CareQuality Commission

The state of health care and adult social care in England 2015/16

ACUTE HOSPITALS, COMMUNITY HEALTH SERVICES AND AMBULANCE SERVICES

STATE OF CARE


MAP/Cuff
87
mmHg
116
mmHg
Diastolic
mmHg
Pulse Rate
9
bpm
SpO2
100
%
V100
CARESCAPE

Acute hospitals, community health services and ambulance services

Key points

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

Introduction

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

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

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

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

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

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

On the central waiting times measure for referral to hospital treatment times (where 18 weeks should be the maximum), there has been a decline in performance during the year: at March 2016, 8.5% of patients who were waiting had been on the list for more than 18 weeks. This is set against a target of 8% and performance varied across the country from 7.5% in NHS England's north region to 9.7% in London.

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

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

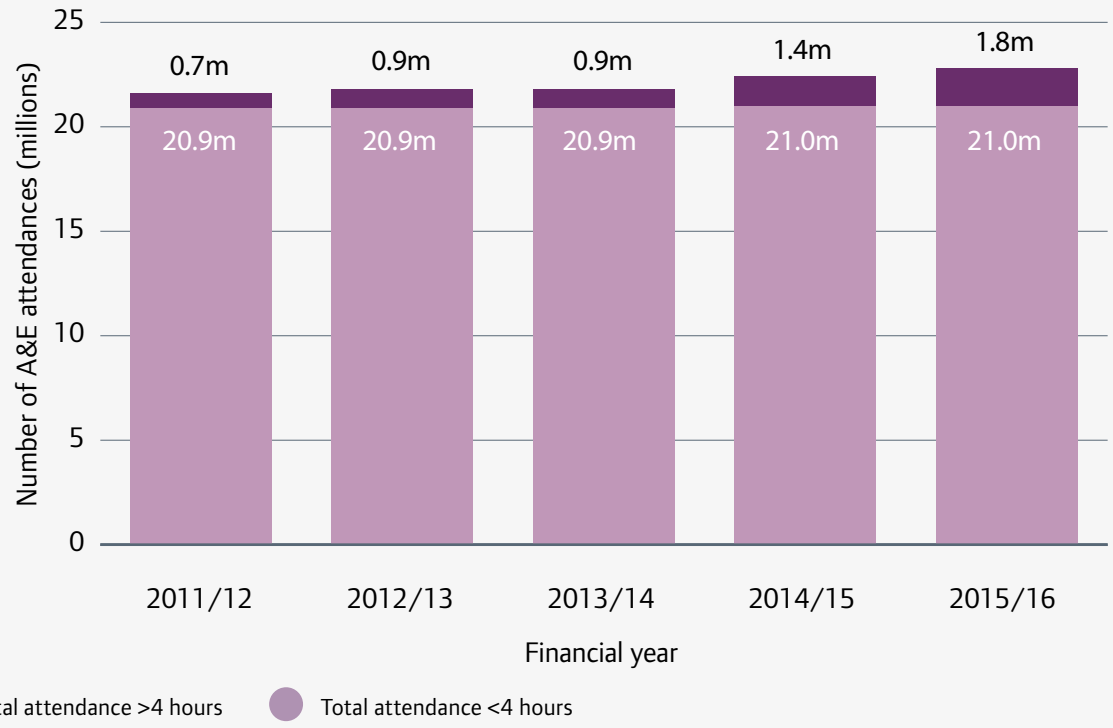
Our analysis shows that, although the whole system has struggled with maintaining the A&E four-hour target, better rated trusts have been more successful than those rated requires improvement or inadequate (figure 2.10).

