social care sector, but this does not mean that we will compromise on our purpose of ensuring people receive care that is safe, effective, compassionate and high-quality. Our inspections show that services of all types and in all circumstances can provide high-quality care for people. Where there is poor care, we will encourage improvement, but we will also take action to stop unsafe care and protect people from abuse and avoidable harm.

The main areas that contributed to inadequate ratings relate to a lack of good governance, and issues with safe care and treatment, staffing and person-centred care. This may mean that providers and leaders

Figure 2.3 Change in overall ratings on re-inspection in adult social care



Source: CQC ratings data, 31 July 2017.

were failing to check the quality of their care, seek the views of people using the service, administer medicines safely, and make sure that staffing levels are adequate to provide care in a person-centred way.

The actions we take depend on how serious the problems we have identified are and how they affect the people who use the service. Actions range from giving providers notices setting out what improvements they must make and by when, to placing them in 'special measures', which gives them a clear timetable within which they must improve the quality of care they provide. We also have enforcement responsibility for health and safety incidents in the health and social care sector. These cases have covered a wide range of safety issues, including medication errors, uncovered radiators and use of bed rails. Recurring themes, which have been highlighted in legal analysis,[63] included:

- Issues with documentation: for example, errors in medication dosages and strengths, and timings not being accurately recorded.
- Risk assessments: for example, one care home was found to have no proper system for assessing the risks to the health and safety of people using services (including failing to prevent a blind resident repeatedly falling in her room and a resident repeatedly choking).
- Equipment: for example, a person living with dementia suffering burns after falling against a radiator because of a lack of radiator covers or pressure sensor mats to alert staff to the person getting out of bed.
- Staff training: for example, a person fell out of a shower commode chair because staff did not know about a national safety alert about the importance of safety/posture belts and did not understand how to fit chair straps safely.

Improvement through a change of manager

In December 2015, we inspected a 58-bed residential care home providing care to older adults with a range of support and care needs. We found that the manager in place was not knowledgeable, approachable or responsive. Staff were process-driven and did not support people in a caring way that protected their dignity and privacy. The combination of these two aspects led to the service being rated as inadequate.

After this first inspection, the acting manager left their post and a new manager was appointed. At the second inspection the manager, with support from the owner, had been able to achieve a great deal of improvement in a short period of time. This included:

- Staff teams were mixed up so that "problematic cliques" could be broken up and staff could be exposed to best practice at other parts of the service.
- Person-centred care training for staff. This included dignity challenges that aimed to give staff a better understanding of how it feels to be cared for, for example being fed by another person while wearing a blindfold. At the second inspection, staff commented on how important the training had been for their role.
- More frequent staff meetings and weekly memos to improve communications between staff and the manager.

The overall rating of requires improvement reflected the work that the manager had been able to achieve, but still showed there was more to do.

At the third inspection the inspector saw improvements in the areas identified at the previous inspection and no new issues, and was able to rate the home as good.

Hospitals, community health services and ambulance services

Key points

- Fifty-five per cent of NHS acute hospital core services were rated as good and 6% as outstanding (6%). This compares with 51% rated as good and 5% rated as outstanding last year. At the trust level, 11 NHS acute trusts were rated as outstanding.
- A majority of community health services were providing good (66%) or outstanding (6%) care. Three of the 10 ambulance trusts were rated as good and one as outstanding.
- Pockets of poor care exist, even in services rated as good. We continued to see a large amount of variation in the quality of care of services within individual hospitals and between hospitals in the same NHS acute trust.
- The safety of NHS acute hospitals remains a concern with 7% rated as inadequate for the safe key question. Ratings have improved though, as last year 9% were rated as inadequate for safety.
- Staff recruitment and appropriate skills mix were a concern in most sectors. We found NHS acute services relying too much on agency staff, and emergency departments with not enough medical staff. We have concerns that community and ambulance services are also facing staffing challenges.
- We continued to find that good leadership from senior leaders through to frontline staff, combined with strong staff engagement and a positive organisational culture, helps to ensure good quality care and drives improvement.

Introduction and context

In March 2017 we published *The state of care in NHS acute hospitals 2014 to 2017*, a report that captured our findings over the last three years of our programme of inspections of NHS acute hospitals.[64] The report showed that we now know more about the quality of care in our hospitals than ever before, and we have a unique baseline of quality against which we can monitor improvement.

In this chapter we look at the whole range of emergency and secondary care that we regulate, comprising NHS acute trusts, ambulance services, community health services and independent hospitals. The findings from our NHS acute programme report are summarised along with findings from the wider sector. We report on mental health services in the mental health chapter.

As we have highlighted in part 1 of this report, the pressure and demand on emergency and secondary care has continued to increase this year. The model of acute care that has been in operation since the NHS first started cannot continue to meet the needs of today's ageing population. In NHS acute hospitals, the steadily increasing demand for urgent and emergency services, coupled with continued delays around transferring patients from hospitals to home or community care, mean that patients are being kept too long in acute services. This system flow is not working and people are frequently not being cared for in the right place for them. This is a risk to the health and wellbeing of people. We continue to see a variety of pressures across the sector:

- Emergency and elective admissions to hospitals have risen substantially in the last six years (page 15 to page 16, figures 1.1 to 1.3).
- Ambulance calls increased from 8.2 million to 9.8 million from 2011/12 to 2016/17, an increase of 20%.[65] In 2016/17, there were 680,000 ambulance hours lost due to turnaround times at A&E taking longer than the maximum target of 30 minutes.[66]
- Waiting times have steadily worsened – from April 2011 to April 2017, the number of patients at the end of each month waiting to start treatment on the 18-week pathway increased by 53% from 2.47 million to 3.78 million.[67]
- In acute hospitals, bed occupancy has remained above the recommended maximum of 85% since at least the start of 2012/13. From January to March 2017, it was the highest ever recorded at an average of 91.4%.[68]
- The number of days that people were delayed in hospital waiting for domiciliary care more than tripled from March 2014, peaking in December 2016 at more than 42,000 days (although since then there has been some improvement). However, the majority of delays remain attributed to the NHS (acute and non-acute services). In March 2017, 55% of all days delayed at hospital were attributed to the NHS, compared with 37% to adult social care, and 8% to both.[69]

Our programme of local system reviews is looking at how people move between health and social care, including delayed transfers of care, and where there are opportunities for improving how the system works (page 39).

The NHS's most important resource – the dedicated workforce – is feeling the strain, and staff resources are stretched. As we highlight in part 1, across the NHS, including in some of the main staff groups, data from NHS Digital based on advertisements on the NHS Jobs website suggests there was an increase in vacancies between March 2015 and March 2017 that outstrips any increase in the total number of posts.[70] As we also mention in part 1, there has been a sharp drop in the number of new nurses arriving from the EU to register to work in the UK.[71] We have found NHS acute services relying too much on agency staff, and emergency departments with not enough medical staff.

The reported financial deficit for all NHS providers had reduced from £2.4 billion at the end of 2015/16 to £791 million at the end of 2016/17.[72] However, as noted in part 1, the Nuffield Trust have argued that the underlying deficit remains substantial despite the significant savings that providers have already delivered.[73] Providers are being asked to make further productivity gains to build sustainable services, at the same time as new models of care are being created to meet the changing needs of the population.[74]

Overview of quality

Overall and key question ratings

NHS acute trusts

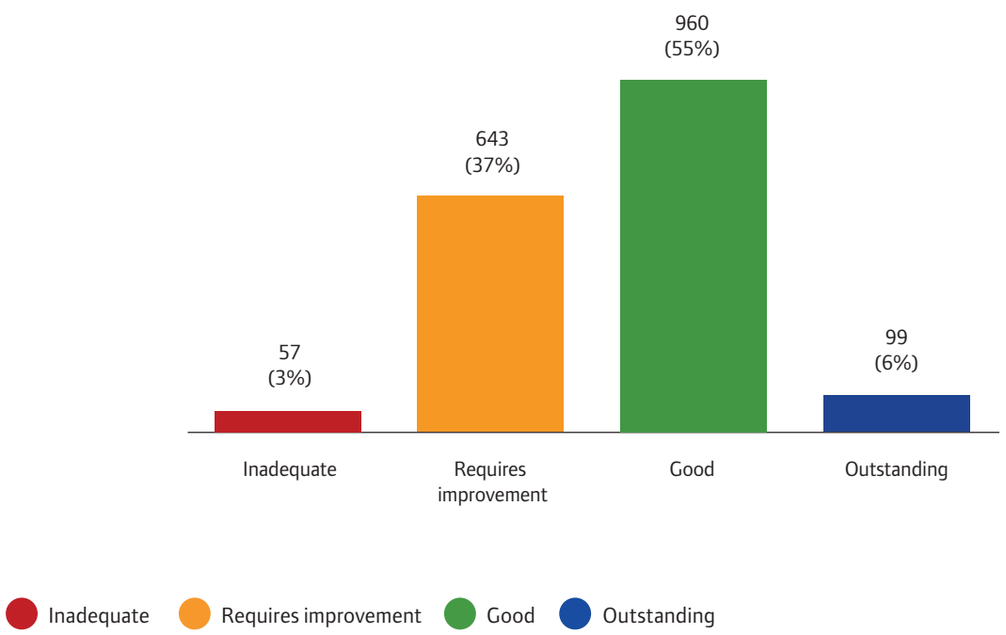
Our ratings look at the whole picture of NHS acute care, providing ratings at:

- core service level (where patients directly experience the quality of care being given, for example by a maternity or surgery service)
- hospital level (ratings are combined from each of the core services)
- trust level (ratings are combined from one or more hospitals and other services).

At the core service level most people were receiving good or outstanding care and the overall quality of care has improved since last year.

At 31 July 2017, 55% of NHS acute hospital core services were rated as good and 6% as outstanding (figure 2.4). This compares with 51% rated as good and 5% rated as outstanding last year. Note that at this time last year not all core services had been rated.

Figure 2.4 NHS acute hospital core service overall ratings



Source: CQC ratings data, 31 July 2017, total 1,759 core services.

However, people may experience a variation in quality depending on which core service they use, often within the same hospital – 37% of core services were rated as requires improvement and 3% were rated as inadequate. Urgent and emergency services and outpatient services were more likely to be rated as inadequate (figure 2.5).

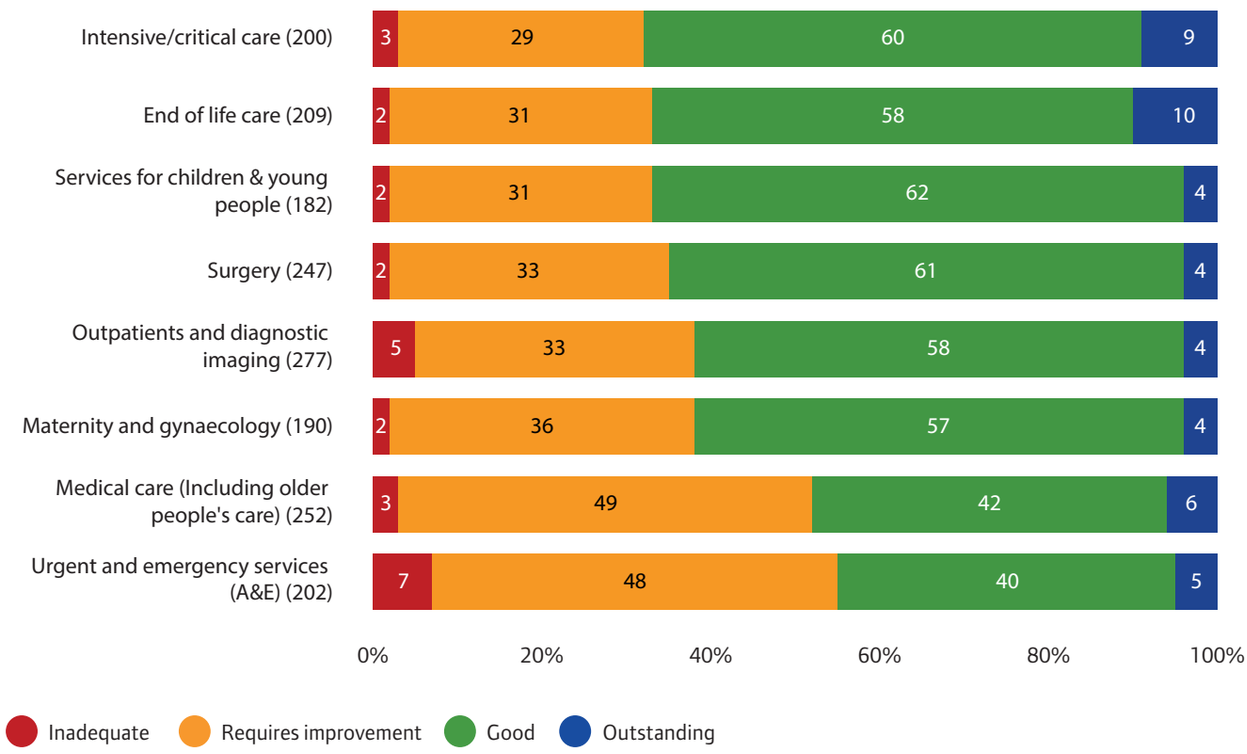
At the acute hospital and the acute trust level, the good and outstanding ratings tend to be slightly lower due to their complexity and the variation of quality that often occurs within hospitals and between hospitals in the same trust.

At hospital level, 40% of acute hospitals were rated as good and 6% were rated as outstanding. Just under half of hospitals (49%) were rated as requires improvement with 5% rated as inadequate (figure 2.6). Overall this is a slightly improved picture compared with last year, although variation in the quality of care remains.

The safety of hospitals remains our biggest concern with 7% of NHS acute hospitals rated as inadequate for the safe key question. Despite the unprecedented pressures that acute hospitals are facing, ratings have improved from last year when 9% were rated as inadequate for safety. This largely reflects improvements in the safety cultures of providers, with staff more ready to speak up about their concerns and trusts more willing to act on them.

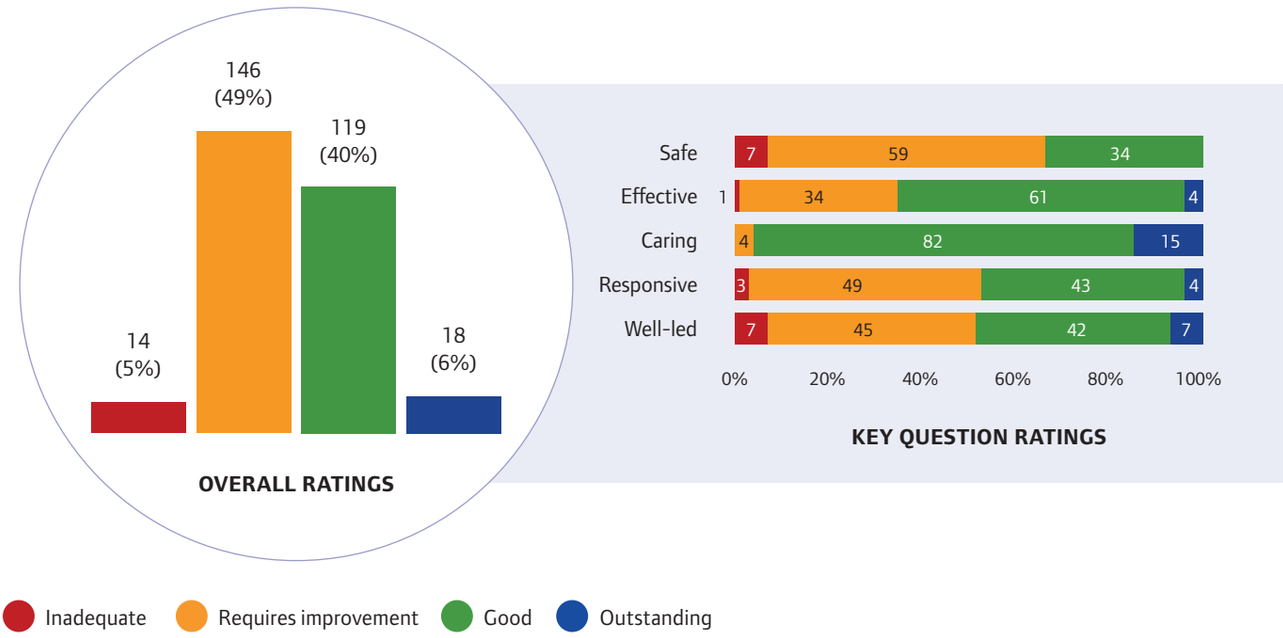
At trust level, 34% of NHS acute trusts were rated as good and 7% as outstanding (figure 2.7). Last year, 28% were rated as good and 4% were rated as outstanding. However, 51% of trusts were rated as requires improvement and 8% as inadequate.

Figure 2.5 NHS acute hospital overall ratings by core service



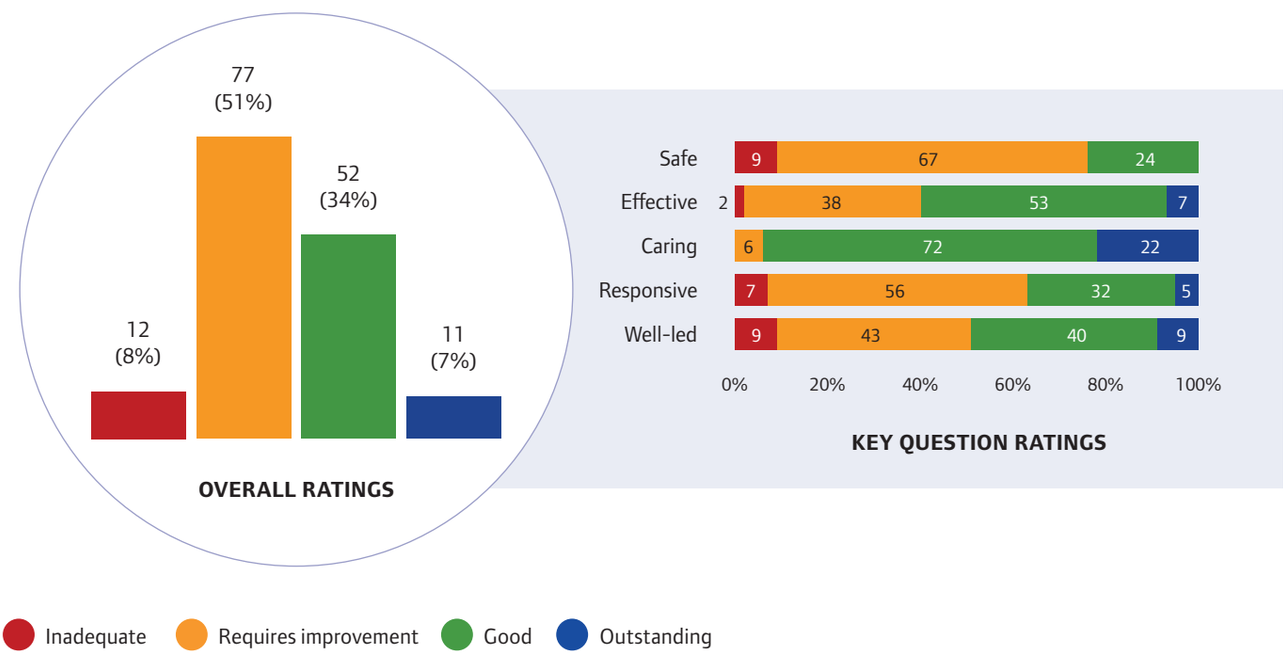
Source: CQC ratings data, 31 July 2017.

Figure 2.6 NHS acute hospital ratings overall and by key question



Source: CQC ratings data, 31 July 2017, total 297 hospitals.

Figure 2.7 NHS acute trust ratings overall and by key question



Source: CQC ratings data, 31 July 2017, total 152 providers.

Where trusts were doing well for being responsive, they had a person-centred-approach and addressed issues from the patient's point of view. Inspectors saw examples of trusts that had invited community members, for example from Black and minority ethnic (BME) populations, to sit on their board. They also saw trusts that provided a service tailored to the needs of particular local groups, for example refugees.

Although not the lowest rated question, we do have concerns about the 43% of trusts rated as requires improvement for well-led and the 9% rated as inadequate for well-led. This is because the quality of leadership, management and governance is an important influence in driving improvement in the quality of care.[75] This compares with the 50% of acute trusts rated as requires improvement and the 8% rated as inadequate for well-led last year.

However, 40% of trusts were rated as good for the well-led key question and 9% were rated as outstanding. This compares with 36% rated as good and 6% rated as outstanding last year.