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

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

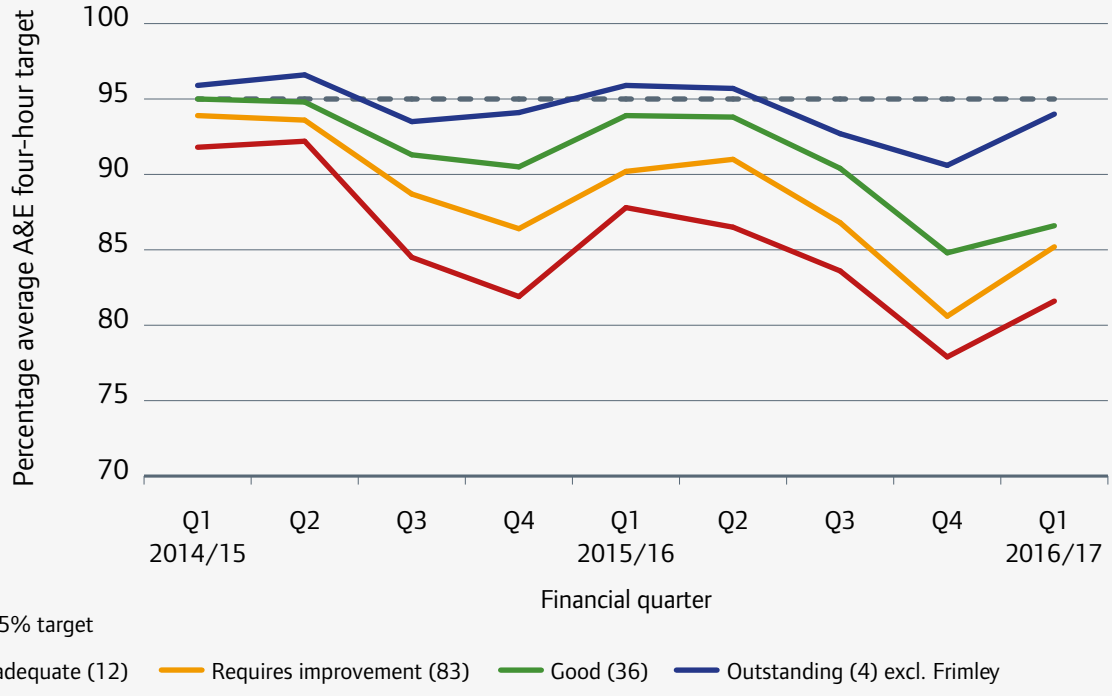
In part 1 of this report, we show that despite the constraints, some providers are managing their finances while keeping a focus on quality. There is a weak correlation between our ratings and the deficits in acute non-specialist trusts – those with higher ratings tend to be better at balancing their

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



Source: NHS England

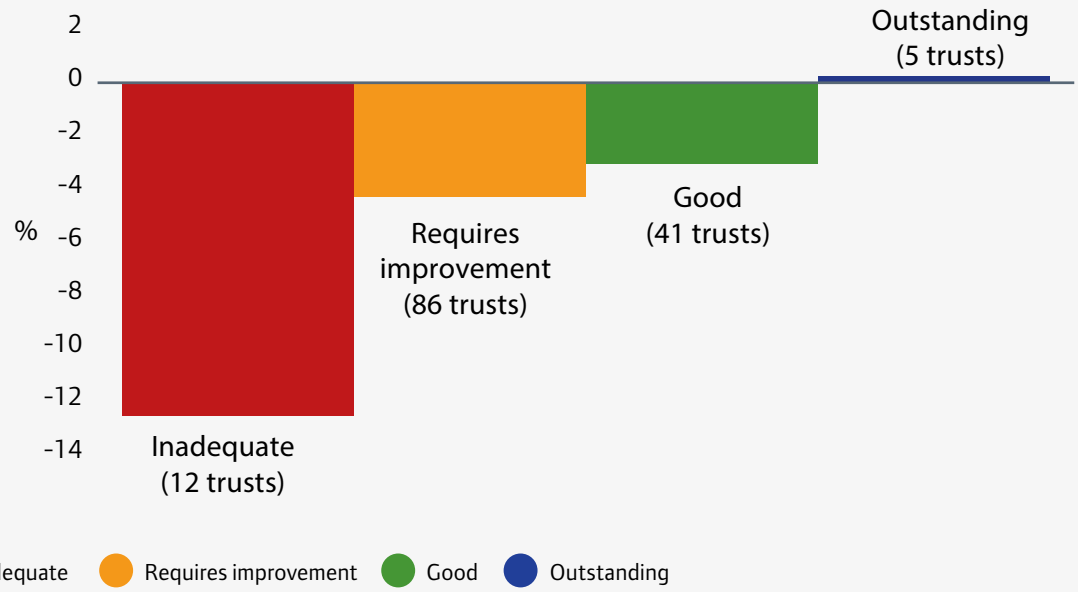
Figure 2.10 Average quarterly A&E four-hour target by rating, April 2014 to June 2016



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

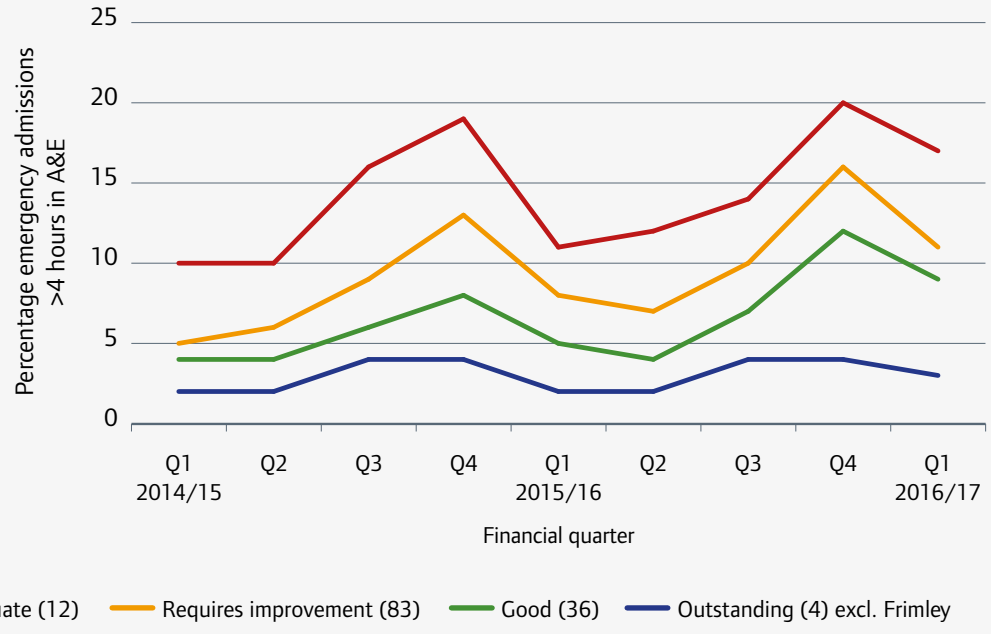
Note: Frimley Health NHS Foundation Trust has been excluded as the time period covers its acquisition of Heatherwood and Wexham Park Hospitals NHS Foundation Trust, which skews the results artificially.

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



Source: CQC ratings data, NHS Improvement

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



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

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

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

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

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

Overview of quality

NHS acute trusts

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

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

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

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

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

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

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

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

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

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

It is not unusual to see one or two good core services in a hospital that otherwise has a poorer rating. Likewise, a good hospital may have at least one core service that needs to improve.

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

Of all the core services we rate, critical care and end of life care received the highest percentage of outstanding ratings (8%). Critical care also received the fewest inadequate ratings (2%). Services for children and young people received the most ratings of good (63%).

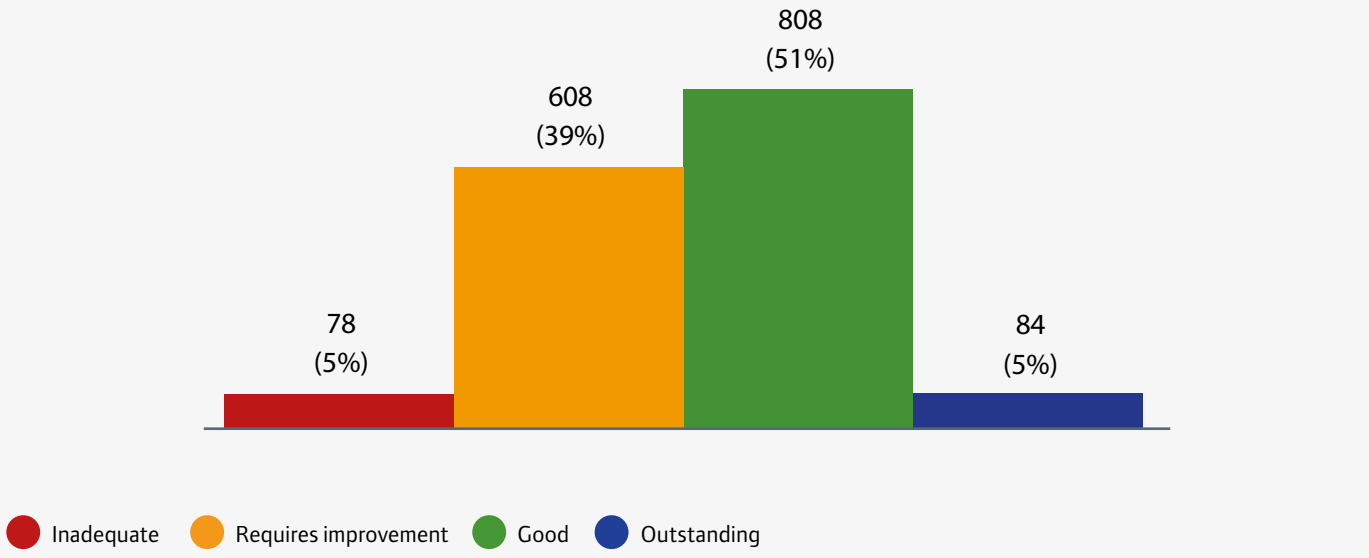
End of life care services are a good example of the variation in quality that exists between hospitals. While 8% of these services were outstanding and provided personalised care that met the needs of individuals, 4% were rated inadequate and 37% were rated requires improvement.