Ambulance services

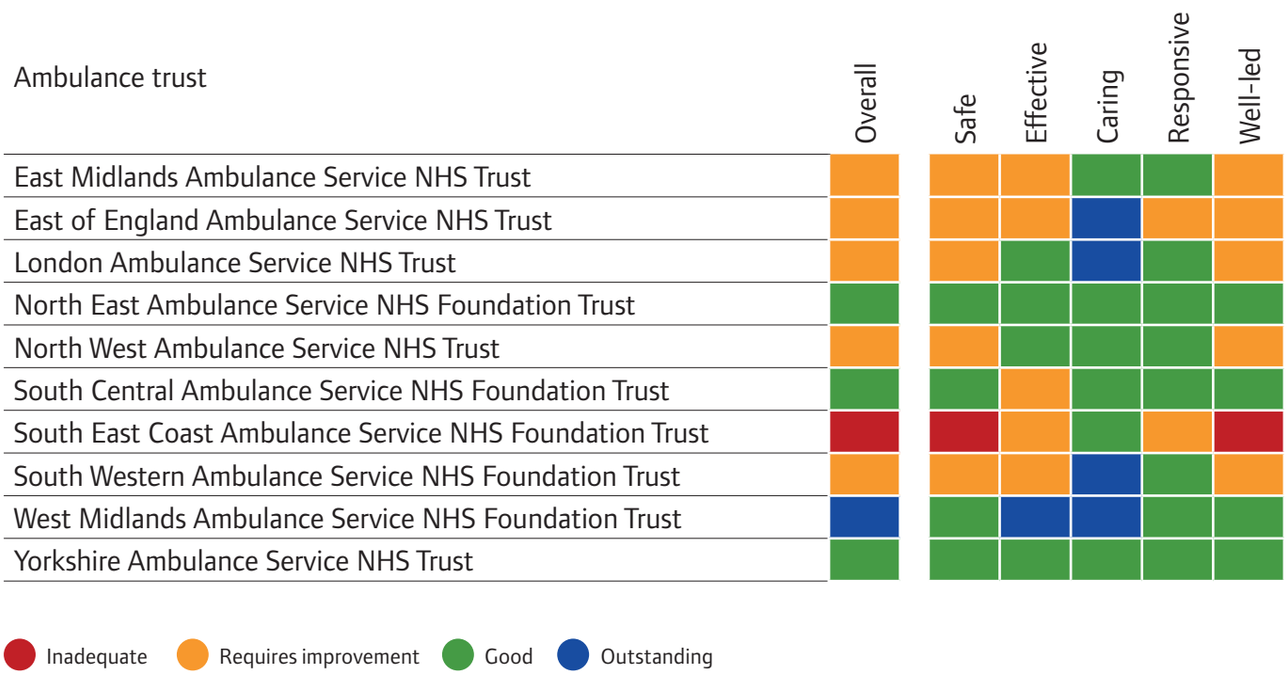
Ambulance services provide a vital link between members of the public and urgent and emergency care.

We have rated all 10 NHS ambulance trusts in England (note that additionally, Isle of Wight NHS trust provides ambulances services). There are also around 260 registered independent ambulance providers that vary from corporate to voluntary to family-owned providers. We do not rate independent ambulance providers, although this may change in 2018 following a Department of Health consultation.

We rated one NHS ambulance trust as outstanding overall and three as good. However, the quality of care is variable across this sector with five trusts rated as requires improvement and one trust rated as inadequate (figure 2.8).

Major incidents such as the London and Manchester terror attacks and the Grenfell tower fire have brought the exceptional commitment and responsiveness of the frontline staff in emergency

Figure 2.8 NHS ambulance trust ratings overall and by key question



Source: CQC ratings data, 31 July 2017.

services to public attention. Six of the 10 trusts were rated as good for the caring key question and four as outstanding. Eight of the 10 trusts were rated as good for the responsive key question. The safe and well-led key questions were most likely to be rated as inadequate or as requires improvement.

Ambulance trusts had a lower staff engagement score in the 2016 NHS staff survey compared with other NHS sectors.[76] We have some concerns around staffing in the ambulance service, which may affect the ability of providers to follow reporting processes and learn from events. We are likely to explore these issues, among others such as leadership, and report on our findings in due course.

Our programme of inspecting independent ambulance services continues, and we have inspected more than 70 providers. We have some common care quality concerns around medicines management, cleanliness and infection control practices, and ensuring appropriate recruitment checks.[77] At 31July 2017, we had taken enforcement action against 12 providers.

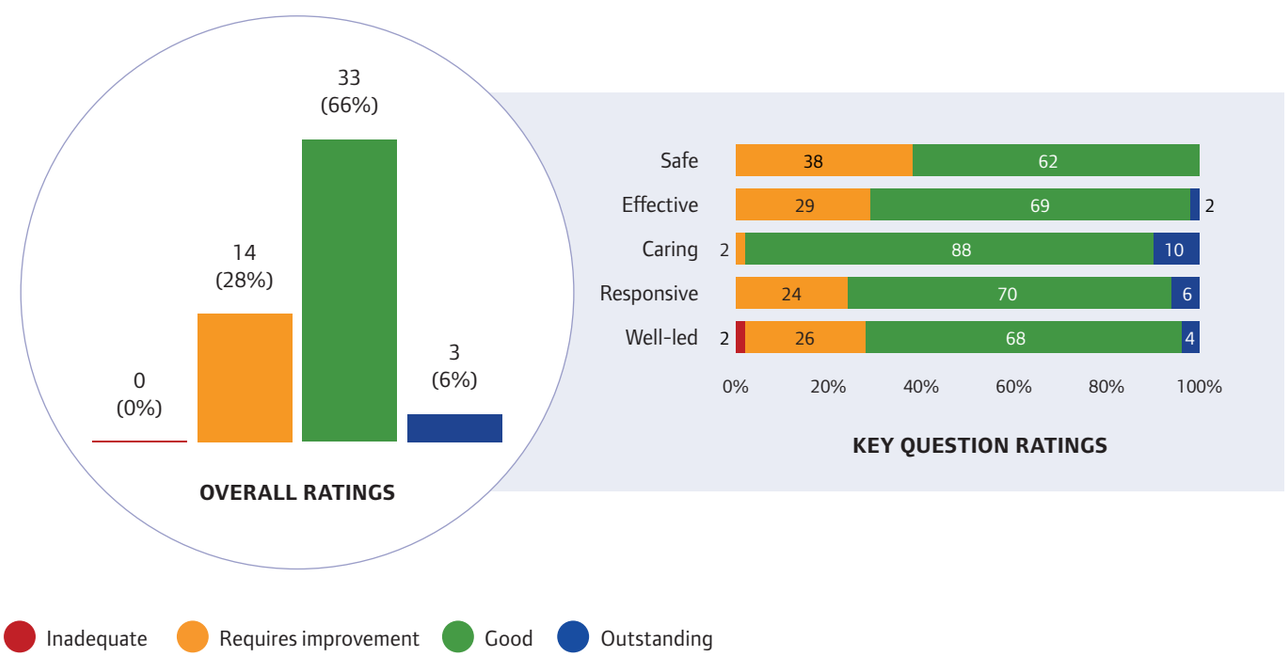
Community health services

Community health services are used by people who need long-term care or regular support and are provided in locations such as clinics that are closer to home, or in a person's own home. Community health services include, for example, physiotherapy, health visiting and care for people with long-term conditions such as diabetes.

Community health services span a range of different types of organisations and settings. There are 18 specific NHS community health trusts but care is also provided by more than 30 NHS acute trusts and more than 20 NHS trusts that also provide mental health services. There are also more than 100 independent community health services, often social enterprises, charities and community interest companies.

We have now inspected and reported on all community health services. As at 31 July 2017, a majority of those that were rated were providing good (66%) or outstanding (6%) care (figure 2.9).

Figure 2.9 Community health services ratings overall and by key question



Source: CQC ratings data, 31 July 2017, total 50 providers.

The caring key question was very positive with 88% of services rated as good and 10% as outstanding for caring. The highest number of requires improvement ratings were under the safe key question.

Most core services were rated as good or as outstanding. Community dental services had the best care with 66% of services rated as good and 22% as outstanding, followed by community sexual health services.

We have some concerns around staffing shortages, particularly in community adult services and inpatient services, and around variation of caseload size in both adult services, and children and young people's services. However, we do see community services working well in partnership with acute hospital services and others to provide integrated care. We will report on our findings in due course.

Hospices

Hospices were generally rated as good (70%) with a quarter rated as outstanding – this was higher than for any other secondary care service (figure 2.10). Since 31 July 2017, the date at which ratings in this report are based, one hospice has been rated as inadequate.

Hospices also performed very well for safety in comparison with the majority of other types of services – 88% were rated as good and 1% as outstanding. And hospices are very caring and compassionate with a third rated as outstanding for caring.

We looked at two examples of hospices that provide high-quality care that is typical of hospices rated good or outstanding. We found some common factors that led to their strong performance, and that show best practice. The staff were genuinely committed to person-centred care and really took time to understand people and to support their emotional, social and financial needs, as well as physical needs. There were high staffing levels, enabling better monitoring and attention to personalised care. Good partnership working with other professional services and the local community, and a supportive and well-led culture were also common factors.

Independent acute hospitals

Independent acute hospitals provide services to insured, self-funded and NHS patients. They almost exclusively provide elective services, such as orthopaedic surgery. They can range from corporate hospital groups to specialist surgeries and providers of specific treatments.

By 31 July 2017 we had rated 197 independent acute hospitals, with 64% rated as good and 7% as outstanding. There were 27% rated as requires improvement and 2% rated as inadequate (figure 2.11).

We will publish a detailed report later in 2017/18 on our findings from our first programme of inspections of independent acute hospitals. We intend to explore leadership in the sector and anticipate sharing insights on how well providers' governance systems allow them to proactively manage risk. We will look at areas such as managing incidents and learning from them. Specifically, we intend to consider how well provider governance systems monitor consultants' practicing privileges to ensure they are working within the agreed scope of practice to protect patients effectively. We will also look at how well providers ensure effective multidisciplinary meetings take place and how providers monitor clinical outcomes.

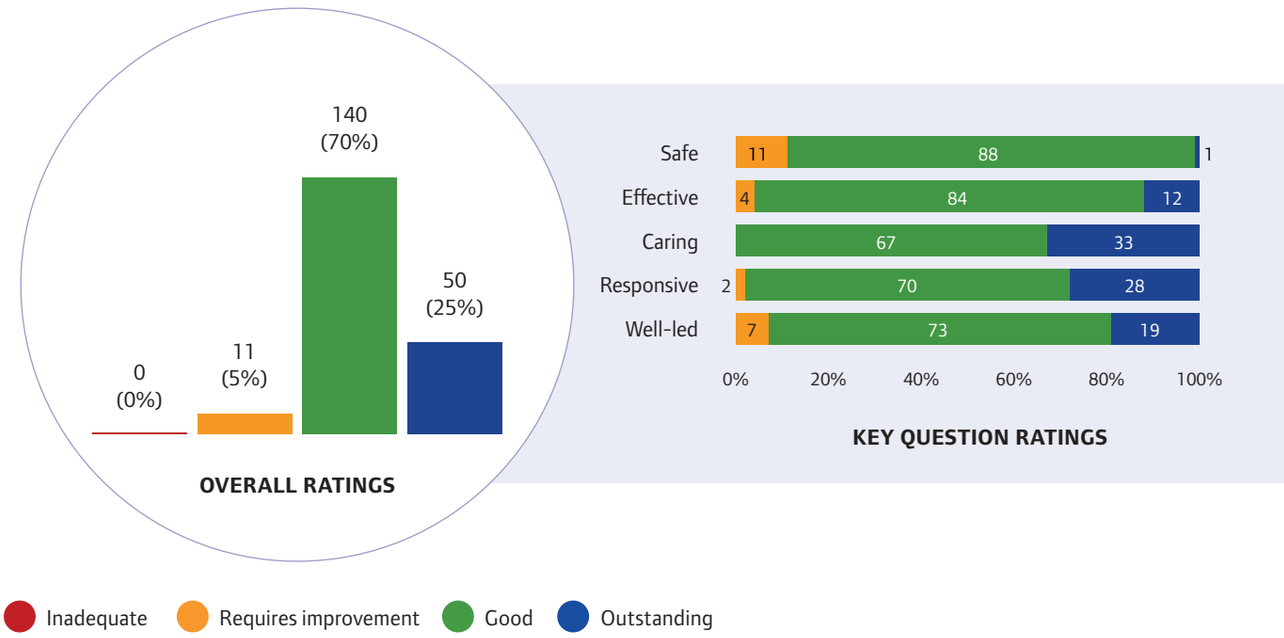
High-quality care

People using services have a right to expect the best care possible. We have found examples of good and outstanding care that providers can learn from and we have identified three important areas that help drive high-quality care – good leadership, a positive organisational culture and a focus on safety.

Good leadership

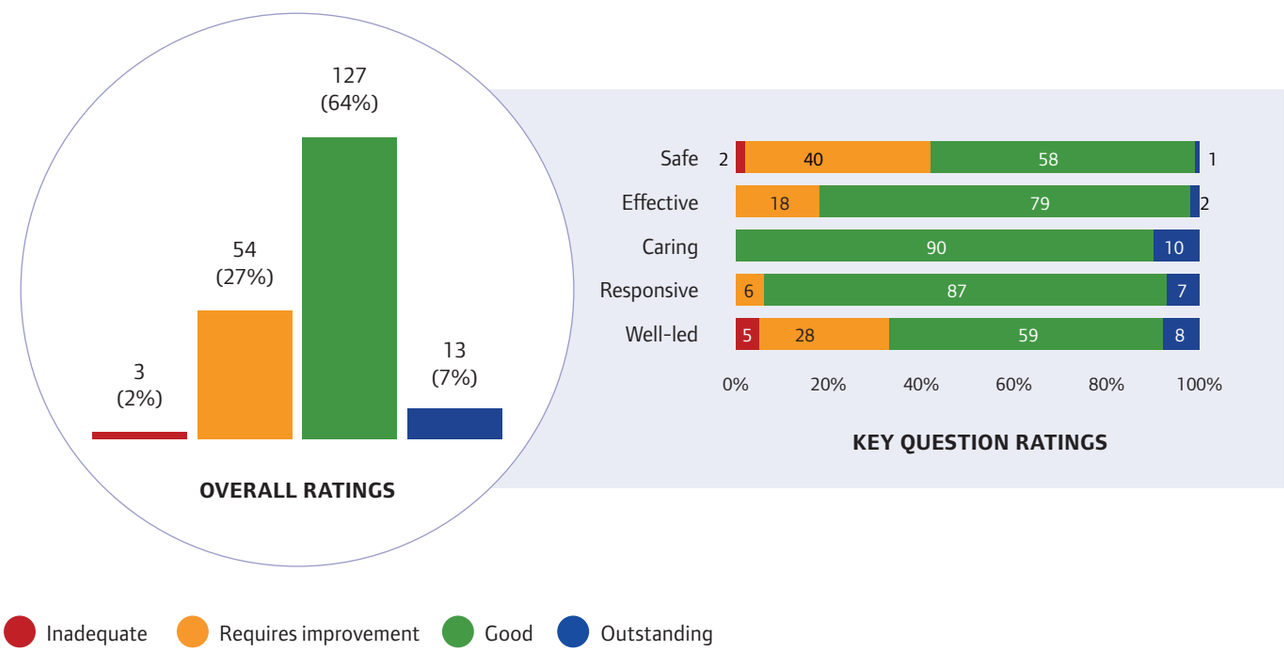
As highlighted in our NHS acute programme report, good leadership – from a board level, through to frontline staff – plays a crucial role in providing high-quality care. Good leadership genuinely puts the person at the centre of care, supports staff to learn and innovate, and promotes an open and fair culture.

Figure 2.10 Hospice ratings overall and by key question



Source: CQC ratings data, 31 July 2017, total 201 locations.

Figure 2.11 Independent acute hospital ratings overall and by key question



Source: CQC ratings data, 31 July 2017, total 197 hospitals.

In NHS acute trusts rated as good or outstanding, we usually found they performed equally well under the well-led key question. In almost all of the trusts rated as outstanding we saw leaders who were:

- passionate about the delivery of high-quality care for patients
- actively engaged and sought the views of staff and patients, and were committed to organisational development
- had a clear vision and strategy that was understood by staff
- made sure that governance was strong, so that problems were dealt with swiftly
- had a clear model for quality improvement across the trust.

In part 1 of this report, we highlight that the best services collaborate at a local level. Good leaders work closely with different parts of the health and social care system to provide a more joined-up and person-focused experience. We have seen some good examples of integration, particularly between acute and community care with the aim of bringing care closer to home. However, these examples tended to be at the developmental stage.

Inspectors saw good integrated care between an independent ambulance service and a specialist children's NHS acute hospital service. The two services worked closely together to ensure that sick children from across England could be transported to receive specialist care. The hospital provided a designated doctor and nurse and the ambulance service provided two vehicles. The strong leadership behind this partnership that put the patient's needs at the centre was thought to be a driving force in making it happen.

Inspectors saw acute trust and community trust leaders working together to jointly deliver an acute care service in a community setting. A very positive result of this partnership has been improved continuity of care for patients who need to attend pulmonary rehabilitation clinics and reduced pressure on acute services. They have been able to attend appointments closer to home in a local community venue and to see their own consultants there.

Positive and engaged organisational culture

The culture of an organisation clearly reflects the quality of its leadership and is essential to the delivery of high-quality care. A culture where all staff are fully aligned with the organisation's vision and values, and are inspired to work as a team helps to sustain and improve the quality of care.

In NHS hospitals rated as good or outstanding, boards actively engaged with staff to support them to learn from mistakes and to be honest about problems with patients and families.

Organisational culture is reflected in the NHS staff survey. The 2016 survey looked at all trust types and showed an overall improvement in staff engagement scores since 2012, with more than half of all respondents (59%) saying they often or always look forward to going to work, and 74% of all respondents saying they feel enthusiastic about their job. Too many staff reported a blame or bullying culture in their workplaces, with 13% of respondents saying they had experienced bullying or harassment from their manager, and 18% from other colleagues. Staff at NHS acute trusts have told us that the poor culture of clinical teams and the barriers they face to delivering good quality care are the most common reasons for them wanting to change jobs. Staff wellbeing and engagement need to be a priority for all types of NHS trusts.

CQC now assesses how well NHS trusts have implemented the NHS Workforce Race Equality Standard (WRES) as part of assessing the well-led key question. WRES looks at the experiences of BME staff. We have found that, as with other staff indicators, a strong and effective commitment to equality is an essential part of a culture that delivers high-quality care. There have been some improvements in the implementation of WRES but progress is slow. We have found that services rated as outstanding almost always have effective plans in place for looking at the WRES (see the equality in health and social care chapter).

Focus on safety

At the heart of providing good care is keeping people safe. Safety also has a strong link with leadership. It is rare for NHS acute trusts to be well-led but to have substantial problems with safety.

NHS acute trusts that performed well in this area genuinely put safety as a top priority. They had good monitoring and reviewing activities that gave staff a clear, accurate and current picture, so that risks could be looked at on a daily basis. They also had embedded systems and operational processes for keeping people safe and protected. Staff felt empowered to speak out about safety issues and there was a supportive learning culture.

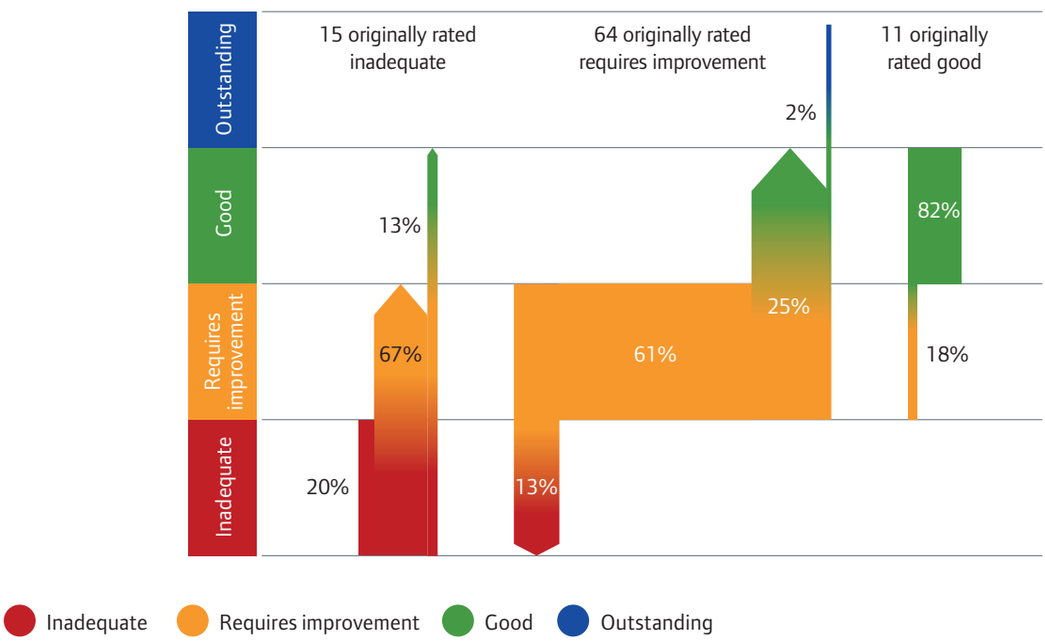
Ensuring staffing levels and skills mix are well planned, implemented and reviewed was found to be another important part of a good safety culture. NHS acute trusts that were rated as good or outstanding for safety had staffing plans in place to respond quickly and adequately to emergencies and they anticipated likely changes in demand.

Improvement

Despite the pressures facing the sector, providers are able to improve. With our baseline of quality we can better identify improvement. We have re-inspected 90 NHS acute hospitals since their first rating. Of the 15 hospitals originally rated as inadequate and re-inspected, 10 (67%) improved their overall rating to requires improvement and two (13%) to good. Of the 64 hospitals rated as requires improvement, 16 (25%) improved to good. We have seen one hospital improve from requires improvement to outstanding (figure 2.12).

Most improvements in NHS acute hospitals were against our safe and well-led key questions – these then helped to drive up the overall rating. The core services that improved the most tended to be those that had the lowest ratings on first inspection.

Figure 2.12 NHS acute hospital re-inspection overall ratings



Source: CQC ratings data, 31 July 2017.

We have also seen improvement in other sectors. Of the eight independent hospitals we have re-inspected since their first rating, one improved from inadequate to good; three from requires improvement to good; and one from good to outstanding. The other three remained the same.

We have re-inspected three of the 10 NHS ambulance trusts. One trust improved from inadequate to requires improvement, one from requires improvement to good and one remained at requires improvement.

Sixteen hospices had been re-inspected as at 31 July 2017. Of eight originally rated as requires improvement, five improved to good and one to outstanding. Of eight originally rated as good, three improved to outstanding. The rest remained the same.