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

Community health services

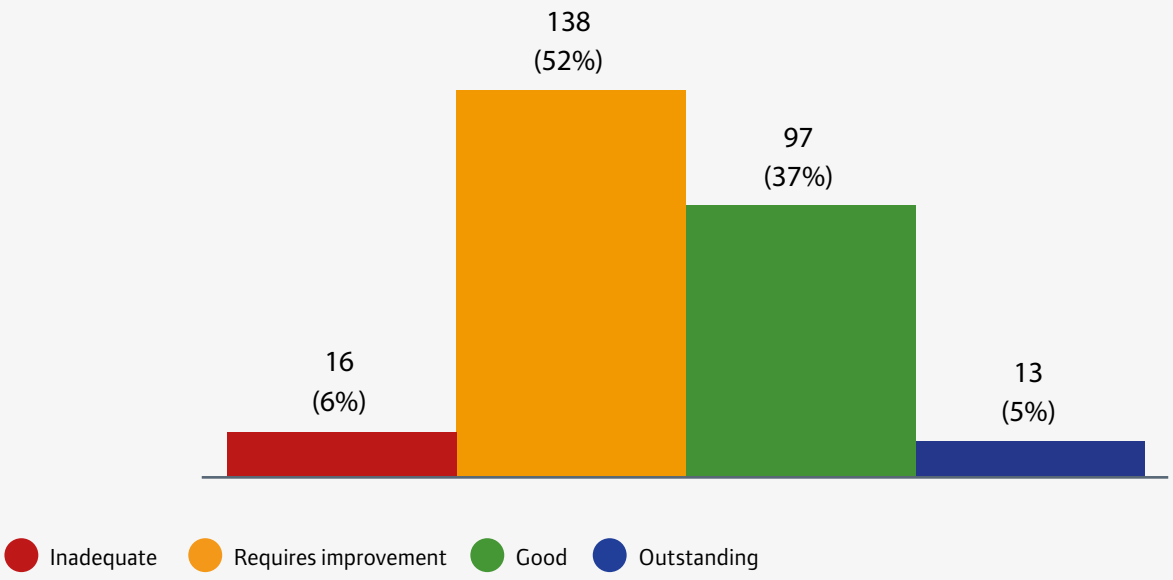
Community health care is provided by a range of different organisations. There are 18 NHS community health trusts that only provide community health services to their local population. Community health services are also provided by more than 30 NHS acute trusts and more than 20 NHS mental health trusts. In addition, there are more than 100 independent community health services

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



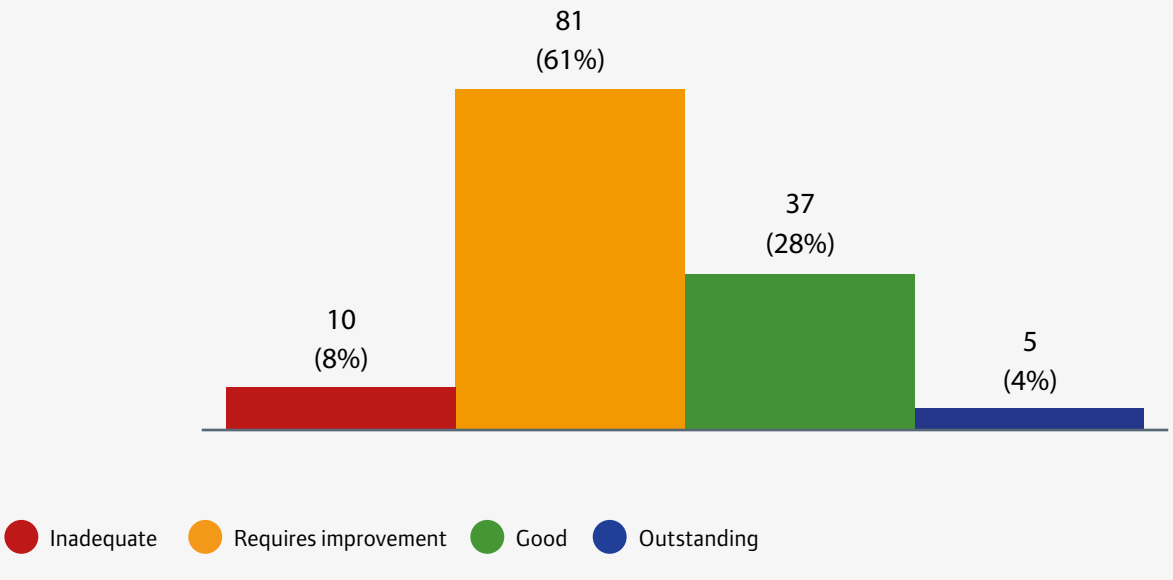
Source: CQC ratings data, total of 1,578 core services

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



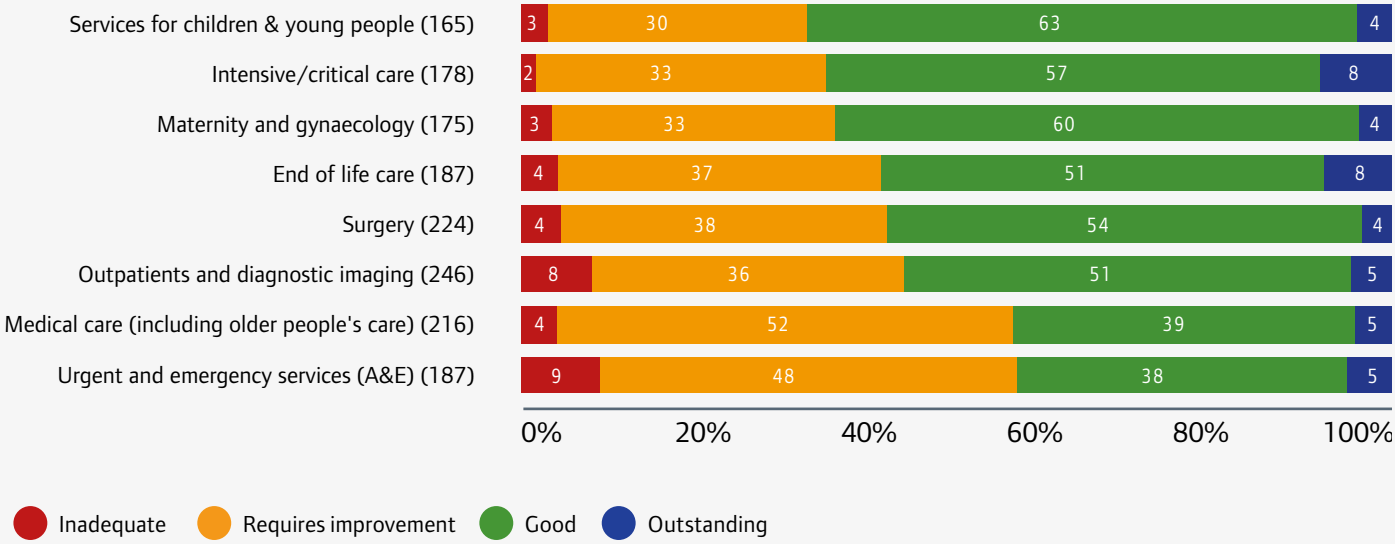
Source: CQC ratings data, total of 264 acute hospitals

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



Source: CQC ratings data, total of 133 acute trusts

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



Source: CQC ratings data

New ideas to improve patient care

Western Sussex Hospitals NHS Foundation Trust

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

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

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

The consultants told us the executive team, and medical director in particular, were supportive, approachable and encouraging of new ideas. For example, hospital staff worked in partnership with a local charitable trust to provide a cardiac buddy service for people with long-term heart conditions, working on the wards and in exercise classes. The scheme had been developed as a result of patient feedback.

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

– many of these are not-for-profit social enterprises and community interest companies.