How services improve

In extensive interviews with eight NHS acute trusts (findings published in our *Driving improvement* report), the trusts that had improved were ready and open to change, and were receptive to our inspection findings.

Good leadership and governance were key components of those trusts that improved. They helped drive change but they had to be at every staff level including staff in clinical leadership roles.

When clinical leaders, such as consultants, ward managers and lead nurses, were effectively engaged and worked together with managers, this helped bridge the gap between senior leaders and frontline staff. This is supported by external research into the link between medical engagement and improving the quality of care.[78]

In the trusts that had improved, we saw good quality improvement initiatives that focused particularly

Northampton General Hospital NHS Trust – a commitment to quality and safety

This acute trust was rated as requires improvement when we first inspected in March 2014. Although there was some good practice, we identified areas for improvement including staffing, governance and managing medicines.

We have since re-inspected four core services. We found substantial change had taken place, particularly in establishing an inclusive and supportive staff culture with a focus on patient safety. There was a compassionate and whole team drive to improve the quality of care throughout the hospital. All four core services inspected had improved their ratings to good.

Medicines management procedures were being followed and there were enough medical and nursing staff to meet the needs of patients.

There was outstanding practice. The end of life care service – a service that had needed to really improve – had implemented a volunteer companion scheme for dying patients who may not have visitors. An end of life care room had been situated next to the resuscitation area. There was also clear guidance for situations where the patient was a child or young person. The hospital's stroke service had been rated highly by the Sentinel Stroke National Audit Programme.

There was a focus on providing integrated pathways of care, particularly for patients with multiple or complex needs, such as in the geriatric emergency service.

Senior leaders were proactive in engaging with staff and almost all staff were positive about the Board and senior management. Staff were proud of the hospital and referred to the 'Team NGH' spirit and culture.

on safety – for example, five of the eight trusts were working with the Virginia Mason Institute as part of a programme led by NHS Improvement. The programme supports healthcare organisations to develop a more patient-centred culture and to continuously improve. We also saw other local improvement initiatives, for example frontline staff who were involved in suggesting new ways to improve care, and trusts that did mock inspections to assess their quality of care on an ongoing basis.

Special measures

Despite the very encouraging signs of improvement, we have seen deterioration in some services. This is concerning for people using those services. Eight NHS acute hospitals originally rated as requires improvement dropped to an inadequate rating and two originally rated as good dropped to requires improvement.

NHS Improvement's special measures for quality regime provides support to improve for all types of NHS trust that have serious failings in their quality of care (usually with inadequate ratings in at least two out of the five key questions, one of which is for well-led). Since July 2013 when special measures started, 31 NHS trusts have entered special measures and, as at 31 July 2017, 16 have exited due to achieving enough improvement (these figures include one mental health trust). Trusts that improve and that exit special measures most quickly are those that are transparent about their quality problems and receptive to feedback.

London Ambulance Service NHS Trust – open to improvement and cultural change

Rated as inadequate in October 2015, London Ambulance Service NHS Trust was placed in special measures. Inspectors had serious concerns around staff training and culture, safety and performance.

Since then the trust has made good progress in turning around the quality of care. Thanks to an improved staff culture – including a focus on tackling bullying and harassment, better medicines management, and the recruitment and training of 700 new staff members – improvements were clearly visible at our re-inspection in February 2017.

Processes, such as those to learn from incidents, had improved. We saw good collaborative working between emergency operations centres, ambulance crews, resilience staff and external agencies. This work was coordinated to support seamless care for patients and to help find alternative care pathways to avoid unnecessary admissions to A&E.

However, there are still areas that need more work – for example, improving the communication between senior level and frontline staff; further improving medicines management; and meeting national performance targets for high priority calls.

Now rated as requires improvement, the trust remains in special measures as it continues its improvement journey.

Mental health

Key points

- We rated 68% of NHS core services as good and 6% as outstanding. Among independent services, 72% of core services were rated as good and 3% as outstanding.
- Twenty-four per cent of NHS core services were rated as requires improvement as at 31 July 2017, as were 23% of independent core services. And a small number were rated as inadequate: seven core services (1%) in NHS trusts and four core services (2%) among independent services.
- We are concerned about the high number of people in 'locked rehabilitation wards'. Too often, these are in fact long stay wards that institutionalise patients, rather than a step on the road back to a more independent life in the person's home community.
- We are concerned about the very wide variation between services in how frequently staff use physical restraint in response to challenging behaviour. Wards where the level of physical restraint was low had staff trained in the specialised skills required to anticipate and de-escalate behaviours or situations that might lead to aggression or self-harm.
- Some mental health wards still accommodate patients in dormitories. Patients, many of whom have not agreed to admission, should not be expected to share sleeping accommodation with strangers. This arrangement does not support people's privacy or dignity. Also, a number of acute and rehabilitation wards still admitted both men and women to the same wards. Some of these do not comply with the requirement to eliminate mixed-sex accommodation.
- We found some excellent examples of staff enabling patients to access GPs, dentists and healthcare clinics, and promoting physical exercise and healthy eating. However, we also found community mental health services where staff did not ensure that patients had their annual physical health checks.

Introduction and context

This year we published *The state of care in mental health services 2014-17*, which gave detailed findings from CQC's initial programme of comprehensive inspections in specialist mental health services.

The landscape of specialist mental health care in England is complex. Care is provided by mental health NHS trusts and independent mental health providers for people with a wide range of mental health needs in a variety of settings and locations – both in hospital and in the community. Many of the NHS trusts that provide mental health care are very large and operate over a wide geographical area.

The independent sector manages a substantial proportion of national provision of mental health inpatient services for children and young people, long stay and rehabilitation wards, wards for people with a learning disability or autism, and medium and low secure forensic wards. The NHS funds much of the care provided in these independent hospitals through contracts with NHS England or clinical commissioning groups.

There has been a steady rise in the number of people in contact with mental health services over the last few years. This has contributed to a substantial increase in the maximum waiting times for routine appointments for children's and young people's community services in the NHS. The maximum wait for an appointment has risen from 11 weeks in 2012/13 to 26 weeks in 2015/16.

The total number of detentions each year under the Mental Health Act rose by 26% from 2012/13 to 2015/16.[79] The fact that a high and increasing proportion of inpatients are detained under the Mental Health Act is evidence that only those people who need immediate, intensive treatment and care are admitted to a mental health ward. As a result, admission wards are a high risk environment. This is reflected in NHS Benchmarking Network data for NHS services in 2015/16 that show the high number of incidences of violence towards staff (538 per 100,000 occupied bed days), and of violence towards other patients (286 per 100,000 occupied bed days).

To provide safe care, mental health admission wards need a well-staffed team of experienced mental health workers who know the patients and work together well. To provide effective care, the team must contain staff from a range of disciplines who can provide the full range of treatments and interventions – physical, psychological and social. Future developments in community mental health services must not distract attention from the importance of improving the quality and safety of mental health wards.

The high and perhaps growing demand for mental health care has been accompanied by a steady decline in the number of NHS mental health nurses. From January 2010 to January 2017, the number of full-time equivalent psychiatry nurses fell by 12%, from 40,719 to 35,845.

The pressure on beds, and inability of community services to provide an alternative to admission, mean that too many people with mental health conditions are admitted to acute wards or psychiatric intensive care units some distance from their homes (known as 'out of area placements'). NHS Digital have reported that, at the end of May 2017, there were 857 such patients across the country counted as 'out of area'. Of these, 96% (821) were deemed 'inappropriate', although this is likely to under-estimate the true scale of the problem.[80]

A survey by the British Medical Association found that visits to people placed out of area entailed a four-hour drive or a six-hour trip by public transport. There is a government ambition to end inappropriate out of area placements in acute inpatient services for adults by 2020/21.[81]

CQC's ongoing review into children and young people's mental health services is finding a particularly complex and fragmented picture – care that is planned, funded, commissioned, provided and overseen by many different organisations, who frequently do not work together in a joined-up way. Some families felt this lack of joined-up working meant they had to wait till their child's mental health reached crisis point before they got any help.

Overview of quality

Core service ratings

We have now completed comprehensive inspections of all specialist mental health services in England. As well as rating the whole provider, we also rate certain 'core services' that we always inspect (see box).

Our inspectors have found many examples of good and outstanding care – but we also found too much poor care, and far too much variation in both quality and access across different services.

Overall, the performance at core service level of NHS trusts and independent providers was very similar. There were 68% of NHS core services rated as good as at 31 July 2017 and 6% were rated as outstanding (figure 2.13). Among independent services, 72% were rated as good and 3% as outstanding.

However, a substantial minority of NHS trust and independent services must improve the quality of care they provide. Twenty-four per cent of NHS core services were rated as requires improvement as at 31 July 2017, as were 23% of independent core services. And a small number were rated as inadequate: seven core services (1%) in NHS trusts and four core services (2%) among independent services.

Where we find poor care, we take action to make sure it improves. As we reported in *The state of care in mental health services 2014-17*, across the two-year period from April 2015 to March 2017, we issued 21 warning notices to NHS mental health trusts and 91 to independent mental health providers. Across the entire sector, we also issued one urgent notice to impose a condition, one non-urgent notice to impose a condition and two non-urgent notices to cancel registration.

Figure 2.14 shows the overall rating for each core service, across both NHS and independent providers. Some types of service performed particularly well, especially community mental health services for people with a learning disability or autism (81% rated as good and 8% as outstanding)

Core services for specialist mental health services

In specialist mental health services, we always inspect the following 11 core services where they are provided.

Inpatient mental health

- Child and adolescent 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
- Wards for older people with mental health problems
- Wards for people with a learning disability or autism
- Forensic inpatient/secure wards

Community mental health and crisis services

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

and community-based mental health services for older people (75% rated as good and 10% as outstanding). It is difficult (and perhaps inadvisable) to make comparisons between the ratings for different types of services. However, it is striking that there is a 23 percentage point difference between community mental health services for people with a learning disability or autism and acute wards for adults of working age and psychiatric intensive care units, in terms of the proportion that we rated as good or outstanding (89% compared with 66%).

Ratings by key question

As well as the overall rating, we give all services a rating for each of the five questions we ask of all care services. These allow us to look into greater detail at the issues that matter to people: are services safe, effective, caring, responsive to people's needs and well-led? Figure 2.15 shows how NHS trusts and independent locations were rated against the five key questions across all their core services. There are close similarities among the ratings given at key question level to NHS and independent core services.

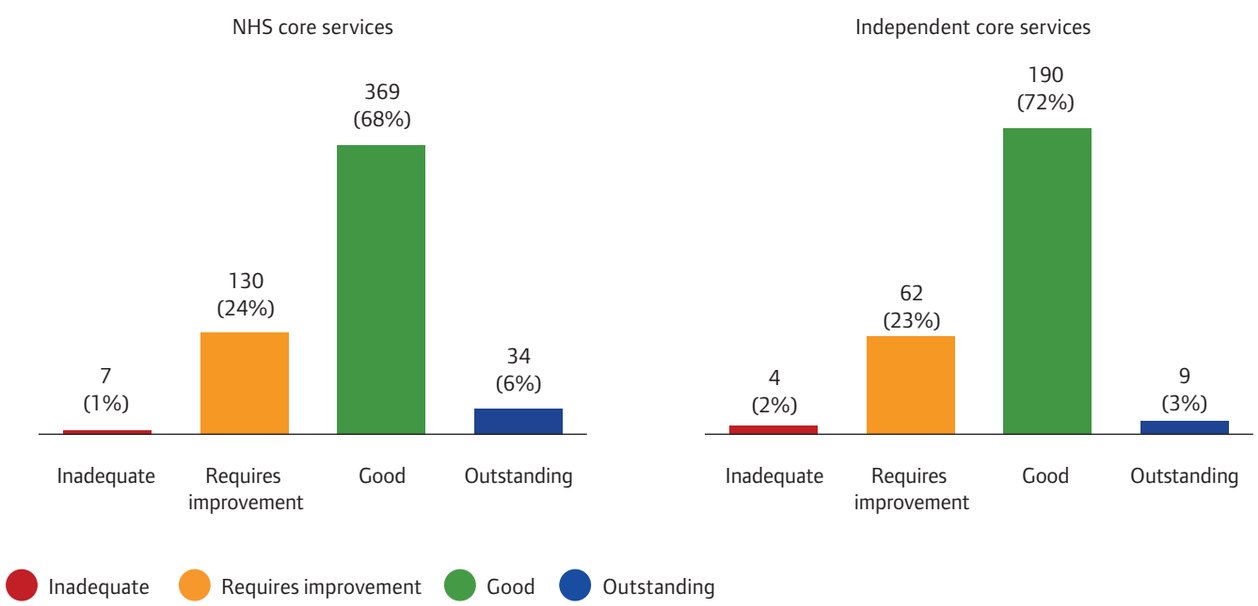
A number of themes contribute to this pattern of ratings for the key questions.

Safe: our biggest concern is about safety

Three per cent of NHS core services and 5% of independent core services were rated as inadequate at 31 July 2017. A further 36% of NHS core services and 32% of independent core services were rated as requires improvement. A number of factors contributed to these ratings:

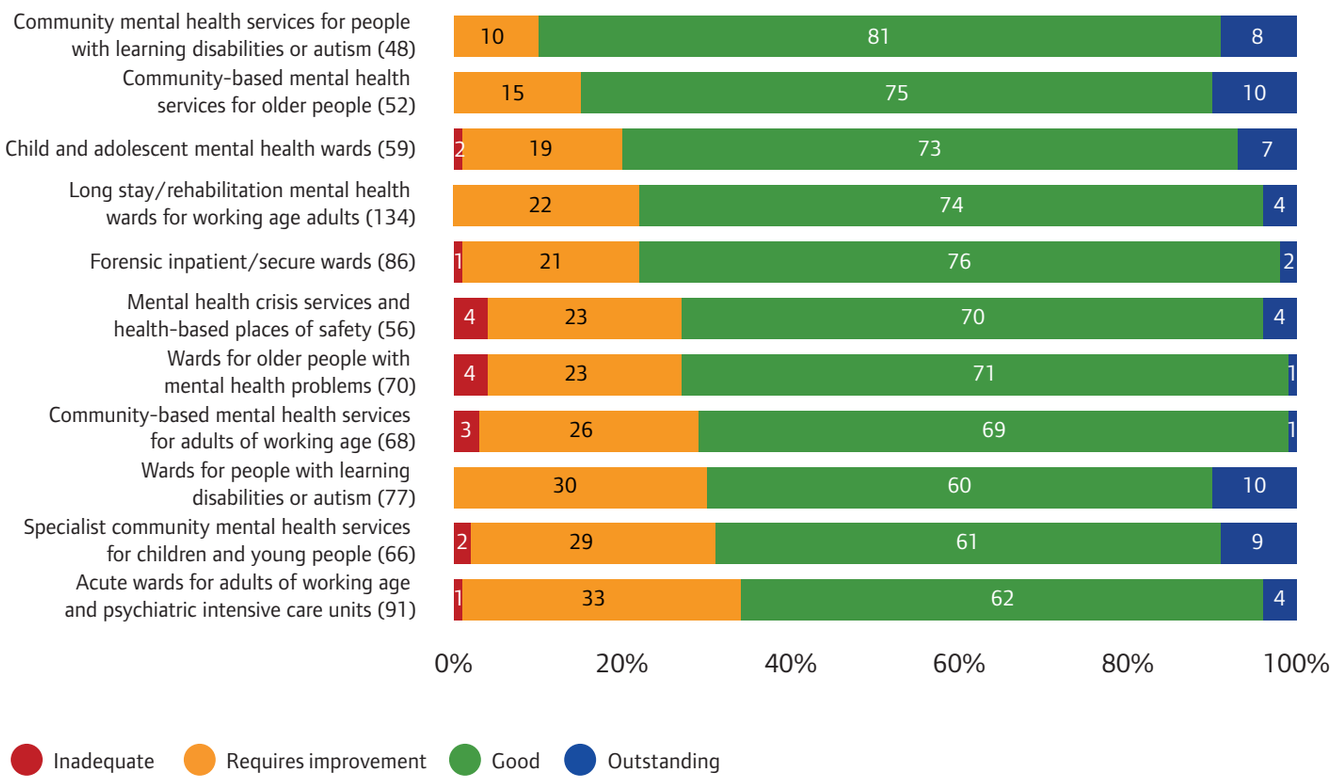
- The poor physical environment of many mental health wards. Many inpatient facilities were not designed to meet the needs of the group of patients that are admitted to acute mental health wards today. Their design does not permit staff to observe all areas easily and many wards contained fixtures and fittings that people who are at risk of suicide could use as ligature anchor points.

Figure 2.13 Mental health core service overall ratings



Source: CQC ratings data, 31 July 2017, total 540 NHS core services and 265 independent sector core services.

Figure 2.14 NHS and independent combined overall ratings by core service



Source: CQC ratings data, 31 July 2017, total 540 NHS core services and 265 Independent sector core services.

Figure 2.15 Mental health core service overall ratings by key question

Source: CQC ratings data, 31 July 2017.

- Some services struggled to ensure that mental health wards are staffed safely at all times. The shortage of mental health nurses is greater in some parts of the country than others. The problem was worse in services that had high levels of sickness and high rates of staff turnover. The resulting negative effect on morale can create a cycle of increasing sickness and further staff turnover that can be difficult to break. Many providers used bank and agency staff to fill shifts. This can work well, provided the nurses who are filling in know the patients, their nursing colleagues and the ward routine. When this was not the case, it could affect patients' experience and continuity of care. In the worst cases, it could affect safety – our inspectors have reported medication errors made by staff who were not familiar with the service and who may not have had enough training or a proper induction to a ward. Even the basics, such as putting notes on care plans, had not always been completed by agency staff due to lack of training.
- Staff in both inpatient and community services did not always manage medicines safely. We found examples where staff did not store or transport medicines securely or keep them at the correct temperature, did not keep accurate records when they administered medicines and did not monitor patients' physical health necessary to keep them safe.

Our inspectors have seen some good initiatives to embrace a culture of safety. For example, in one NHS trust, wards had embedded a 'Safewards' approach. The seclusion room was rarely used as staff had improved how they talked and listened to patients to minimise incidents. When an incident did occur, they used reflective practice to understand the reason for the challenging behaviour and to consider how they could have handled it better. The inspector reported a much calmer and happier ward and that staff felt safer. The success was due to genuine staff engagement and buy-in to the idea of using the Safewards techniques all the time – not because someone had told staff to do it, but because they believed in it. Staff felt supported by the trust by making resources available and for training to happen.

Effective: care needs to be holistic and recovery-focused

When we look at whether care is effective, we want to find out whether the service is providing people with care, treatment and support that achieves good outcomes, promotes a good quality of life and is based on the best available evidence. Staff need to take a holistic and recovery-focused approach to people's care and treatment. The majority of services provide care that is good or outstanding in this regards (71% of NHS trusts and 68% of independent services were rated as good, and 3% and 1% respectively were rated as outstanding).

However, a substantial minority need to improve, with 24% of trusts and 30% of independent services being rated as requires improvement. Services need to more to get the basics right consistently. We found examples of care plans that were not completed consistently, not holistic, not dated or missing from care records.

On pages 84 to 86, we highlight particular issues around services that need to ensure rehabilitation wards are geared towards people's recovery, and around the need to pay attention to people's physical health as well as their mental health.

Caring: mental health services can be proud of their staff

Across all services, the vast majority of staff genuinely cared about the people who used their services. The overwhelming majority of NHS and independent services were rated as good or outstanding for having caring and compassionate staff (NHS: 88% good, 9% outstanding; independent: 93% good, 5% outstanding). With very few exceptions, staff formed relationships with their patients that were respectful and compassionate and they treated patients with dignity and respect.

We have also seen many examples of staff involving carers and families, and of services providing specific support for carers. Families have complimented the attitudes of staff and the support that they have received, with staff making sure that families were involved with care planning and received regular updates.

The one area where mental health staff could do better as caring professionals is by engaging patients as true partners in their care. This issue has been flagged up by our Mental Health Act reviewers as well as by our inspectors. In too many services, care plans do not truly reflect the patient's voice. We will pay closer attention to this issue in future inspections.

Responsive: people often cannot access the service best equipped to meet their needs.

Our inspectors found community child and adolescent mental health services with very long waiting times, a mental health crisis team that did not provide 24-hour cover and patients whose discharge had been delayed because of the unavailability of suitable accommodation or a community care package.

Well-led: services need good leadership to become outstanding

Overall, 21% of NHS core services and 17% of independent services needed to improve in terms of their leadership. The influence of good leadership on staff cannot be overestimated. The NHS Staff Survey provides invaluable information on the views and experiences of people working in the NHS. Compared with the acute sector, those who work in mental health and learning disability trusts report poorer levels of overall satisfaction, and they are less likely to recommend the organisation as a place to work or receive treatment. On the other hand, they report better experiences of staff support, team working, line management and working practices. Worryingly, a higher proportion of mental health staff also reported experiencing harassment, bullying, abuse or physical violence from patients, relatives or the public in the 12 months prior to the survey.

When we analysed a number of inspection reports, we found six key themes that contributed to a rating of good or outstanding for well-led: leadership, a clear vision and set of values, a culture of learning and improvement, good governance, quality assurance, and engagement and involvement.[82]

In part 1 of this report, we highlight that the best services collaborate at a local level to deliver care that is centred on the needs of individuals. Our inspectors have seen examples of services identifying an issue or a need for patients and then working together, at times across sectors, to solve that need.

Sometimes, this is about bringing better physical health to those with mental health conditions For example, at one NHS trust, GPs came twice a week to provide care for mental health inpatients, and at an independent mental health hospital, there was a GP clinic next to an acute mental health ward.