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

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

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

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

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

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

Independent acute hospitals

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

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

NHS ambulance services

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

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

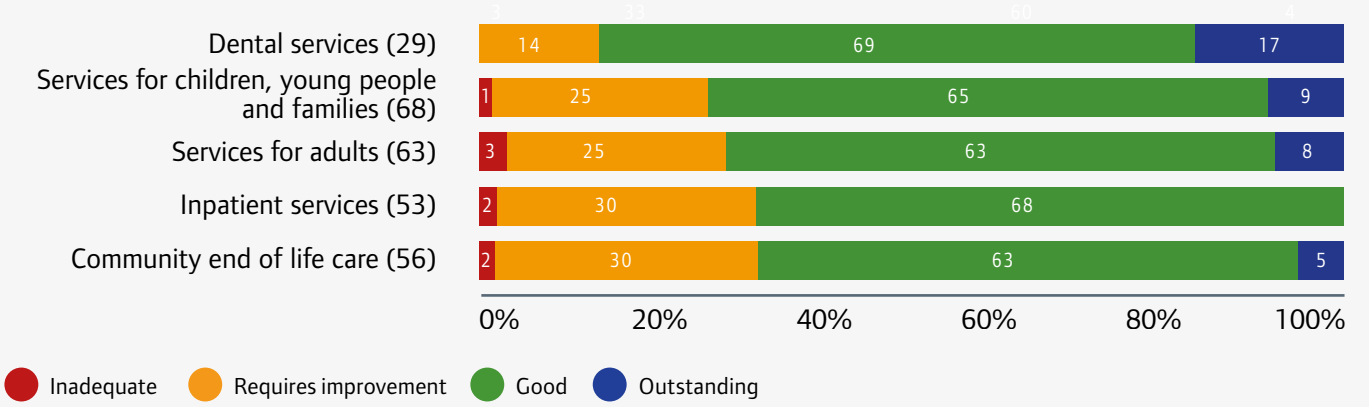
However, there is no doubt that ambulance services are under extreme pressure. Nationally, the targets for ambulance response times and a shortage of paramedics present a significant challenge. The first round of comprehensive inspections of NHS ambulance trusts has provided CQC with evidence of where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

Safety

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

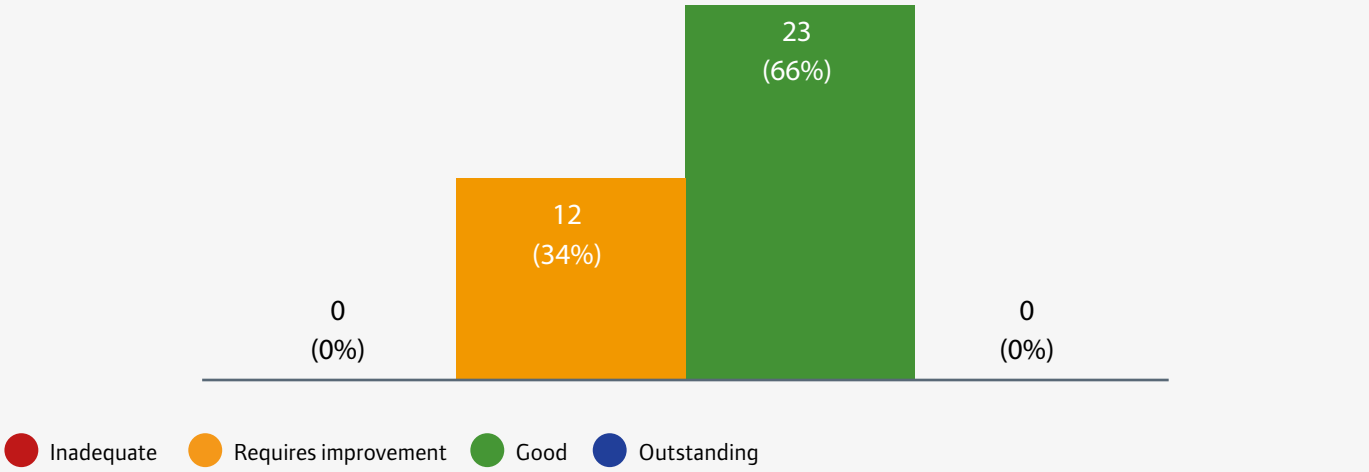
Ensuring consistently safe care remains the single biggest challenge for hospital providers in terms of the quality of care.