At the acute adult inpatient and the psychiatric intensive care unit wards of one NHS trust, a registered nurse had been recruited to focus on the physical health of patients. Our inspector reported that this had a positive impact – the physical health care of patients was better monitored and deterioration was spotted quicker. This had been recognised by ambulance services and A&E, who had noticed that the notes accompanying the patient were of better quality and, as a result, they had a better understanding of the person's presentation.

Another example of services coming together was in South London, where trusts, police, ambulance and voluntary organisations were building a framework to identify places of safety for people who had been detained under section 136 of the Mental Health Act. The aim was to share information about availability of places of safety to provide support for a person in crisis and avoid them being detained in a custody cell, police car or ambulance.

Aggregated ratings

We also provide overall trust level ratings (in the NHS) or combined location level ratings (in the case of independent services) by aggregating the ratings of key questions awarded across all the core services provided by that trust or independent location. For example, if we have rated three out of the 11 core services as requires improvement for an individual key question (such as safe), then we would normally rate the NHS trust as requires improvement for safe.

The size and complexity of NHS mental health trusts, and the variability between core services, means that it is possible that in some hospitals a few poorer performing core services may affect their overall rating.

Fifty-nine per cent (32 out of 54) NHS trusts were rated as good overall as at 31 July 2017 (figure 2.16). We have rated two trusts as outstanding – Northumberland, Tyne and Wear NHS Foundation Trust and East London NHS Foundation Trust. Both trusts provide care in hospitals and round-the-clock care in the community that are world-class. They have leaders, both at a provider and ward level, who shape the care they deliver around the people who receive it.

However, 35% of NHS trusts (19) were rated as requires improvement overall. There was also one NHS trust (2%) rated as inadequate at 31 July 2017.

For the independent mental health locations, there were 73% (166) rated as good as at 31 July 2017, and 4% (eight) rated as outstanding. However, a substantial minority of locations need to improve: 22% (49) of independent locations were rated as requires improvement and 1% (three) as inadequate.

Key issues

Locked mental health rehabilitation wards

More than 50 years after the movement to close asylums and large institutions, we were concerned to find examples of outdated and sometimes institutionalised care. We are particularly concerned about the high number of people in 'locked rehabilitation wards'.

The Royal College of Psychiatrists does not recognise locked mental health rehabilitation wards as a service model. The purpose of these wards is poorly defined. Also, patients are often admitted to a rehabilitation ward a long way from their home. This risks the person becoming isolated from their friends and families and can make it difficult for staff in local community services, that should facilitate discharge and provide aftercare, to maintain regular contact.

We were surprised at how many beds there were in hospitals of this type. From the information available to us, we identified 357 mental health rehabilitation wards. Of these, 248 were locked and 109 were unlocked. Rehabilitation wards provided a total of 4,936 beds, of which 3,587 (73%) were in a locked ward. The independent sector provided more than two-thirds of the rehabilitation beds that were on a locked ward.

We concluded that, too often, these locked rehabilitation hospitals are in fact long stay wards that institutionalise patients, rather than a step on the road back to a more independent life in the person's home community. In the 21st century, a hospital should never be considered 'home' for people with a mental health condition. This principle underpins the drive to transform care for people with a learning disability. It applies equally to those with severe and enduring mental health conditions.

In a number of cases, we found that these hospitals did not employ staff with the right skills to provide the high-quality, intensive rehabilitation care required to support recovery. This could result in people using these services feeling hopeless and powerless, and failing to fulfil their potential to regain control of how they live their lives.

These hospitals must more actively support patients to acquire the skills they need to live more independently and be more proactive in planning discharge. At the same time, health and social care commissioners must ensure that suitable accommodation and intensive community mental health support is available in the person's home area.

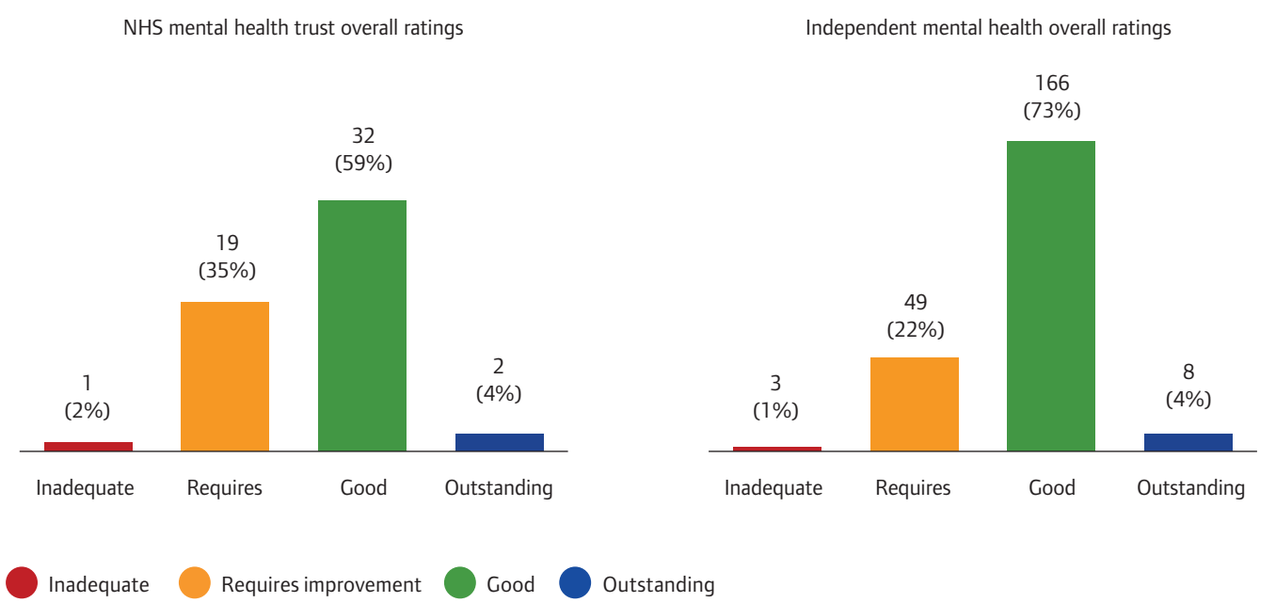
High secure hospitals

In 2016/17, our inspections of the three high secure hospitals in England found that all three had a shortage of nursing staff. At Broadmoor Hospital and Rampton Hospital, this restricted patients' access to therapies and activities. The low staffing levels at Rampton Hospital sometimes increased the risk to patients. One effect of the staffing shortage at Broadmoor Hospital and Rampton Hospital was that patients who were subject to night-time confinement also had restricted access to day-time activities. We were also concerned that staff at Broadmoor Hospital and Rampton Hospital did not monitor and review patients in seclusion and long-term segregation in line with guidance in the Mental Health Act Code of Practice.

The combination of night-time confinement and restriction on day-time activities is unacceptable – the 2013 guidance to the security directions sets out arrangements for general night-time confinement that "should only be put in place where it is considered that this will maximise therapeutic benefit for patients, as a whole, in the hospital. For example, confining a group of patients at night may release staff to facilitate greater therapeutic input for patients during the day".

We will monitor the response of the trusts that manage Broadmoor Hospital and Rampton Hospital closely. We have shared our concerns with the Secretary of State and discussed our findings with NHS England Specialised Commissioning and the National Oversight Group for High Secure Services.

Figure 2.16 Mental health NHS trust and independent service overall ratings



Source: CQC ratings data, 31 July 2017, total 54 NHS trusts and 226 independent locations.

We have recommended that all three high secure hospitals work more closely together to share best practice and to address the concerns that we have identified.

Physical restraint

We have found examples, in all types of inpatient core service, of good practice in managing behaviour that might put patients or staff at risk of harm. Those wards where the level of restraint was low or where it was reducing over time had staff trained in the specialised skills required to anticipate and de-escalate behaviours or situations that might lead to aggression or self-harm. Staff on some wards made excellent use of positive behaviour support plans to anticipate and defuse situations that might have resulted in challenging behaviour. On many inspections, our inspectors have concluded confidently that staff used physical restraint or seclusion only as a genuine last resort.

However, more than three years after publication of the Department of Health's guidance 'Positive and Proactive Care: reducing the need for restrictive interventions', we are concerned about the very wide variation between services in how frequently staff use physical restraint in response to challenging behaviour. We have also found a number of instances where staff were not recording all incidents of restraint and not documenting or recording seclusion or long-term segregation as required by the Mental Health Act Code of Practice.

We are committed to improving how we assess the use of restrictive interventions. In future, we will pay much closer attention to whether services have in place an active programme to reduce and minimise the use of restrictive interventions; and the extent to which they are able to demonstrate the impact of this programme.

Use of dormitories on mental health wards

We identified a number of wards that had dormitory accommodation. In the 21st century, patients—many of whom have not agreed to admission—should not be expected to share sleeping accommodation with strangers, some of whom might be agitated. This arrangement does not support people's privacy or dignity.

Sexual safety on wards for people with a mental health condition or a learning disability

Seven years after the NHS issued guidance to eliminate mixed sex accommodation in all hospitals, we identified a number of acute and rehabilitation wards that still did not comply. This is a particular concern in mental health wards, where the patient group might include a mix of those who are disinhibited and those who are vulnerable to sexual abuse. When this is the case, staff have a heightened responsibility to ensure that patients are safe from sexual harassment and sexual violence. We have taken action against services that did not follow NHS guidance on eliminating mixed sex accommodation. We will explore the issue of sexual safety on mental health wards more closely.

Physical health of people with a mental health condition a learning disability

One of the goals of the Five Year Forward View for Mental Health is that "by 2020/21, at least 280,000 people living with severe mental health problems should have their physical health needs met". Our inspectors found a mixed picture. We found some excellent examples, particularly in forensic wards, of staff enabling patients to access GPs, dentists and healthcare clinics, and promoting physical exercise and healthy eating in response to the growing numbers of patients at risk of obesity and associated conditions such as diabetes. However, we also found community mental health services where staff did not ensure that patients had their annual health checks, and where they failed to monitor the effects of medication and services for older people where there was lack of integration of physical and mental health care.

Clinical information systems

Too many of the clinical staff we talked to voiced their frustration about the clinical record systems that they have to work with. Staff sometimes have to work with a confusing combination of electronic systems and paper, or with a number of different electronic systems because these systems 'do not talk to one another'. Clinical staff often spent a high proportion of their working time entering information into electronic records. Because of the

nature of the information entered, this problem often affected qualified nurses more than healthcare assistants. Despite this effort, too often staff were unable to locate or retrieve information that others had recorded.

This problem had a real impact. It consumed staff time that could have been better spent in face-to-face contact with patients, increased the likelihood that essential information about risk was not communicated to staff who needed to know, and might have led to sub-optimal care plans that did not reflect the contribution of all members of the multiprofessional team or sometimes the voice of the patient.

Residential substance misuse services

We inspect, but currently do not rate, independent sector services that provide structured drug and alcohol treatment where people have to be resident at the service in order to receive treatment. This includes medicine-assisted recovery programmes (and prescribing to prevent a relapse), such as detoxification or stabilisation services.

In 2016, in response to early inspections under our new comprehensive inspection approach, we wrote to all registered residential treatment providers to make them aware of our concerns about the quality of care being provided to people undergoing withdrawal from drugs and/or alcohol. We have now completed more inspections of these services, and we are in the process of reviewing these, to bring the picture up to date before the end of 2017.

Services for people with a learning disability or autism

Sixty per cent of wards for people with a learning disability or autism were rated as good at 31 July 2017, and 10% as outstanding; 81% of community services were rated as good, and 8% as outstanding. Many services worked well with other health and social services to build partnerships to meet the needs of people using the service and carers.

Although we found examples where staff had achieved a marked reduction in the use of physical restraint and seclusion, we remain concerned about the high use of restrictive interventions in some inpatient services.

The Transforming Care programme is tasked with ensuring that people in England with a learning disability or autism are only admitted to a mental health hospital when that is the intervention most suited to their needs at that time. Hospital must never be considered 'home' for people with a learning disability; they have a right to live in settled accommodation of their choice in their local community. This requires robust multidisciplinary community services, including 24/7 access to crisis care services, improved access to mainstream health care and the embedding of positive behaviour support across the health and care sectors.

Progress with Transforming Care has been patchy across England to date. Contrary to the aims of the programme, some patients have been in hospital for a long time and their care plans lacked evidence of active discharge planning.

Although we do not penalise providers for any lack of progress that is not within their control, we are increasingly checking that the Transforming Care 'building blocks' are in place. These include active participation by hospitals in care and treatment reviews, the implementation of positive behaviour support in both hospital and community services, and care in hospitals that is clearly discharge-oriented. We have also taken action to ensure that new providers who apply to register learning disability services are adhering to the model of care advocated by the Transforming Care programme. Our publication, *Registering the Right Support*, outlines our new approach.

Improvement

As at 31 July 2017, we had re-inspected and reconsidered the overall rating of 126 NHS mental health trusts and independent mental health locations (figure 2.17).

Providers that needed to improve have made real progress when they have taken on board our findings and committed to tackle problems proactively and learn from others.

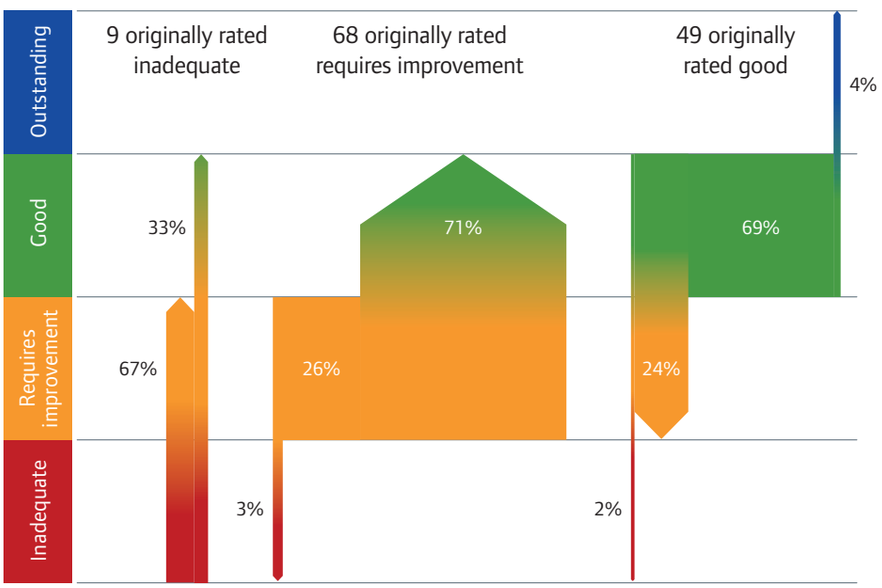
All of the nine services that were originally rated as inadequate and we re-inspected improved their rating – three to a rating of good and six to requires improvement. In addition, of the 68 services that were rated as requires improvement and were re-inspected, 48 (71%) improved their rating to good.

These improvements were testament to good leadership and strong determination to improve, at both board and ward level, the development of close links between leaders and front line staff, and those staff feeling part of a culture that delivers high-quality care.

We have seen a large number of providers that are actively seeking to learn and improve, and many have approached the outstanding trusts and others in a spirit of collegiate learning and a willingness to work together to improve the quality of mental health care.

However, we have also seen the quality of care in some services deteriorate – including some previously rated as good. Of the 49 services originally rated as good and re-inspected, 12 (24%) were re-rated as requires improvement and one went down to inadequate. In addition, two of the 68 services originally rated as requires improvement also deteriorated to a rating of inadequate.

Figure 2.17 NHS and independent mental health re-inspection overall ratings



Source: CQC ratings data as at 31 July 2017, total 126 re-inspections.

We reported in *The state of care in mental health services 2014-17* that the NHS core services with the most improvement (up to 31 May 2017) were forensic inpatient/secure wards, long stay/rehabilitation mental health wards for working age adults and wards for people with a learning disability or autism.

The independent core services that had improved the most up to 31 May 2017 were forensic inpatient/secure wards, child and adolescent wards, and community services for working age adults.

Northamptonshire Healthcare NHS Foundation Trust – quality improvement in action

This mental health and community trust was rated requires improvement in August 2015.

The quality of care at the trust was found to be inconsistent, particularly in community health services. For example there were worrying staff shortages, particularly community nursing staff and therapists. There were safety issues in a number of wards and in the gardens of one of the hospitals. There was also not enough training for staff or adequate supervision.

Despite the issues, we did see some outstanding practice in specific areas, such as older people's mental health. We also felt the trust had a strong leadership team capable of moving the trust forwards and improving.

In early 2017 we returned to inspect and found significant improvement. We rated the trust as good. The senior leaders had been instrumental in delivering the vision of quality improvement in the trust. The board were role-modelling the vision and values, and this was reflected in the high level of commitment to continuous improvement from staff at all levels. The trust was now meeting the target of 95% of patients being followed up within seven days of discharge.

People using the services of the trust were actively involved in helping with activities such as recruitment. There were very robust safeguarding policies in place and the trust was working collaboratively with partner agencies and to protect vulnerable adults and children.

We continue to monitor the trust as it completes further recommended improvements.

Primary medical services

Key points

- The quality of care in general practice overall is good, with 89% of GP practices rated as good and 4% rated as outstanding overall. This means that almost 49 million people are registered with practices that CQC has rated as good and nearly three million people have access to care rated as outstanding overall.
- We have seen improvement in dental care in England in the last two years: after re-inspecting dental practices where we had taken enforcement action, most had improved.
- High-performing GP practices are increasingly using non-traditional roles such as advanced nurse practitioners, care coordinators or healthcare assistants to support GPs and reduce referrals to secondary care or avoidable hospital admissions. These practices are also working collaboratively and using multidisciplinary working to improve patients' experience.
- Our main concern across all providers in primary care is the steps they take to ensure the safety of their services. The main issues we found included problems relating to poor governance systems and processes to manage risk and learn from incidents so that they are less likely to happen again, and poor leadership with unclear roles and responsibilities.
- General practice continues to face pressures as the rising demand for GP services is not being matched by a growth in the workforce to meet needs, which means that people may find it harder to access an appointment with a GP.
- 61% of urgent care and out-of-hours services were rated as good and 8% as outstanding. Poor care was a result of challenges in managing patient demand and recruiting and retaining the workforce.
- Online primary care services offering remote consultations over the internet, by text-based platforms or video link, are improving people's access to care. We have taken action on initial concerns around safety measures and safeguarding patients, and have seen improvement on re-inspection.
- There have been improvements in health care for children in the care of a local authority (looked after children), but local organisations need to improve access to speech and language and occupational therapies and a diagnostic pathway for children with autistic spectrum disorder.

Introduction and context

Primary care services are the first point of contact for most people's healthcare needs and therefore play a fundamental role in any local healthcare system. Around 90% of patient interaction in the NHS is with primary care services.[83]

General practice in England manages complex multiple health conditions for a growing and ageing population. The number of people aged 65 and over is projected to increase in all regions of England by an average of 20% between mid-2014 and mid-2024.[84] Although increased life expectancy is testament to improvements in health care, the demand for GP services is not being matched by a parallel growth in the workforce to meet these needs, which means that people are finding it harder to access an appointment with a GP.[85] To address this, NHS England is investing £2.4 billion as part of the General Practice Forward View, to grow the general practice workforce in both number and mix of skills, and improve the technology and infrastructure to support them.[86] This is vital to encourage more multidisciplinary and integrated care for people.

Technological innovation offers the potential to transform and improve healthcare services. We have seen a growing number of applications to register from organisations offering remote consultation to patients in England. These services offer patients more convenient access to medical advice, treatment or medicines. As part of our commitment to encourage improvement, innovation and sustainability in care, we are working collaboratively with other regulators to align the expectations of those we regulate, and adapt how we regulate in a changing online landscape of care.

Access to primary care dental services plays an important role in the oral and dental health of the population. Good dental care contributes to people's overall health: early diagnosis of mouth cancer and preventative treatment and advice for children and adults is now part of a visit to the dentist. But some people have better access than others: for example, homeless people, people in care homes, and people who misuse drugs or alcohol are less likely to receive dental care.

Furthermore, in the two years ending 30 June 2017, 22.2 million adult patients were seen by an NHS dentist, representing 51% of England's adult population. Similarly, in the 12 months to 30 June 2017, the number of children seen by an NHS dentist was 6.8 million, which is 58% of the child population.[87] Despite free dental care for children, 80% of children aged up to two and 60% of those aged one to four in England did not visit an NHS dentist in the year to the end of March 2017.[88] If children don't see a dentist regularly, the impact is felt in secondary care, as tooth extraction is a common procedure in hospital for children under four.[89]

As well as inspecting primary health care in community settings, CQC inspects healthcare services in:

- prisons, youth offending institutions and immigration centres in partnership with HMI Prisons, Ofsted and HMI Probation
- secure training centres in partnership with Ofsted and HMI Prisons
- youth offending teams in the community in partnership with HMI Probation, HMI Constabulary and Ofsted
- police custody suites in partnership with HMI Probation and HMI Constabulary.

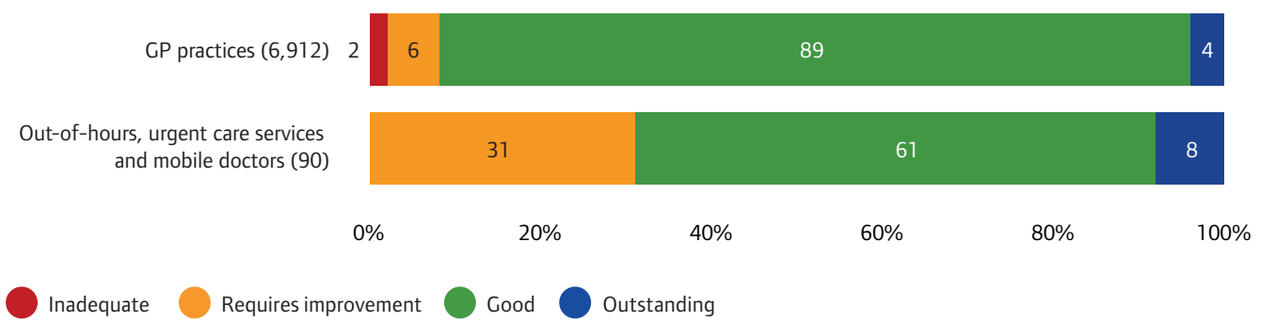
We also inspect all registered health services that provide services to children, and focus our inspections on where we believe there is the greatest risk. Our Children's Services team provides expert child safeguarding advice in our regulatory inspections and carries out a programme of specialist inspections.