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



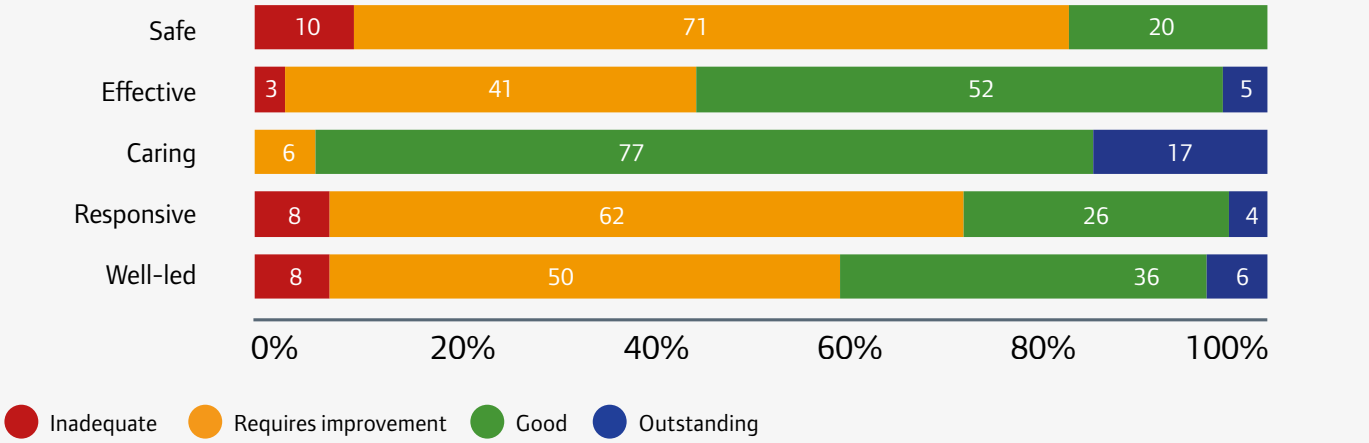
Source: CQC ratings data

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



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

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



Source: CQC ratings data

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

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

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

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

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

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

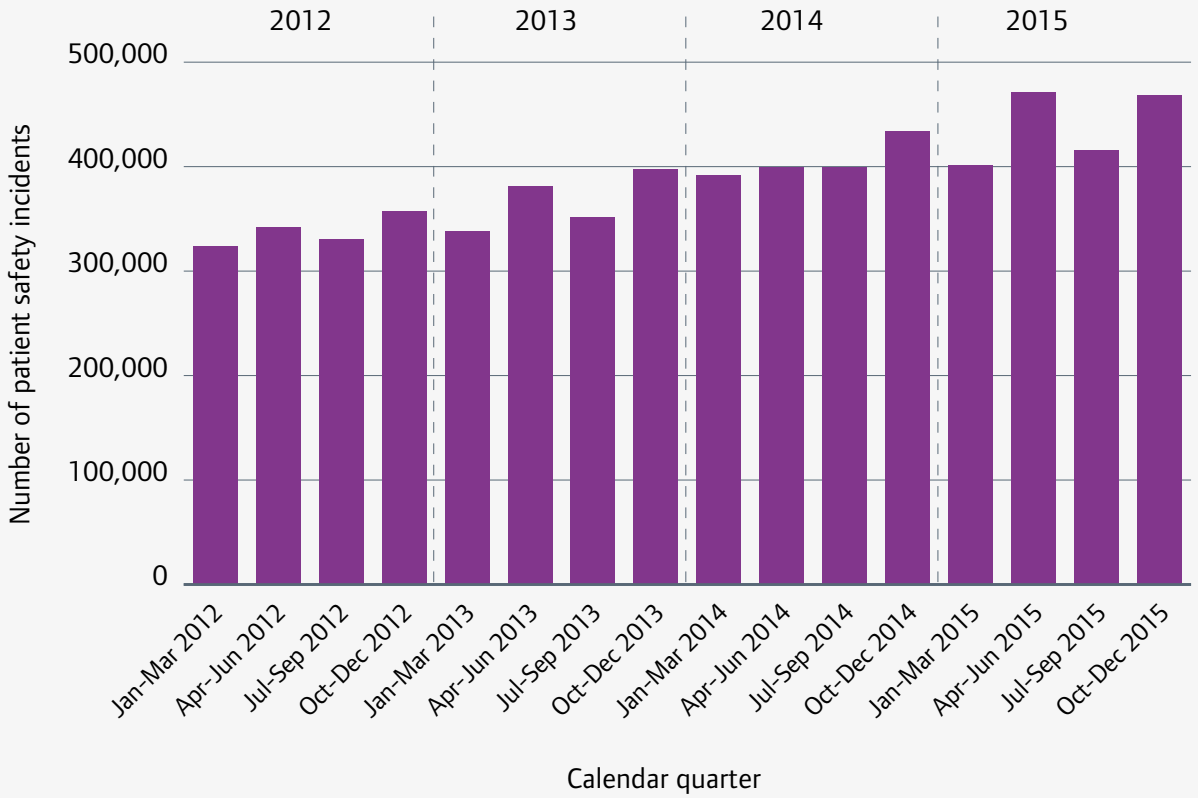
Leadership

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

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

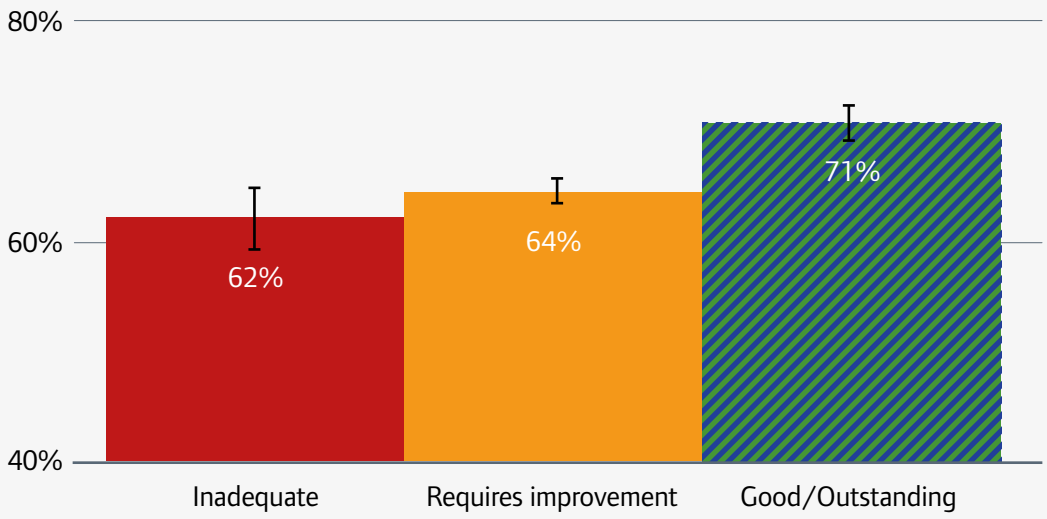
- Trusts with good leadership had embedded values, engaged staff who put the needs of patients first, shared information and learned from incidents.
- Inspectors found the key to a well-led organisation was having a visible and approachable leadership team.
- In good and outstanding hospitals, boards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

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



Source: The National Reporting and Learning System

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



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

The 2015 NHS staff survey further supports our findings. Staff in trusts that have received higher ratings tend to recommend their organisation as a place to work and/or receive treatment (figure 2.21). Creating the right culture in which staff feel valued and motivated, and where patients are at the heart of all decisions, is only possible through good leadership and strong clinical engagement.

How good and outstanding hospitals respond to people's needs

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

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

We have carried out qualitative analysis to understand the differentiating factors between acute hospital trusts that are rated outstanding and those rated inadequate. Most important are their ability to monitor and act on issues that are identified, sharing the learning from incidents, having a strategy that is communicated and understood by all staff, and promoting a culture of openness.

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

Responsive: what good looks like

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

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

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

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

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

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

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

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

Inspirational leadership and remarkable consistency

Northumbria Healthcare NHS Foundation Trust

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

The consistency of outstanding ratings across all four hospitals was remarkable. To achieve this across so many sites was a first. It shows that it is possible to achieve excellence even when services are widely dispersed geographically.

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

- Inspirational leadership and strong clinical engagement had ensured that a recent reconfiguration of services had been managed effectively.
- There was strong integration of all services between the hospital and community, particularly in end of life care services.