Enabling people to access primary care services is a key part of what we look at in inspections. We have started a programme of inspections of primary care for military personnel, as people in the armed forces are entitled to receive the same high-quality care as civilians.

Overview of quality

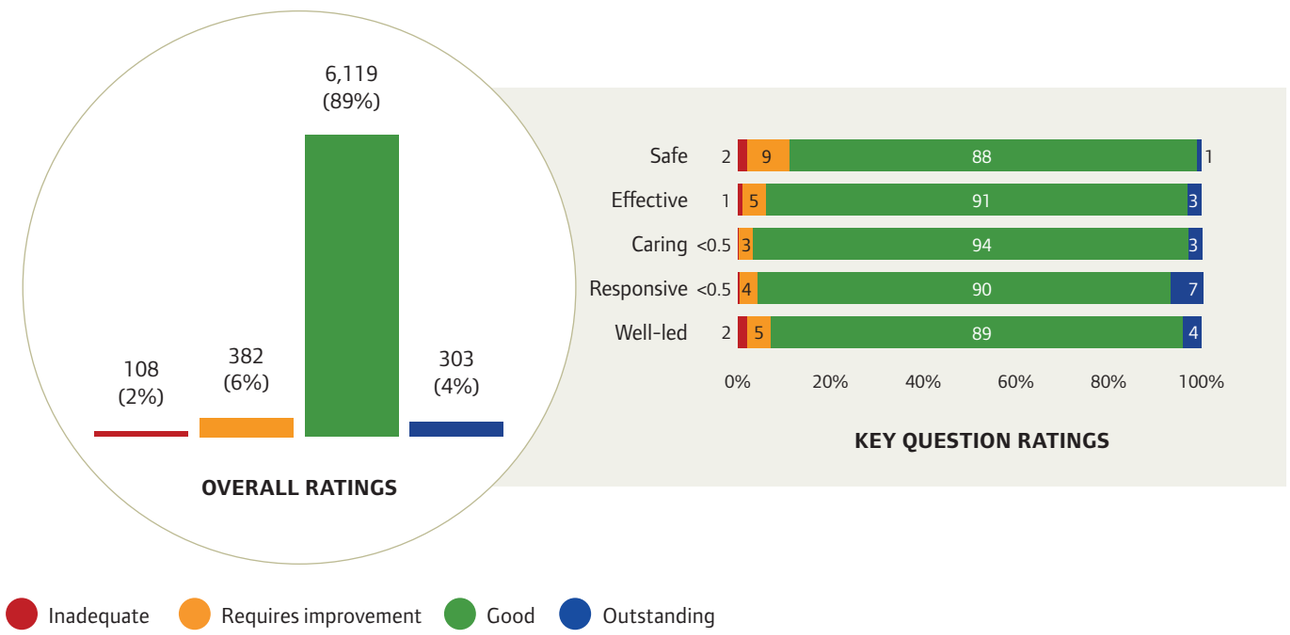
Regulation of primary care is tailored to each different type of service. We do not give a rating to all types of service but, overall, we have found that the majority of providers are meeting regulations, which means that people are receiving good quality care (figure 2.18). As discussed in part 1, with new ways of delivering primary care in the community, people may not always need to see the GP of their choice, but receive care from a clinician in a more appropriate setting in the community. Our main concern across all providers in primary care is how they ensure the safety of their services and the steps they take to achieve this.

Figure 2.18 Overall ratings in primary health care by service type



Source: CQC ratings data, 31 July 2017.

Figure 2.19 Ratings for GP practices overall and by key question



Source: CQC ratings data, 31 July 2017, total of 6,912 GP practices.

General practice

We recently published findings from our first programme of comprehensive inspections of general practice. In this, we reported that of all the health and care sectors that CQC regulates and rates, GP practices have consistently received among the highest ratings.[90]

This is commendable when set against the increasing pressures facing GPs in terms of the capacity of general practice to meet the rising demand. In our first programme of inspections (7,365 first inspections), 79% were rated as good and 4% were rated as outstanding overall. This figure has improved further as practices have improved after we have re-inspected: at 31 July 2017, the proportion of practices rated as good increased to 89%, and 4% were rated as outstanding overall (figure 2.19).

Our first inspections found some practices where care had fallen short of the quality that people should be able to expect. On first inspection, 13% of practices were rated as requires improvement and 4% were rated as inadequate overall. But, after re-inspections throughout the programme, this figure has reduced to 6% rated as requires improvement and 2% rated as inadequate overall.

For patients in England, this means that almost 49 million people are registered with practices that CQC has rated as good and nearly three million people have access to care from practices rated as outstanding overall.

Our experience from inspections of general practice points to particular key characteristics that contribute to high-quality care, and therefore good and outstanding ratings:

- There is proactive engagement with patients to identify and understand the health needs of the local population.
- Practices use this understanding to create a strategy and provide services to respond effectively to meet these needs, sometimes in innovative ways.
- There is strong leadership with a good mix of multidisciplinary skills, and good external relationships and partnership working to share learning with others in the wider health and care community.

However, not everyone benefits from high-quality general practice, as one in eight practices still needs to improve the quality of care for patients. Almost 650,000 people in England are registered with practices rated as inadequate overall.

Our inspections highlight problems and point practices to areas where they need to take action to improve. Overall performance for the safe key question continues to be the poorest of all the five key questions, as it shows the largest percentages of ratings of requires improvement and inadequate. Where we found poor quality care, we took action to protect the public by following up the improvements needed to address our concerns. In some extreme cases where we found very poor quality care – particularly unsafe practice that put patients at risk – we worked with NHS England and took more serious action more proportionate to our concerns. In a small number of cases, we used our urgent enforcement powers to cancel a provider's registration.

In our first inspection programme, the main issues we found relating to the safe key question included problems for poor systems and processes to manage risk so that incidents are less likely to happen again. Poor performance for safety is often a result of problems with a practice's overarching systems and governance, which results in safety being a low priority and a culture that does not value ongoing learning from safety incidents.

Ratings for the responsive key question can reflect people's access to a GP appointment, as seen in both the GP patient survey and feedback from patients themselves. The 2016 GP patient survey showed that, when patients tried to contact the NHS when their GP practice was closed, a third reported that they then went to A&E, which puts pressure on these hospital services. Less than one in 10 saw a pharmacist, which highlights the potential for greater use of this service in the community.[91]

The findings from our first inspections pointed to practices using non-traditional roles such as advanced nurse practitioners, care coordinators or healthcare assistants to support GPs and help with the workload, and also reduce referrals to secondary care or avoidable hospital admissions. This reflects the importance of having a multidisciplinary team and mix of skills in general practice.

New roles to improve care for patients

We have seen some changes in the ways that staff in general practice work across sectors to improve care, such as the new role of care coordinator.

This is an externally funded position that enables an employee to work across several GP practices, to provide additional services to more vulnerable people such as older and socially or physically Isolated patients. They can advise people about services that they may not be aware of, support people to access care at home or in the community, rather than being transferred to secondary care, and communicate any concerns about a person's health directly to their GP.

Inspectors described the role of a care coordinator as one of providing individualised care that met the patient's specific needs, offering support and guidance where appropriate. In relation to mental health, one inspector described a situation in which the care coordinator was very concerned about the capacity of the person they were visiting. To address the concerns, the care coordinator not only secured a GP home visit for the person, but they also raised a 'significant event' as they were not convinced that the person had the mental capacity to understand the advice they were giving about the services that could help them.

Improvement

Throughout the inspection programme, we have re-inspected 1,700 practices (figure 2.20).

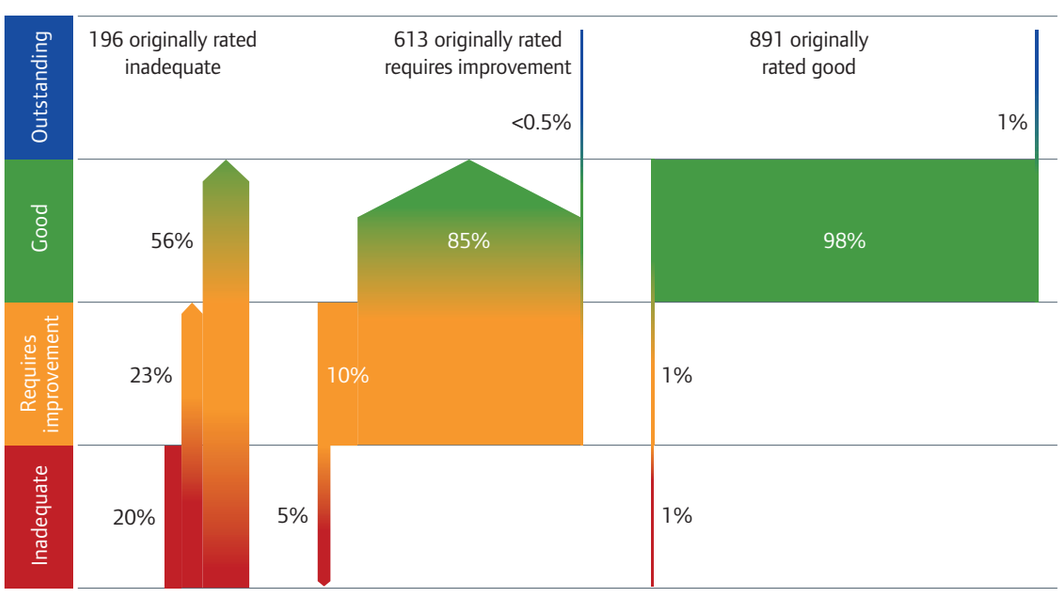
The improvement seen on re-inspection was driven largely because the leadership in improved practices acknowledged that there were problems in the practice. They were willing to learn from the findings of the inspection, motivated to change, keen to learn from what was wrong and keen to access support to try to improve. All practice staff embraced the findings from the inspection as an opportunity to improve.

Our report on the first programme of inspections noted that practices that had improved from a rating of inadequate to good used varying degrees of external support to deliver improvements. A programme that was offered to support struggling practices was run by the Royal College of General Practitioners and commissioned and funded by NHS England to help them adapt to meet the growing demand from their patients. However, now funded by clinical commissioning groups, such support needs to be sustainable and consistent to ensure that good and outstanding general practice remains at the centre of a strong local health system.

We noted from re-inspections that some practices were able to drive improvements with refreshed leadership, and some improved by working with another practice or forming a larger federation.

In part 1, we discussed the importance of collaborative working with other local services. We found that multidisciplinary working – with both a mix of skills within a practice team and externally with other local healthcare services – is an indication of a practice that provides high-quality care. This includes effective links with the wider health economy, including other GP practices, providers in other sectors such as care homes, community or acute trusts and hospital consultants, and the voluntary sector.

Figure 2.20 Change in overall ratings on re-inspection in general practices



Source: CQC ratings data, 31 July 2017.

Primary care dental services

The picture for the dental sector is positive. Every year, we inspect 10% of providers based on a model of risk and random inspection, as well as inspecting in response to concerns. In 2016/17, we carried out comprehensive inspections of 1,131 dental practices. The outcomes were consistent with the previous year and showed that the majority (88%) of dental practices that we inspected were meeting regulations relating to all five key questions.

This picture is consistent across the country and across all funding types. Nationally, 111 dental practices inspected (10%) 'required action', which means they needed to improve in specific areas where we had concerns. We also needed to take enforcement action against 22 practices (2%) (figure 2.21). Where we did find concerns we found that, on re-inspection, practices had acted quickly to address issues and show improvement.

Looking at the outcome of inspections, most breaches of the regulations related to the well-led key question, which is similar to the previous year (figure 2.22).

Improvement following re-inspection

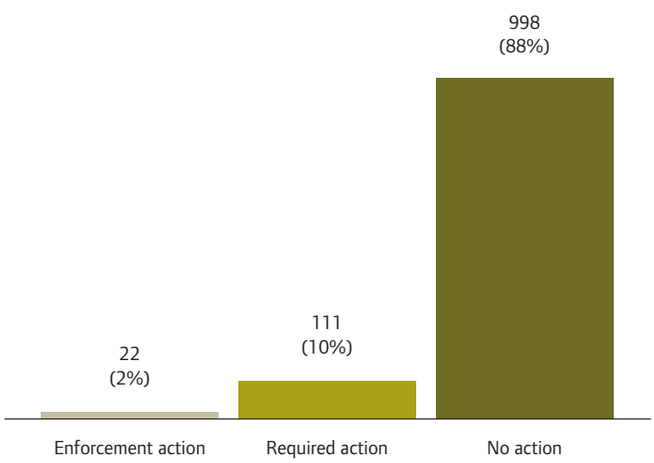
CQC carried out an unannounced inspection focused on the safe key question after we received concerns. We found significant concerns around the cleanliness of the practice in general and risks around a lack of medical emergency equipment and out-of-date medicines.

The practice also provided dental care in local care homes for patients who could no longer access the surgery. Care home staff told us they had raised concerns with the practice about treatment and consent. We found there were no risk assessments or policies to guide this domiciliary service and no medical emergency equipment or medicines to mitigate the risk while treating patients outside of the main practice.

When we gave formal feedback to the provider, they accepted the findings and realised the risk this posed to staff and patients. They took urgent action to stop providing services and we imposed an urgent suspension for two weeks to allow the practice to make improvements. During this period we reviewed the action plan and ensured that the practice had support – both for the staff and also to implement the improvements practically.

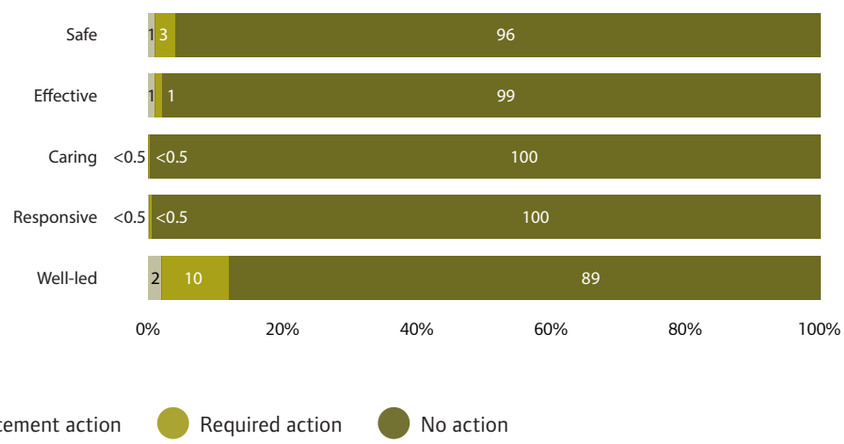
When we re-inspected, we found the practice met all five key questions. It was evident the practice had worked as a team to implement changes to provide safe care and treatment, and the practice manager had supported staff with training and development. The provider and staff appreciated the continued support during their suspension and, with improvements in place and staff having a better understanding of their roles and responsibilities, this transferred into effective patient care in a clean environment.

Figure 2.21 Overall dental inspection outcomes 2016/17



Source: CQC inspection and enforcement data 31 July 2017, total 1,131 locations.

Figure 2.22 Dental inspection outcomes 2016/17 by key question



Source: CQC inspection and enforcement data, total 1,131 locations.

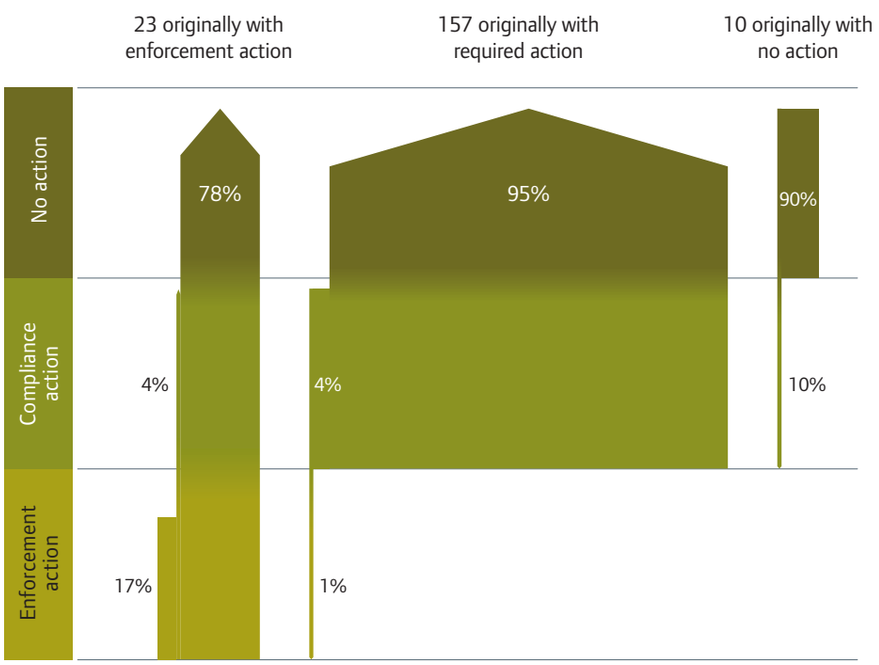
The regulation relating to good governance was the most often breached: 105 practices required action and we took enforcement action in 16 practices. This was often a result of the leadership of a practice not being properly engaged with the processes that are needed to ensure safety. For example, although they may have a documented process relating to treatment, equipment or recruitment, staff may not be applying it correctly, or they may not even have a process at all. Another reason for poorer performance on the well-led question is a lack of awareness or ownership of issues that CQC has highlighted, and therefore not taking action to address them.

Good leadership affects how the whole practice is run, and the experiences of patients. We have seen how a good practice manager with delegated responsibility can make a valuable contribution to a well-led practice, although many small practices can still achieve this without the need for a manager.

We have seen improvement in many dental practices that we re-inspected during 2015/16 and 2016/17: of 23 practices where we originally took enforcement action, 18 have improved and now have no action needed (figure 2.23).

Improvement has been encouraged by a number of regulatory bodies through the Regulation of Dental Services Programme Board, which aims to improve how we work more effectively together and reduce duplication for dental providers. Professional improvement is a large part of this work, and dentists are encouraged to lower professional risk through local peer support mechanisms and peer review and clinical audit. For the public, these joint initiatives have helped to clarify the processes of complaining about dental services and, above all, to improve the quality of dental care.

Figure 2.23 Change in inspection outcomes on re-inspection for dental practices



Source: CQC inspection and enforcement data, 2015/16 and 2016/17.

Urgent care services

CQC's regulation of urgent care services in England comprises NHS 111, GP out-of-hours services and urgent care centres. (We report on ambulance services in the chapter on hospitals.)

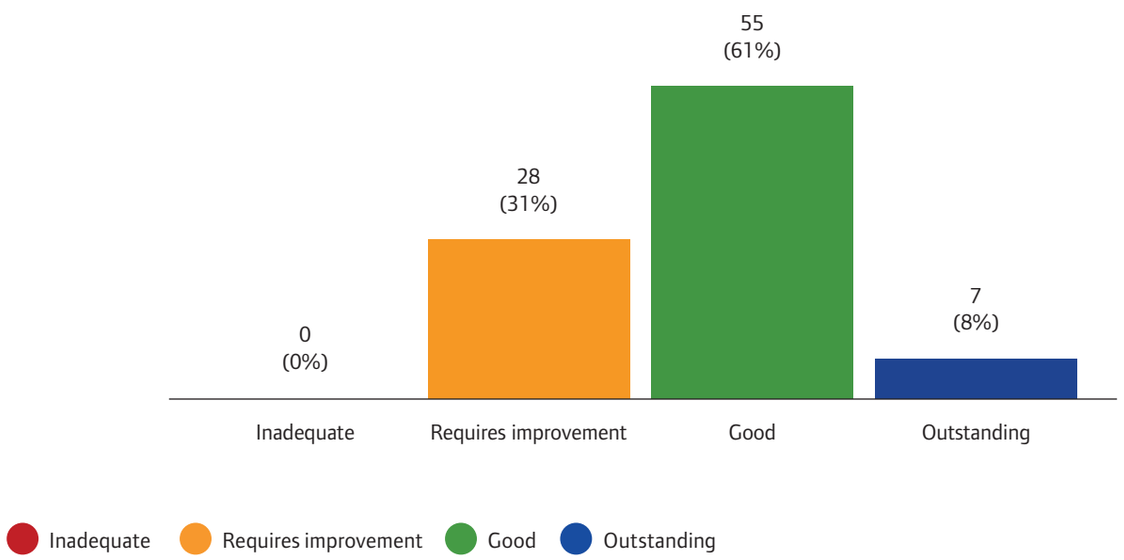
We completed all inspections of GP out-of-hours services and urgent care centres in March 2017 and rated the majority of providers (61%) as good overall, with a further 8% rated as outstanding (figure 2.24). Where the quality of care fell short of what patients should expect, our inspections showed that some providers were not managing challenges that are common to the sector as a whole. These two key challenges were:

- managing patient demand
- recruiting and retaining the workforce.

The diverse nature of urgent and emergency care services presents challenges – both to providers and to CQC's inspections. For example, an urgent care centre can range from being a small scale 'bolt-on' to another type of service. This can be a GP out-of-hours service in a GP practice that is also commissioned to see non-registered patients and typically staffed mainly by sessional GPs working shifts in small 'hubs' at unsociable hours. Whereas a larger dedicated out-of-hours provider with multiple urgent care centres can see 30,000 or more patients a year. These larger services have the benefit of local knowledge and clinical expertise of this particular staffing model. Even so, it is a challenge for all providers of out-of-hours care, whether small or large, to ensure that the workforce is engaged with management, kept up-to-date and able to participate in improving quality. This is because the workforce operates outside of usual office hours, and in many cases in remote locations, with high levels of locum provision and minimal supervision. NHS 111, in keeping with other call centre-based organisations, also faces particular challenges around retaining staff.

Good leadership is therefore vital. Services that provided higher standards of care have addressed these challenges: their leadership team was in touch with their workforce, ensured sufficient resources with robust governance and provided clear clinical and managerial direction. But where

Figure 2.24 Overall ratings for GP out-of-hours, urgent care services and mobile doctors



Source: CQC ratings data, 31 July 2017, total 90 services.

leadership was lacking, it led to services performing poorly. We found that safety concerns often arose when patients had to pass from one provider to another, for example, when patients attended an emergency department and were re-directed to a co-located, but separately provided, urgent care centre. To manage this safely, staff need to have the appropriate training and processes to manage patients who may deteriorate.

We have seen a trend towards integration, both of smaller providers combining and different types of provider integrating. On the whole, we found that services were safe and effective. The majority received positive feedback from people who valued their responsiveness and convenience. Where patients expressed concerns, it was almost always about waiting times caused by the problem of capacity and demand.

Online providers of primary care

Technological innovation offers an opportunity to drive improvement in healthcare services, and to offer more convenient access for patients to advice, treatment and medicines. As at 28 September 2017, there were 40 independent sector companies registered with CQC that provide online primary care services, including remote consultation with clinicians over the internet by text-based platforms or video link. CQC has seen a year-on-year increase in applications to register such services.

From the first 28 inspections we have published, four providers were meeting the regulations and providing safe care. But we had concerns about the care delivered by some providers, which did not meet the regulations as there were insufficient measures to ensure safety and to safeguard patients.

We took a range of enforcement action to address these concerns: 15 providers received a warning notice or, in the most serious cases, their registration was suspended. A further nine providers received a requirement notice alone.

We have published the reports of re-inspections for five providers, and seen improvement in three.

To provide consistent expectations of those we regulate and the people who use their services, we have committed to aligning our regulatory approach in this sector with the quality regulators in Wales, Scotland and Northern Ireland, and also the Medicines and Healthcare products Regulatory Agency, the General Pharmaceutical Council, the General Medical Council, and the Nursing and Midwifery Council.

Medicines optimisation

Our specialist pharmacy inspectors contribute to inspections in all sectors that we regulate and advise on the safe and effective use of medicine. In primary care inspections, the focus was on services where we had identified risks around medicines. In 2016, controlled drug prescribing by pharmacists in NHS primary care almost doubled from 127,547 items to 253,683, continuing the trend from the previous year. We found that some patients are prescribed very large doses of particular controlled drugs to manage their pain. While this may be clinically appropriate for some patients, others may need a review of their medicines and be prescribed a slow release preparation instead. As well as better outcomes for patients, this would also avoid over-prescribing and diversion of these drugs that have the potential to be misused.[92]

Children's health and safeguarding

Access to good health care is particularly vital for children who may be in a vulnerable situation, for example when they have no family to advocate for them or are in the care of a local authority (looked after children). Between 1 August 2016 and 31 July 2017, CQC's specialist inspectors in the Children's Services team carried out 53 inspections.

'Children Looked After and Safeguarding' (CLAS) inspections review health services offered to looked after children and the arrangements for safeguarding children and young people at risk of, or experiencing, significant harm. Although there is no rating or judgement, we make recommendations to improve services, and require the local area to produce an action plan in response.

Following our summary report *Not Seen, Not Heard* on the early findings of inspections in 2016,[93] inspectors found that organisations are taking action to improve. For example, the health needs of looked after children are being identified earlier in initial health assessments and reviews, and local authorities are giving increasing priority to the voice of the child in their care. Health organisations are also increasingly starting to identify the 'hidden' child, when a child is placed inappropriately in an adult mental health or substance misuse service.

The Special Educational Need and Disability joint programme with Ofsted inspects the progress of local areas in implementing the Children and Family Act 2014. We focus on the overall effectiveness of how local areas identify the special educational needs and/or disabilities of children and young people aged from birth to 25, how they are meeting those needs and how they improve their outcomes.

Of the 31 inspections in this year, 11 resulted in a written statement of action for the local partnership to improve the experiences of the children and their parents and carers. This included improving children's access to speech and language and occupational therapies and access to a diagnostic pathway for autistic spectrum disorder/condition. We also found that health providers need to use outcome measures so that they can measure the impact of their work and use this to inform education, health and care plans for children.

The multi-agency Joint Targeted Area Inspection (JTAI) programme involves CQC, Ofsted, HMI Constabulary and HMI Probation. Each JTAI has a specific focus on the experiences of children and young people who are at risk of, or experiencing, significant harm, including children in need and children subject to a child protection plan.

The joint focus on Child Sexual Exploitation found that the multi-agency response was effective and had contributed to improvement since 2014, as all agencies had identified, understood and agreed strategic goals in tackling child sexual exploitation. The programme found that where professionals had the time and capacity to build trusting and consistent relationships with children and young people, they could more effectively identify them as being at risk and take action to protect them. Importantly, success involved having the right resources. However, in some areas, the strategic focus did not always translate into effective practice and, in too many areas, the health community had allocated insufficient resources to tackle the issue.[94]

There are also concerns that not all children and young people have easy access to sexual health services, and that not all frontline health professionals have the necessary skills to identify child sexual exploitation, and are not always using the tools and checklists to help identify children at risk.

The JTAI programme focusing on children living with domestic abuse looked at six local authority areas. It found that the most successful interventions involved multi-agency working, with inspectors highlighting midwifery as a strength in five out of six areas. Midwives were knowledgeable about the risks of domestic abuse to unborn children, they engaged well with mothers and worked effectively with other agencies to protect children. However, as a widespread public health issue, domestic abuse needs a long-term strategy for prevention and recommendations for improvement were needed across all agencies.[95]

Health and justice

Our regulatory activity in the criminal justice system is informed by people's wider experience in custodial settings, which can affect how health and social care services meet their individual needs. These people are in highly vulnerable situations, and their health outcomes can be affected by limited access to services because of the strictly controlled prison regimes and levels of staffing. The degree of health and personal care needs for these people is rising. For example, the number of older people in prisons is growing, as is the number of adults and children who use illegal substances and those with mental health conditions. To address these issues, we work with partners to make sure that the prison itself takes action, as well as the health or social care provider.

From April 2016 to March 2017, we issued 43 requirement notices to 19 different providers delivering health and care services in criminal justice and immigration detention settings. We led on nine focused follow-up inspections where we had previously found breaches of regulations or had specific concerns that people's needs were not being met. Common areas of regulatory breach were poor governance, safety and person-centred care. In following up the breaches, we found services had made improvements to the safety and quality of services to improve people's experience.

Regulating services in the criminal justice and immigration sectors has enabled us to take part in thematic work to better understand people's experiences, which will inform recommendations for improvement and our future inspection activity. With HMI Prisons, we are exploring the support offered to adult prisoners who need social care. In partnership with HMI Probation, we are looking at the support offered within the community to people in contact with probation services, who illegally use psychoactive substances, which are extremely problematic. Clearly, the use of psychoactive substances (predominantly 'spice') in some prisons has a significant impact on the health and wellbeing of prisoners and potentially staff. We have also found that where its use is most prolific, healthcare staff are frequently diverted from delivering routine care and treatment to patients because they are dealing with medical emergencies caused by using 'spice'.

As part of a joint inspection programme, we look at the health element of youth offending services to ensure that health outcomes for this vulnerable group are monitored. This informs our inspections of other settings within the custodial estate and gives an indication of young people's experience of transition between services.

Equality in health and social care

Key points

- Engaged leadership around equality, developing person-centred care, and embedding equality into quality improvement is crucial to improve outcomes for everyone using health and social care services.
- There is a strong link between equality for staff working in services and the quality of care provided. This is now shown by our ratings of NHS trusts. Rigorous national action on race equality for NHS staff is starting to show results, but there is more to do to achieve equality for staff in both health and social care.
- Many organisations could learn from outstanding services that have a strong focus on equality, and from services that are making good progress in specific areas such as the NHS Workforce Race Equality Standard. Trusts that treat people equally and with dignity and respect are more likely to achieve a higher overall rating.
- There are still differences in access to care for people in some equality groups. Some are less likely to say they have received good information about services, so they may find it more difficult to navigate the health and social care system.
- We continue to have concerns about the experiences of care for people in some equality groups, such as people with mental health conditions who are receiving care in acute hospitals. There are signs that work on improving equality is static in adult social care, with half of services still not taking any specific action on equality in the previous 12 months. Services need to move beyond having an equality and diversity policy into actively ensuring equality for people using their services.
- Providers and the health and social care system as a whole need to work together to achieve equality of outcomes for particular groups of people, including through commissioning services and joint working such as the sustainability and transformation partnerships.

Introduction

In this chapter we look at equality of access, experience and outcomes for people who use health and social care services, and for staff working in these services in 2016/17.

This chapter meets our requirements 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: age, disability, gender, gender reassignment, pregnancy and maternity, race, religion and belief, and sexual orientation. We reported on equality for CQC staff in our *Annual report and accounts 2016/17*.

Equality of access

People in some equality groups are still finding it harder to access services than others.

Inequality in access may result in different patterns of service use. For example, a study carried out in 2013/14 showed that people with mental ill-health were 4.9 times more likely to have emergency admissions in acute hospitals than others, but only 19% of these admissions were to support mental health needs.[96]

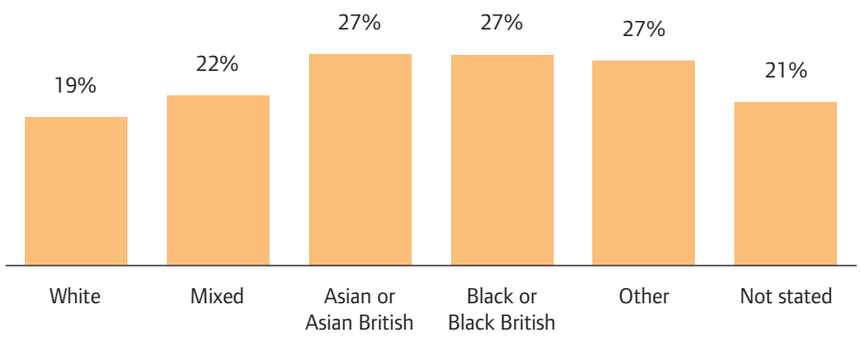
Getting information about services is a critical factor in equality of access. In the 2016 national adult social care survey, Asian or Asian British people were more likely to have difficulty finding information about services, closely followed by Black or Black British people (figure 2.25).[97]

The staff that work in health and social care have an important role in helping people to navigate the health and social care system. In the 2016 NHS adult inpatient survey, patients overall were less positive about staff sharing information with them, compared with 2015. This was based on survey questions covering both information given during a hospital stay and on discharge.[98]

Some people were less likely to report that staff shared information well with them, including:

- people aged over 80
- people with a mental health condition
- people with a longstanding physical health condition
- Jewish people.

Figure 2.25 Percentage of people who found it fairly difficult or very difficult to find information about support, services or benefits in the past 12 months



Source: 2015/16 Adult Social Care Outcomes survey.

In the 2015 survey, a wider range of equality groups reported a poorer experience around being discharged from hospital, including people with a learning disability and people from a range of Black and minority ethnic (BME) groups.[99] However, in in 2016 these groups did not have a significantly different experience to others for the specific questions about information given on discharge, and about sharing information overall. This suggests that there may be improvements in how well information is provided for people in some equality groups, although some are still at a disadvantage.

Some groups of people are also more likely to have difficulty in making a GP appointment than others. In the 2016 GP patient survey, Asian/ Asian British people in particular were less likely to report a positive experience (65% positive) than other groups, particularly White people (79%) and Black/African/Caribbean/Black British people (77%). Analysing responses by religion and belief, Christians reported the most positive experience (81%), along with Jewish people (76%), both significantly higher than Muslims (66%) and Sikhs (64%). These differences may be related to language issues. Overall, people in age bands of 65 and over were more likely to report a positive experience than people in age bands of 54 and under, when making an appointment with a GP.[100]

One of CQC's current equality objectives is to consider how we look at equal access to pathways of care in our regulatory work.[101] This includes looking at access to primary care and referrals to other services for migrants, asylum seekers, Gypsies and Travellers who face particular barriers.

Equality of experience

Everyone should experience good care, no matter who they are. This consistency is an essential part of providing high-quality care. The 2016 NHS adult inpatient survey suggests that some equality groups have a worse experience when using acute hospital services.[102]

Ensuring all people who use services have equally good experiences of hospital care

The Christie NHS Foundation Trust is a specialist cancer trust serving the population of Greater Manchester and Cheshire. We rated the trust as outstanding in November 2016. The leadership team had examined the demographics of people who use their services and had taken steps to ensure equal access, involvement and inclusion for all people. For example, the trust had:

- improved physical accessibility and easy to read information on cancer treatments
- responded to patient feedback and complaints to improve equality – for example, improving the use of British Sign Language interpreters for deaf patients
- engaged the LGBT community in Manchester, through work with the LGBT Cancer Alliance and having a presence at Manchester Pride, as well as working with a Macmillan LGBT project worker to improve the understanding of LGBT issues among staff
- upgraded the chapel, prayer room and multi-faith room, which are now well-used by patients, visitors and staff with much positive feedback
- ensured that all surveys include equality monitoring and that patients who do not read English have interpreter support to complete surveys.

Example from *Equally outstanding: Equality and human rights - good practice resource,* Care Quality Commission.[103]

In particular, respondents with a mental health condition reported a poorer experience of care in a number of areas including: being treated with dignity and respect, how care was coordinated, having confidence and trust, and the emotional support they received.

The survey showed some distinct differences for lesbian and gay people, who reported a poorer experience for receiving emotional support, the coordination and integration of their care and being treated with dignity and respect. The average score for being treated with dignity and respect while in hospital was also lower than average for people aged 16 to 35 and those with a long-standing physical condition.

However, when adjusted for demographic groups, the survey showed that people were significantly more likely to say that they were treated with dignity and respect in acute hospital trusts with higher CQC ratings (figure 2.26).

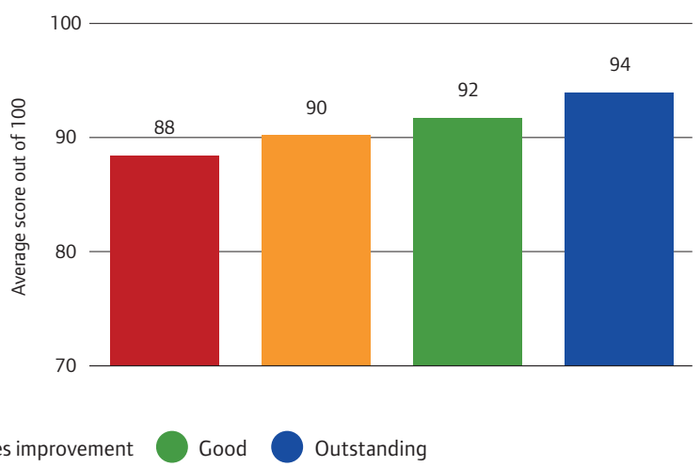
In trusts rated as outstanding, there was also less difference between the responses from people with a mental health condition and others. So, not only were all people more likely to report being treated with dignity and respect, but there was also less inequality of experience between people with a mental health condition and others in trusts with a higher rating.

In primary care services, people in BME groups were less likely to report good experiences of their GP practice compared with White British people. This has generally remained static over time, but worsened in 2016/17 for Bangladeshi people and Gypsies and Irish Travellers.[104] We have found on inspection that GP practices rated as good or outstanding have a well-developed awareness of the needs of their local population. This stems from proactively engaging with patients through both standard methods, such as surveys and patient participation groups, and more innovative methods to reach particular groups.

Our analysis of the NHS adult inpatient survey over the last three years has shown that people with a mental health condition report poorer experiences than others in acute hospitals. Although the questions analysed are not exactly comparable, this is not reflected in the analysis of people's experiences in GP practices in the GP patient survey.

Delivering good person-centred care can improve the experience of each individual. But some inequality needs attention at a service level, as well as at an individual level. For example, we have found on inspection that some mental health services have

Figure 2.26 People's experience of being treated with dignity and respect in hospital, by overall CQC rating



Source: CQC 2016 NHS adult inpatient survey, CQC ratings December 2016.

not considered all the needs of people in all equality groups, beyond the most obvious requirements such as providing interpreters and a multi-faith room.

A strong focus on person-centred care in adult social care services can help to promote equality for individuals. However, in our *Equally outstanding* resource, we state that as in mental health services, equality issues also sometimes need to be considered beyond the individual level at a service level, for example providing staff training about specific equality issues or making the service more welcoming to particular groups. Services were generally less good at capturing equality information for some groups, such as lesbian, gay, bisexual and transgender people (LGBT), that would help to provide person-centred care and to plan service-level improvements.

From our analysis of 10,000 adult social care provider information returns in 2016/17, although over 99% of adult social care services told us that they have equality and diversity policies and procedures, only 46% said that they had carried out any specific work on equality for people using their service in the past 12 months. This was the same as in 2015/16, and was lower than two years ago – although different providers are surveyed each year, so year-on-year comparisons can be difficult to make.

Figures were even lower for promoting equality for specific groups of people. For example, only a fifth (20%) of residential adult social care services told us that they had done work to ensure equality for lesbian, gay and bisexual people and only 13% had worked on equality for transgender people. There is little change from last year, despite a body of evidence that shows this work is necessary for LGBT people to feel safe and confident when using care services.[105] In services with poorer ratings we sometimes find that consideration of meeting the needs of people with protected characteristics, such as LGBT people and people from BME groups, can be tokenistic. These services still have a way to go to demonstrate responsive care for people in these groups. Through our equality objectives, we continue to focus on the quality of care for LGBT people who use adult social care.

Adult social care services rated as good or outstanding in 2016/17 were slightly more likely to have carried out some specific work on equality in the past 12 months than those rated as requires improvement or inadequate. However, there was variation when we looked at whether services had focused on specific equality characteristics and compared this to ratings.

Involving people in a meaningful way to improve equality and quality of care

We rated East London NHS Foundation Trust as outstanding in September 2016. This mental health trust's approach to quality improvement involved frontline staff and patients in making services better for everyone. As part of this they developed an equality, diversity and human rights strategy that commits to:

- assessing inequalities in how Black Caribbean and Black African people access and experience services
- reducing sexual orientation discrimination in inpatient and outpatient environments
- finding out how well the trust complies with human rights law in inpatient wards by using an independent human rights expert to interview patients, and then working with frontline staff and patients to improve how the service protects and promotes people's rights
- increasing the diversity of staff at senior management level
- improving staff engagement at all levels.

Example from *Equally outstanding: Equality and human rights - good practice resource,* Care Quality Commission

The links between outstanding care and equality work were particularly strong for hospices. Seventy-five per cent of hospices rated as outstanding in 2016/17 had carried out some work on equality for disabled people, but only 55% of hospices rated as good had done so. Eighty-eight per cent of hospices rated as outstanding had carried out some work around equality for people of different religions and beliefs, compared with 63% of hospices rated as good.

In our *Equally outstanding* resource, we laid out the ethical, business and economic reasons why services need to pay attention to equality and human rights – as well as the legal requirements. We also learned from health and social care services rated as outstanding that have focused on equality and human rights to improve care. We found that in high-performing services, leaders were enthusiastic and committed to equality, there was a culture of equality and human rights, and staff applied 'equality and human rights thinking' to quality improvement. These services worked with people and organisations from outside to develop both their thinking and their practice.

However, it is not just providers rated as outstanding that pay attention to equality to improve care. In our report *Driving improvement*, we highlighted NHS trusts that have improved and have focused on equality for staff and patients, including Cambridge University Hospitals NHS Trust and Leeds Teaching Hospitals NHS Trust.[106]

Equal outcomes

The role of providers

It can be hard to measure the link between quality of care and outcomes, such as improved health or reduced mortality, for whole population groups, let alone particular equality groups. The way that health and social care is organised in local areas will have a large part to play in reducing inequality in outcomes for people in particular equality groups. But services have a role too.

In 2015/16, the life expectancy of women with a learning disability was around 18 years shorter than for other women, and for men with a learning disability life expectancy was around 14 years shorter than for other men.[107] The 2013 confidential

Making care homes more inclusive for LGBT people

A project by Anchor Trust and the University of Middlesex aimed to address the discrimination, prejudice, misunderstandings or ignorance that LGBT people can face – or fear they will face – when using adult social care services. People can be afraid to 'come out' when needing care, which in turn affects their wellbeing.

The project team worked with community advisors to develop more LGBT-inclusive environments in six Anchor care homes in London. They found that a range of work was needed to enable care home staff to deliver person-centred care for LGBT people. This included developing staff training, cultural safety for LGBT people, the responses of the service to risks of harassment, and outreach with the local LGBT community. The project developed a service assessment and development tool for the community advisors.

The Waterside care home participated in the project, and the resulting benefits to people contributed to a rating of outstanding for the responsive key question following our inspection.

In July 2017, Anchor Trust's work on this project won the Community Impact Award at the Employers Network for Equality and Inclusion (ENEI) Awards.

Example from *Equally outstanding: Equality and human rights - good practice resource*, Care Quality Commission

inquiry into premature deaths of people with learning disabilities found that a lack of reasonable adjustments in health services was a key contributing factor to premature death, with 38% of the deaths being potentially avoidable, compared with 9% of deaths for people who did not have a learning disability.[108]

There is inevitably a time lag between improved access, experience and treatment and better outcomes. A study by the Learning Disability Observatory of death certificates from 2001 to 2014 showed that the median age of death for people with a learning disability had risen, as it had for the rest of the population.[109] However, the median age increased more for people with a learning disability than for others – so the gap in life expectancy was getting smaller. Though the causes of this are unclear, better care for people with a learning disability was likely to be a contributory factor.

But there is no room for complacency. As our report *Learning, candour and accountability* shows, many NHS acute and community trusts are still not able to identify people with a learning disability or an enduring mental health condition in their care, and therefore they are not able to systematically review adverse incidents or deaths for these groups of people to learn how care can be improved for them.[110]

People with severe and prolonged mental ill-health are at risk of dying on average 15 to 20 years earlier than other people. Two-thirds of these deaths are from avoidable physical illnesses such as those caused by smoking.[111] In 2014/15, the mortality rate for people with a mental health condition was 227% higher than the rate in the general population; in 2009/10 the rate was 210% higher, which shows that the inequality is growing.[112]

Health outcomes for people with long-term conditions may be improved if people are supported to manage their own health. There is variation in how people in different ethnic groups felt about having support in the last six months from local services or organisations to help with their long-term health condition(s). White people were most likely to report having enough support (65% positive) and Black/African/Caribbean/Black British people the least likely (53% positive).[113] People who are deaf or have a hearing impairment were also less likely to report having enough support.

All services have an important role in preventing premature or avoidable deaths or avoidable ill-health for people in a wide range of equality groups. For example, we highlighted good practice in diabetes care for people with a learning disability and people from BME communities in our report, *My diabetes, my care*.[114]

Empowering all patients to achieve their health goals

Herstmonceux Integrative Health Centre is a GP practice in rural East Sussex. We rated the practice as outstanding in January 2017. The practice's ethos is about empowering patients to achieve their health goals and "providing safe and effective quality health care in an environment of equality and respect".

The practice runs schemes such as a patient library, singing workshops and healthy walks. Some schemes focus on specific groups:

- to respond to social isolation, there is a monthly coffee morning for older people
- young men are the biggest users of the local food bank and are vulnerable to poor mental and physical wellbeing, so the centre is currently developing work with them
- patients with long-term conditions work with their GP to develop a "Health Vision" and a "Health Coach" helps the person put the vision into practice.

The practice evaluates many of its initiatives to assess the benefits of "integrative" approaches and to make a case for future NHS funding for a wide range of activities.

Example from *Equally outstanding: Equality and human rights - good practice resource*, Care Quality Commission

Working together in local areas

In *Equally outstanding*, we state that providers cannot address health inequalities alone. Commissioners, regulators and policy makers – and people who use services – all have a role in helping to reduce inequalities.

But more than this, organisations need to work together to reduce inequality. The NHS *Five Year Forward View* aims to address the health and wellbeing gap – alongside gaps in quality of care and in NHS funding and efficiency. Looking at the inequalities faced by particular equality groups is integral to tackling some of the largest health and wellbeing gaps.

The purpose of sustainability and transformation partnerships (STPs) is "to help ensure that health and social care services in England are built around the needs of local populations". This can only be achieved by also considering the different needs within a local population – including needs relating to equality characteristics.

Our analysis of published STP plans and other documents in January 2017, found that most STPs were focusing on geographical inequality and few STPs were systematically considering equality groups as part of their work to address the health and wellbeing gap. All 44 STP plans mentioned reducing health inequalities but only 24 mentioned any issues for specific equality groups. Also, we found evidence that only five STPs had carried out equality impact analyses of their plans. However, 13 STPs did say that they would do these in the future.

Workforce equality

In 2016, there was a small overall reduction from 2015 in the percentage of NHS staff experiencing bullying, harassment or abuse from other staff, across all types of trust. However, the proportion of staff who say their organisation acts fairly with regard to career progression regardless of ethnic background, gender, religion, sexual orientation, disability or age has dropped by a small percentage, year on year, since 2013.[115]

The link between equality for staff and the quality of care in the NHS has been well-established.[116, 117, 118] An analysis of our ratings and the NHS staff survey results also showed a clear pattern between the quality of care and staff experience of discrimination in the NHS, with staff in trusts with lower ratings more likely to say they have experienced discrimination (figure 2.27).

Building equality into service re-commissioning

Greater Manchester NHS Transformation Unit is an NHS improvement agency that specialises in transforming health and care services. The unit tested how to build equality considerations into service re-commissioning, in a pilot to redesign general surgery services across Greater Manchester.

This involved engaging with local equality groups to find out the main issues in the plans to change surgery services.

These issues were then used as a factor when looking at different options for delivering services. The unit also looked at providers in the area to identify good practice, for example in giving disabled people access to a service. This good practice was then used as a contractual requirement for providers in the re-commissioned services to bring all services up to the same standard as the best services.

There is a similar pattern when looking at the likelihood of staff experiencing harassment, bullying or abuse from other staff and when looking at whether consultants and nurses in acute trusts believe there are equal opportunities for career progression.[119]

In the NHS, there has been a determined effort to address race equality for staff by introducing the NHS Workforce Race Equality Standard (WRES). The 2016 WRES Data Analysis report for NHS trusts found that, although there were some small changes in the right direction at a national level, there is still much work to do.[120] In the 2016 NHS staff survey, BME staff were still significantly more likely to experience discrimination at work and bullying and harassment from other staff, and were less likely to believe there were equal opportunities for career progression.

Since April 2016, we have reported on WRES in 41 NHS trust inspections under the well-led key question. This is only a sample of trusts overall. The following findings should therefore be treated with some caution. We found a mixed picture in most trusts. Positive practice in relation to work on WRES was mentioned in 32 of the 41 reports. Yet 38 of the 41 reports also mentioned areas for improvement in implementing WRES.

Across all ratings, the most commonly mentioned positive practices were:

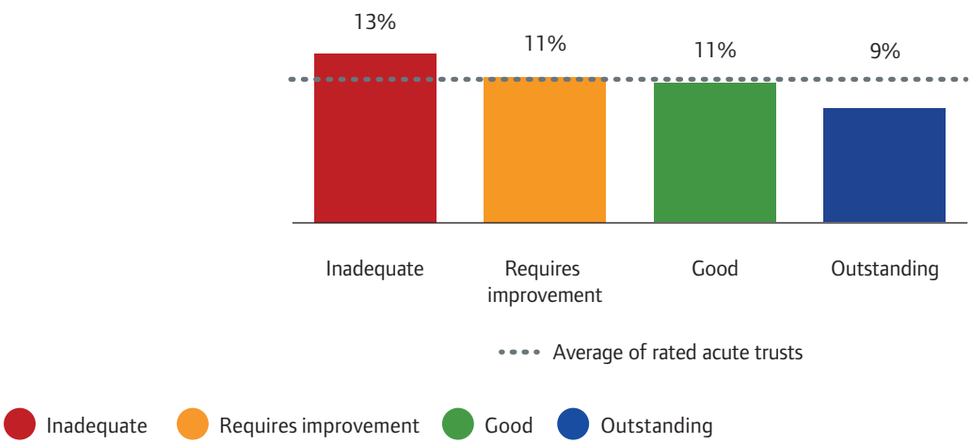
- BME staff overall being representative of the population served
- good leadership on implementing WRES and work to develop an inclusive staff culture
- positive management to address bullying and harassment of BME staff.

The most commonly mentioned areas for improvement were:

- poor leadership, culture and staff engagement, including poor oversight of WRES by trust boards
- poor career progression for BME staff (although there were also several mentions of interventions underway to address this)
- lack of BME representation at senior levels, including on boards
- poor practice in handling bullying and harassment of BME staff.

We found trusts of all ratings had areas for improvement for the well-led key question. This included trusts rated as outstanding – particularly around equality in career progression. Those rated as inadequate tended to have little evidence of improvement being planned or implemented.

Figure 2.27 Staff experience of discrimination in NHS acute and combined trusts



Source: CQC ratings 31 July 2017, NHS staff survey 2016 weighted data.

In contrast, we found that trusts rated as outstanding were more likely to be tackling inequalities between BME and White staff – and some were already seeing good outcomes. For example, in one mental health trust rated as outstanding, BME staff were less likely to be bullied and harassed compared with White staff. Also, BME staff at this trust were no more likely to experience discrimination at work than White staff.

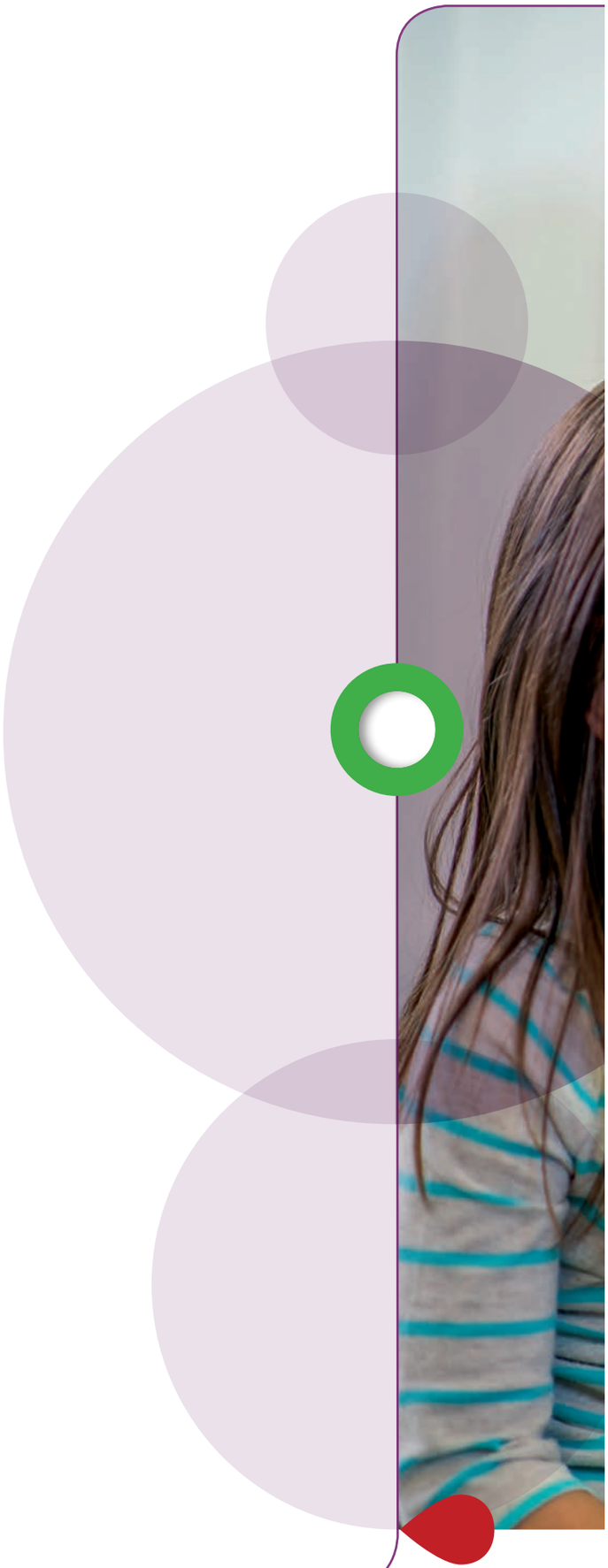
There were a number of examples of trusts rated as inadequate that had particularly poor leadership and engagement around race equality. In one acute trust, BME staff had described an overwhelming feeling of being 'undervalued and bullied'.

Race equality is not the only workforce equality issue that needs to be tackled in the NHS. The 2015 King's Fund report *Making the Difference* found that levels of reported discrimination in the NHS staff survey vary significantly by gender, age, ethnicity, sexual orientation, religion and disability status.

For this reason, we welcome the introduction of the NHS Workforce Disability Equality Standard from April 2018.[121] The implementation of the WRES suggests that having an equality standard with clear indicators can make a difference, although this will take time.

There is less data available on staff equality in other sectors – but this is not to say that there are no equality issues for staff. For example, lesbian, gay and bisexual GPs can face discrimination and bullying in the workplace, in medical training and harassment from their patients.[122] In social care, BME staff are under-represented in management grades; 14.5% of care workers are from a Black, Asian or mixed background but only 8.7% of registered managers are from these backgrounds.[123]

There is little reason to doubt the fundamental principle that creating an open, fair and inclusive culture for staff will bring benefits to people using a range of health and social care services. A common factor that we found in outstanding services that used equality and human rights approaches in their development, was that they had a focus on equality for staff as well as for people who used their services.[124] For this reason, we have extended our equality objectives to include workforce equality in our assessments of the well-led key question in all our inspections. We have reflected this change in our new assessment frameworks for health care and adult social care services, published in June 2017.[125, 126]



The Deprivation of Liberty Safeguards

Key points

- We continue to see variation in the practical application of the Deprivation of Liberty Safeguards (DoLS) with uneven use across the health and social care sector – this can lead to people being at risk of having their rights and liberty restricted without a lawful process.
- However, there are examples of good practice that providers can learn from, for example personalised ways to assess capacity, and using new technology to increase people's independence.
- While staff training levels are relatively good, translating this knowledge into practice is still less effective and needs to improve.
- Staff need more help to understand what constitutes a restrictive practice or restraint, and we have seen some innovative alternatives to restriction.
- DoLS should not be one-size-fits-all – good practice in person-centred care is at the heart of ensuring decisions made around the Mental Capacity Act (MCA) and DoLS are in the person's best interests.
- Delays to the processing of DoLS applications are a continuing problem, although some providers have found ways to work together with local authorities to manage the situation.

Introduction

CQC is responsible for monitoring the use of the Deprivation of Liberty Safeguards (DoLS) in hospitals and care homes and reporting to Parliament through this report on how they are being implemented. At the centre of this is protecting the human rights, dignity and wellbeing of people who are deprived of their liberty while receiving health and social care.

The health and social care sector is under pressure as financial constraints and increased demand from an ageing and vulnerable population converge. In this challenging context, ensuring DoLS are used in a way that is right and fair for people is ever more important. Good local system leadership and collaboration, for example between local authorities and providers, can help with this.

Our inspection reports show that most care home providers comply with DoLS legislation. Where we find they have breached the regulations we take appropriate regulatory action, and there is usually improvement when we go back to re-inspect.

However, eight years on from the introduction of the DoLS, our adult social care, hospitals and mental health inspectors continue to find variation in their implementation and use. There are often misunderstandings and a lack of clarity. This variation is commonly linked to staff not being supported fully to apply their DoLS training to real life practice. It can also result from staff shortages leading to a lack of personal attention to an individual's particular wishes and choices.

This chapter looks at the areas that need to improve and the variable practice we continue to see, while also highlighting good practice that providers and others can learn from.

Context

During 2016/17 there remained a backlog of DoLS applications – according to the ADASS budget survey 2017, "Only 29% of directors who responded to the survey are fully confident of being able to deliver all of their statutory duties this year (including for DoLS), falling to just 4% who think they can do so next year."[127] This is mainly as a result of the Supreme Court ruling (see box) that clarified the definition and widened the potential scope of a deprivation of liberty, which then led to a large increase in applications. Additionally, a common complaint made to the Local Government Ombudsman and mentioned in *The Right to Decide*, is that providers themselves do not always submit their applications in a timely way.[128] The backlog means there is a risk that DoLS may not be authorised or processed in appropriate timescales, individual wishes may not be respected, and rights may not be protected. People are waiting longer than they should to receive independent assessments, advocacy and representation from local authorities.

Recent case law has emphasised that supervisory bodies have a duty to monitor compliance with any conditions that are attached to a person's authorisation under a DoLS.[129] This is positive as the conditions are there to maintain and promote a person's independence and quality of life. We are concerned that the delays in DoLS application processing may affect how quickly these conditions can be integrated in care plans, and therefore potentially cause a lack of clarity in the delivery of care.

Alzheimer's Society has said that enquiries to their helpline, and to staff working with those affected by dementia, suggest that families and others important to the person are sometimes not being properly involved by care homes and local authorities in the DoLS process. They also said that the role of a relevant person's representative and the role of an independent mental capacity advocate are not always properly explained. These enquiries highlight

that families and carers sometimes do not understand that DoLS can be a positive part of care planning. This then leads to fear and uncertainty.

Providers need to notify CQC when they know the outcome of an application or if they withdraw an application. During 2016/17 we received 82,621 notifications – a 33% increase from the previous year when we received 62,237. This increase may reflect the increase in DoLS applications and it could also mean better reporting. It still, however, remains on the lower side of what we would expect given the increased applications to local authorities over the years (this number is higher than the notifications we receive). This is important as, without notifications, our ability to monitor DoLS and check that people are receiving appropriate care is reduced. We can take regulatory action where we find a provider has not met the requirements relating to DoLS, including a failure to notify us of authorisations.

There have been changes this year to the role of coroners in relation to people subject to DoLS. The Policing and Crime Act 2017 introduced changes in April 2017 that mean a person who dies while under a DoLS authorisation is no longer classed as having died in 'state detention' and the coroner no longer has to hold an automatic inquest and investigate the death. However, coroners still have a duty to investigate any deaths where there is a concern, such as about the care or treatment the person received before they died, or where the cause of death is unknown. We welcome these changes as automatic inquests were previously causing emotional distress for bereaved families and needless pressure on services.[130]

A Law Commission review published in March 2017 looked at how to simplify and modernise the DoLS process. The review proposed a draft Bill that would repeal DoLS and replace it with a

The Deprivation of Liberty Safeguards explained

People who are not able to make some or all of their own decisions due to a lack of capacity are protected and empowered by the Mental Capacity Act 2005 (MCA).

The Act sets out who can make decisions for a person who lacks capacity, when and how. It ensures that decisions are made in a person's best interests and that the person is involved in the decision as much as possible.

The Deprivation of Liberty Safeguards (DoLS) were introduced as an amendment to the MCA and came into force in April 2009. The DoLS are additional safeguards to protect the rights of people who are deprived of their liberty in their own best interests to protect their health and safety. A Supreme Court ruling in March 2014 clarified the definition and widened the scope of when someone is being deprived of their liberty. This 'acid test' can be 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.

DoLS are used only in hospitals and care homes. GP practices should be able to provide advice on when they may need to be applied for. Other types of providers should understand DoLS and the implications for when people need to move in and out of their care.

Hospitals and care homes apply for a DoLS authorisation through a supervisory body – this is the local authority. There are six assessments needed to receive a standard authorisation, that can granted for up to a year. An urgent authorisation can be made in exceptional cases.

The Supreme Court ruling (and the clarified definition) has resulted in a very large increase in the number of applications for DoLS authorisations. Over three years, applications have risen from 13,715 in 2013/14 (before the ruling) to 195,840 in 2015/16 – a huge increase of more than 14 times.[132] This increase has created a backlog with the local authorities that process applications. NHS Digital data for applications in 2016/17 was not available at the time of publishing.

new scheme, provisionally known as the Liberty Protection Safeguards. The proposals give more weight to considering a person's wishes, feelings and values, and propose an expansion to cover 16 and 17 year-olds, and all environments in which people may need their liberty safeguarded (likely to be all health and social care settings, including care in people's own homes where the state has a responsibility). We look forward to the government's interim response to the review due later this year, followed by a formal response likely to be in March 2018. We will review our approach in light of this and consider any changes needed to respond to the new scheme.[131] Any transition to a new scheme must not result in any loss of momentum – providers and local authorities should continue to focus on making improvements.

Variation in applying DoLS

We have found that, as in previous years, variation continues in the effective use of DoLS by providers across the health and adult social care sector.

Our adult social care, acute hospital and mental health inspectors have highlighted that this uneven practice often occurs because staff do not fully understand aspects of the legislation, partly due to its complexity, and also as a result of not enough training or translating that training into practice. This can lead to the use of overly restrictive practices; generalised decisions around a person's capacity; and a lack of person-centred care. Where there are staff shortages and pressures, this can also lead to restrictive practices to help save time.

Local authority delays in providing DoLS authorisations have also had an impact as providers often wait too long for clarity, sometimes to the point where a person is at risk of having their liberty deprived unlawfully.

A need to put training into practice

Although we found improved awareness of DoLS across adult social care, acute hospitals and mental health services, our inspectors found that providers often lacked effective practical understanding of how to apply aspects of DoLS legislation. Adult social care inspectors found that DoLS training was sometimes not effective in supporting provider staff to translate training into practical improvements. There were gaps in knowledge about the practicalities of DoLS and how these could impact on a person's care. A concern from our inspectors is that DoLS is often viewed very much as a paper exercise with the application as the end point, rather than the beginning of the care planning process.

Poor practice: Limited staff understanding of DoLS

In an older person's ward at an NHS mental health trust we found that although the trust was providing training on DoLS and the MCA, this was not translating into practice. There was poor adherence and understanding of DoLS.

Patients on the ward were subject to a number of blanket restrictions and we did not find evidence of any formal consideration to reduce or remove these. Staff did not understand the training they had received about important DoLS case law, specifically the landmark ruling in March 2014 from the Supreme Court that provided clarity on when deprivation of liberty should be considered. The trust had provided checklists and policies to support staff to make a decision, but there was no evidence of these processes being followed.

The provider was in breach of the regulation and we issued a requirement notice to make sure that the trust improved training so that staff had a better understanding of DoLS.

Similarly, in acute hospitals, adult social care and mental health services, there were mixed reports of training with concerns about there being good mandatory training rates, often by e-learning, but that there was not always evidence that training was put into practice.

Confusion around the interaction between the MCA and the Mental Health Act 1983 (MHA) was also an area of concern. In mental health services, inspectors reported that staff were sometimes unclear about how the legislation for each act works together.

The challenge of assessing capacity

Capacity is an important area where providers and staff often seemed to lack understanding.

There was often not enough time spent assessing a person's changing capacity. In acute hospitals, adult social care and mental health services, inspectors felt staff needed to be more aware of the importance of assessing different areas of a person's capacity, and the fact that these can fluctuate on a daily basis.

Paperwork was not always detailed enough and evidence to support best interests decision-making for patients was not always available. Best interests decision-making considers the welfare of a person who lacks capacity by looking at previous and current preferences, alongside relevant medical and social issues. Poor practice in this is a common cause of complaint to the Local Government and Social Care Ombudsman as highlighted in *The Right to Decide*.

Adult social care inspectors found that DoLS was often not embedded in standard care planning, and paperwork was kept separately with providers implementing new processes and templates without including areas relating to DoLS. There was a sense that the focus was mainly on the application process and box ticking, rather than the continued, personalised care that each person should have.

Use of restraint and restrictive practices

Restraint and restrictive practices are intentional acts that restrict a person's movement, or freedom to act independently, to reduce or prevent harm to the person or others. They should not be used for longer than is necessary.[133]

Across all sectors, there was a lack of understanding of what restraint or restrictive practices are and how to recognise them. This led to instances where people's rights and wishes were not being respected. Staff need more help to understand what a restrictive practice is and how to develop alternatives.

Restrictive practices were apparent, especially in the adult social care sector where there can be large numbers of people living with dementia-related conditions. Inspectors gave examples of 'blanket' restrictions in adult social care and hospital settings. These were either where a restriction that could potentially be a deprivation had not been identified as that, or where a restriction had been applied to a group of people, rather than on an individual basis. Examples included: people being locked in communal living areas or wards; people not allowed to take part in certain activities; the use of bed-rails to restrict people without a proper risk assessment; and the use of anxiety medication as a chemical restraint. These practices had developed for a number of reasons:

- Historical – some practices had always been in place and so were not questioned by staff or recognised as being restrictive.
- Time-saving – in services where there were not enough staff, sometimes blanket restrictions had been applied to everyone, regardless of an individual's capacity, to help save time or because staff were not available to accompany people.
- Lack of understanding – staff were using restrictive practices unintentionally as they were not clear what constituted one, for example walkers being moved out of reach of people to keep them in bed. Restrictive practices were sometimes continued after a person had regained some or all of their capacity about the specific decision that needed to be made at the time.

Useful tools and guidance for helping staff and providers to better understand restriction and restraint do exist, for example the Local Government Association, the Association of Directors of Adult Social Services, and the Care Provider Alliance: *Promoting less restrictive practice: reducing restrictions tool* provides useful guidance for staff.[134]

Good practice and improvement

Effective practice in DoLS is not one-size-fits-all. Good practice in person-centred care is at the heart of ensuring decisions made around the MCA and DoLS are in the person's best interests.[135] The individual's perspective should be the focus and the aim should be to improve the life of the person requiring DoLS and to preserve their choices and preferences as far as possible with the minimum of restrictions to keep them safe.[136] There is an opportunity for good leadership and collaboration in the local health and care system to drive improvement.

Our adult social care, acute hospital and mental health inspectors found interesting initiatives to drive improvement.

Person-centred care

Inspectors saw approaches to assessing capacity that moved beyond the tick-box method and involved people much more in their own care. In one ward of a mental health hospital, there were capacity assessments that had been written in a conversational style, reflecting and highlighting the voice of the patient to aid understanding of their specific needs.

At a combined mental healthcare trust, we saw well-substantiated best interests decisions with detailed evidence to support them. The information included historical information about the choices made by the person to try to understand their preferences before they lost capacity. The thoughts of families, friends and carers had also been captured.

As technology continues to advance, we are seeing more examples of it being used, in line with best interests decisions, to keep people with limited capacity safe but with enhanced independence. Although assistive technology can support staff by saving time, the focus should always be on the benefits to the individual. The MCA and DoLS should be used to determine this when a person may lack capacity to make a decision. CQC has published information on the use of surveillance technology in health and social care settings and this will be updated in 2018 to look more broadly at the use of technology to support people.

Positive alternatives to restraint and restrictive practice

There are services that are demonstrating good practice around restraint and restrictive practice, and finding positive alternatives and ways to improve.

Inspectors reported that learning disability services in the adult social care sector tended to show better examples of good practice with appropriate guidance on restraint and restriction embedded in care plans. In a small (six-bed) service for people with autism, the manager had set a positive culture where staff and people using the service treated each other as equals. Staff were empowered to develop alternative ways to deal with complex behaviour. For example, a man living in the service had been restrained daily in a previous care setting. Staff in the new service found that if they picked up cushions when the man became angry, he would hit the cushions rather than the staff. This less restrictive practice resulted in him being restrained only twice in six months.

An independent mental health hospital group had shown leadership in the sector by trying to reduce restrictive practices at a national level for its other hospital locations. A team consisting of a staff member, manager and a patient went round a range of the hospital group's locations to identify blanket

Good practice: joint best interests decision-making

A woman being cared for by a domiciliary care agency had always enjoyed going for walks on her own. However, she had changing capacity needs that sometimes meant she couldn't find her way home. The provider met with the woman, her family and staff from the agency to discuss options. A best interests decision was made to place a digital tracker in her shoes so that she could continue to enjoy life on her own terms, while reducing risks and providing reassurance to her family. All involved agreed together that this was the best option.

restrictions and restrictive practices and to talk about these from varying perspectives and work on solutions together.

Some services used Positive Behaviour Support (PBS) to better understand and predict people's behaviour – for it to work well, mental health inspectors mentioned it was important for the leaders and the staff to be positively invested in the process. The PBS framework is a person-centred competency framework that supports staff to understand the meaning and context of behaviour that is difficult or challenging.[137]

Confidence in dealing with the DoLS process

Adult social care, acute hospital and mental health inspectors found some improvements in general awareness of DoLS, particularly around confidence in the application process. In acute hospitals, this was seen to be related to the effect of training being available to senior leaders and to frontline staff, and in making DoLS generally more visible to staff.

We saw good practice in the surgery department of an acute trust where the leadership team had designed a clear flow chart and process for DoLS that was visible to all staff.

System leaders working together

Inspectors saw examples where different parts of the health and care system were working well together to drive improvement in DoLS training and practice.

In a combined healthcare trust we found that the older adult mental health community team had taken the lead on DoLS authorisations for nursing homes as a way of keeping applications moving quickly. This had resulted in a positive culture at the trust where staff stopped feeling like DoLS were someone else's business and instead took ownership of the process. The executive team at the trust had also worked closely with the local authority and prompted them to progress applications.

As part of our work with a local authority area, we heard of an encouraging approach to building training into practice. The local authority was working with the clinical commissioning group and the local trust to provide training on the MCA to services in the area. They had introduced the idea of completing a reflective log. After the training, staff were encouraged to note instances where they had applied the five MCA guiding principles and embedded them in their day-to-day practice.

DoLS improving quality of life after inspection

During the inspection of a care home, the inspector was told about an older woman who had lived there for a number of years, in which time her health had worsened and she had developed a complex dementia-related condition. Over this time her needs had changed and she was now living with the advanced stages of dementia.

Previously the woman had been happy living at the home and had developed good relationships with the staff. However as she became more distressed, as a result of her condition, her behaviour started to challenge staff and to upset other people using the service. As a result of her dementia, she was not able to leave her room independently and could not maintain a safe and comfortable environment in her room. Her records showed that her main contact with other people was when staff came in to do basic care or domestic tasks.

Following the inspection, the provider made a DoLS application. The local authority arranged for specialist staff to meet and assess the woman and to talk with her family. The local authority approved the DoLS application and placed some conditions on the authorisation to improve the woman's quality of life. These included that staff should spend time sitting with her each day and talking to her about her past life and current affairs. They should also take her for a short walk each day.

The DoLS had a positive impact on the woman's wellbeing as she received specialist input from staff with knowledge of complex dementia and was able to stay at the care home. This was an environment she was familiar with and where staff knew her well, but she was supported to have an improved quality of life.

References

1. Office for National Statistics, Subnational population projections for England: 2014-based projections
2. Prince, M and others, *Dementia UK: Update Second Edition* report produced by King's College London and the London School of Economics for the Alzheimer's Society, November 2014
3. https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/bulletins/healthstatelifeexpectanciesuk/2013to2015
4. NHS England, Ambulance Quality Indicators: System Indicators Time Series, https://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/
5. http://content.digital.nhs.uk/catalogue/PUB21748/apms-2014-full-rpt.pdf
6. Five Year Forward View for Mental Health, February 2016
7. NHS Digital, Mental Health Bulletin: 2015-16 Annual Report, November 2016
8. NHS Digital, *Inpatients formally detained in hospitals under the Mental Health Act 1983 and patients subject to Supervised Community Treatment: 2015/16, Annual figures*, 2016
9. Office for National Statistics 2015, 2014-based National Population Projections
10. Marmot M and others, English Longitudinal Study of Ageing: Waves 0-7, 1998-2015, 25th Edition, UK Data Service. SN: 5050
11. Age UK, Briefing: Health and Care of Older People in England 2017, February 2017
12. ONS 2016 mid-year population estimates
13. Kings Fund, *Understanding pressures in general practice*, May 2016
14. Allen G and Dempsey N, Prison Population Statistics, House of Commons Library Briefing Paper SN/SG/04334, 2016, April 2017
15. Fazel and others, 'Health of elderly male prisoners: worse than the general population, worse than younger prisoners,' Age and Ageing 2001: 30403-407, 2001
16. Carers UK, *State of Caring 2017*, July 2017
17. NHS Digital, Hospital Admitted Patient Care Activity 2015/16: Summary report, 2015-16, November 2016
18. NHS Providers news story: https://nhsproviders.org/news-blogs/news/bed-occupancy-rates-hit-record-high based on NHS England bed availability and occupancy data: https://www.england.nhs.uk/statistics/statistical-work-areas/bed-availability-and-occupancy/bed-data-overnight/
19. NHS Improvement, Quarterly performance of the NHS provider sector: quarter 4 2016/17, June 2017 https://improvement.nhs.uk/resources/quarterly-performance-nhs-provider-sector-quarter-4-1617/
20. The Nuffield Trust, *The bottom line: Understanding the NHS deficit and why it won't go away*, August 2017
21. https://www.england.nhs.uk/statistics/statistical-work-areas/bed-availability-and-occupancy/bed-data-overnight/
22. LaingBuisson, The home truths in UK homecare services, June 2017
23. Association of Directors of Adult Social Services, ADASS Budget Survey 2017
24. NHS Digital, Personal Social Services: Expenditure and Unit Costs, England – 2015-16, 2016
25. Association of Directors of Adult Social Services, ADASS Budget Survey 2017
26. Age UK, Briefing: Health and Care of Older People in England 2017, 2017
27. NHS Digital: General and Personal Medical Services, England, June 2017, and ONS mid-year population estimates, 2009 to 2016
28. British Medical Association media briefing, https://www.bma.org.uk/-/media/files/pdfs/news views analysis/press briefings/general-practice.pdf?la=en, April 2017
29. www.prisonreformtrust.org.uk/PressPolicy/News/vw/1/ItemID/435, May 2017
30. Skills for Care, The state of the adult social care sector and workforce in England, September 2017
31. NHS Digital, General and Personal Medical Services, England 2006-2016, as at 30 September 2016, Experimental statistics, published 29 March 2017

32. NHS Digital, NHS Vacancy Statistics England – February 2015 to March 2017 Provisional Experimental Statistics

33. Health Education England, *Stepping forward to 2020/21: The mental health workforce plan for England*, July 2017

34. Skills for Care, Open Access NMDS-SC dashboards, accessed 27 June 2017

35. NHS Digital, Supplementary information – full time equivalent GPs by country group of primary medical qualification: practice level as at 30 September 2016

36. http://www.health.org.uk/news/new-data-show-96-drop-nurses-eu-july-last-year

37. Association of Directors of Adult Social Services, ADASS Budget Survey 2017

38. Competition and Markets Authority, Care homes market study: financial analysis working paper, 2017

39. Care Quality Commission, *Driving improvement: Case studies from NHS trusts*, June 2017

40. Care Quality Commission, *The state of care in mental health services 2014 to 2017*, July 2017

41. Care Quality Commission, *The state of adult social care services 2014 to 2017*, July 2017

42. Care Quality Commission, *The state of care in general practice*, September 2017

43. Care Quality Commission, *Responding to a risk or priority in an area: London Borough of Sutton*, October 2017

44. https://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/

45. http://researchbriefings.parliament.uk/ResearchBriefing/Summary/CBP-7415

46. Care Quality Commission, *Building Bridges, Breaking Barriers*, July 2016

47. Care Quality Commission, *Responding to a risk or priority in an area: London Borough of Sutton*, October 2017

48. Care Quality Commission, *Responding to a risk or priority in an area: Partnership working to deliver health and social care in Cornwall*, October 2017

49. Lakhani, M, Baker, M, Field SJ, *The Future Direction of General Practice: A roadmap*, Royal College of General Practitioners, 2007.

50. Nuffield Trust, *Is bigger better? Lessons for large-scale general practice*, July 2016

51. House of Commons Library: Briefing Paper no. 7415, 20 June 2017 – Delayed transfers of care in the NHS

52. Care Quality Commission, *Equally outstanding: Equality and human rights – good practice resource. How can a focus on equality and human rights improve the quality of care in times of financial constraint?*, September 2017

53. Care Quality Commission, *Driving improvement: Case studies from NHS trusts*, June 2017

54. Care Quality Commission, *The state of adult social care services 2014 to 2017*, July 2017

55. Skills for Care, *The state of the adult social care sector and workforce in England*, September 2017

56. Office for National Statistics, *2014-based National Population Projections*, 2015

57. Institute for Government, *Performance Tracker: A data-driven analysis of the performance of government*, Spring 2017

58. Age UK, *Briefing: Health and Care of Older People in England 2017*, February 2017

59. Skills for Care, *The state of the adult social care sector and workforce in England*, 2017

60. Association of Directors of Adult Social Services, *ADASS budget survey 2017*, 2017

61. Quality Matters Board, *Quality matters*, July 2017

62. What Works Centre for Wellbeing, *Music, singing and wellbeing in adults with diagnosed conditions or dementia*, December 2016

63. http://www.lexology.com/library/detail.aspx?g=d28ebead-0399-40da-9639-5add9d95bda2&l=7UZ7ZPK

64. Care Quality Commission, *The State of Care in NHS acute hospitals 2014 to 2016*, March 2017

65. NHS England, Ambulance Quality Indicators: System Indicators Time Series

66. Data on all NHS ambulance trusts collated by South East Coast Ambulance Service NHS Foundation Trust (data supplied to CQC)

67. https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/

68. NHS Providers news story: https://nhsproviders.org/news-blogs/news/bed-occupancy-rates-hit-record-high based on NHS England bed availability and occupancy data: https://www.england.nhs.uk/statistics/statistical-work-areas/bed-availability-and-occupancy/bed-data-overnight/

69. https://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/

70. NHS Digital, NHS Vacancy Statistics England – February 2015 to March 2017 Provisional Experimental Statistics

71. http://www.health.org.uk/news/new-data-show-96-drop-nurses-eu-july-last-year

72. NHS Improvement, Quarterly performance of the NHS provider sector: quarter 4 2016/17

73. The Nuffield Trust, *The bottom line: Understanding the NHS deficit and why it won't go away*, August 2017

74. NHS England, *Five year forward view*, October 2014

75. Care Quality Commission, *Driving improvement*, June 2017

76. http://www.nhsstaffsurveys.com/Caches/Files/20170306_ST16_National%20Briefing_v6.0.pdf

77. http://www.cqc.org.uk/news/stories/independent-ambulance-providers-%E2%80%93-emerging-concerns

78. Peter Spurgeon and others 'Medical engagement and improving quality of care', in *Future Hospital Journal*, vol.2, no.3: 199-202, 2015

79. NHS Digital, *Inpatients formally detained in hospitals under the Mental Health Act 1983 and patients subject to Supervised Community Treatment: 2015/16, Annual figures*, November 2016

80. NHS Digital, *Out of area placements in mental health services*, May 2017

81. Independent Mental Health Taskforce to the NHS in England, *The Five Year Forward View for Mental Health*, February 2016

82. Care Quality Commission, *The state of care in mental health services 2014 to 2017*, July 2017

83. NHS Digital http://content.digital.nhs.uk/primary-care

84. Office for National Statistics, Subnational population projections for England: 2014-based projections

85. NHS England, GP Patient survey 2016

86. NHS England, General Practice Forward View, April 2016

87. http://digital.nhs.uk/catalogue/PUB30069

88. The Guardian, https://www.theguardian.com/society/2017/jun/08/80-of-under-twos-in-england-failed-to-visit-the-dentist-last-year-says-study, 8 June 2017

89. https://www.rcseng.ac.uk/news-and-events/media-centre/press-releases/child-tooth-extractions-24-per-cent/

90. Care Quality Commission, *The State of Care in general practice 2014-2017*, September 2017

91. NHS England, GP Patient Survey 2016

92. Care Quality Commission, *The safer management of controlled drugs: Annual update for 2016*, July 2017

93. Care Quality Commission, *Not seen, not heard*, July 2016

94. Ofsted, Care Quality Commission, HMI Constabulary, HMI Probation, *Time to listen*, 2016 (updated 2017)

95. HMI Probation, HMI Constabulary, Care Quality Commission, Ofsted, *The multi agency response to children living with domestic abuse*, September 2017

96. Health Foundation, Nuffield Trust and Quality Watch, *Focus on people with mental ill health and hospital use*, October 2015

97. NHS Digital, Personal social services adult social care survey 2015/16, England, October 2016

98. Care Quality Commission, 2016 Adult inpatient survey statistical release, May 2016

99. Care Quality Commission, *The State of health care and adult social care in England 2015/16*, October 2016

100. NHS England, GP Patient Survey 2016

101. http://www.cqc.org.uk/about-us/our-strategy-plans/equality-human-rights

102. Care Quality Commission, 2016 Adult inpatient survey statistical release, May 2017

103. Care Quality Commission, *Equally outstanding: Equality and human rights – good practice resource, How can a focus on equality and human rights improve the quality of care in times of financial constraint?*, September 2017

104. NHS England, England Analysis: NHS Outcomes Framework Health Inequalities Indicators 2016/17, 2017

105. National LGB&T Foundation supported by Department of Health, The Adult Social Care Outcomes Framework lesbian, gay, bisexual and trans companion document

106. Care Quality Commission, *Driving Improvement: Case studies from eight NHS trusts*, June 2017

107. NHS Digital, *Health and Care of People with Learning Disabilities*, 2015/16

108. Norah Fry Research Centre, *Confidential Inquiry into the premature deaths of people with learning disabilities*, 2013

109. Learning Disability Observatory, *People with learning disabilities in England 2015: Main report*, 2016

110. Care Quality *Commission, Learning, candour and accountability*: a review of the way that NHS trusts review and investigate the deaths of patients in England, December 2016

111. Independent mental health task force to the NHS, F*ive Year Forward View for mental health*, 2016

112. NHS Digital, NHS Outcomes Framework 2016/17 Indicator and Domain Summary Tables, November 2017

113. NHS England, GP patient survey 2016

114. Care Quality Commission, *My diabetes, my care*, September 2016

115. NHS staff survey 2016

116. https://www.gov.uk/government/publications/nhs-staff-management-and-health-service-quality

117. Kline, R, *The "snowy white peaks" of the NHS: a survey of discrimination in governance and leadership and the potential impact on patient care in London and England*, 2014

118. https://www.kingsfund.org.uk/publications/making-difference-diversity-inclusion-nhs

119. NHS staff survey 2016

120. https://www.england.nhs.uk/about/equality/equality-hub/equality-standard/workforce-race-equality-standard-2016-report/

121. https://www.england.nhs.uk/about/equality/equality-hub/wdes/

122. British Medical Association and The Association of LGBT Doctors and Dentists, *The experience of lesbian, gay and bisexual doctors in the NHS: Discrimination in the workplace or place of study*, 2016

123. From dashboard accessed 22 June 2017 https://www.nmds-sc-online.org.uk/reportengine/GuestDashboard.aspx?type=Ethnicity

124. Care Quality Commission, *Equally outstanding, Equality and human rights good practice resource, how can a focus on equality and human rights improve the quality of care in times of financial constraint?*, September 2017

125. http://www.cqc.org.uk/assessment-framework-nhs-healthcare

126. http://www.cqc.org.uk/assessment-framework-adult-social-care

127. Association of Directors of Adult Social Services, *ADASS budget survey 2017*

128. Local Government and Social Care Ombudsman, *The Right to Decide: towards a greater understanding of mental capacity and deprivation of liberty*, July 2017

129. http://www.bailii.org/ew/cases/EWCOP/2016/58.html

130. Chief Coroner, *Guidance no. 16A: Deprivation of Liberty Safeguards – 3 April onwards*, March 2017

131. Law Commission, *Mental Capacity and Deprivation of Liberty*, March 2017

132. NHS Digital, *Mental Capacity Act 2005, Deprivation of Liberty Safeguards (England), Annual report 2015/16*, September 2016

133. Department of Health, *Positive and Proactive Care: reducing the need for restrictive interventions*, April 2014

134. Local Government Association, Association of Directors of Adult Social Services and Care Provider Alliance, *Promoting less restrictive practice: reducing restrictions tool*, July 2016

135. https://www.scie.org.uk/publications/mca/care-planning/care-planning.asp

136. https://www.scie.org.uk/mca/practice/care-planning/person-centred-care

137. Care Quality Commission, *Brief guide: Positive behaviour support for people with behaviours that Challenge*, April 2017