- Staff delivered compassionate care, which was polite and respectful, going out of their way to overcome obstacles to ensure this.
- The number of consultants was higher than average, and the trust used advanced nurse practitioners to support doctors.

- community services that responded to local flooding, by linking people with appropriate services beyond health and helping to keeping track of people and families in vulnerable circumstances
- working with GP partners, for example by offering training
- providing free legal advice to patients who had concerns about their family income while in hospital.

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

Improvement

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

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

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

We have found that effective leadership and a positive, open culture are important drivers of change. Where trusts needed to improve, staff were keen for CQC's follow-up inspection to happen: our inspectors have reported examples where they had met people at the trust who wanted them to come back and see the changes and improvements that had been made.

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

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

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

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

Special measures

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

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

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

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

Holistic understanding of performance

North Bristol NHS Trust

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

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

Learning from previous gaps in assurance of the quality and safety of patient care was evident in the emergency department, as a quality dashboard was implemented and reported on through the integrated performance report. This report set out performance across the trust in terms of CQC's five key questions. This enabled a holistic understanding of performance, including safety, quality, activity and financial performance. People's views were taken into account to gain assurance at trust board level through patient stories and the visibility of incidents and complaints. A greater focus was also planned over the next year following the appointment of the head of patient experience reporting to the director of nursing.

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

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

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

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

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

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

Source: CQC enforcement data

Notes:

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

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

Clear commitment from senior leadership

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

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

We carried out a focused inspection in June 2015 to review a range of its services. Urgent and emergency care, medical care and surgery, which had previously been rated as requires improvement, were now good (alongside critical care and children and young people's services, which had been rated as good in 2014).

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

We saw several areas of outstanding practice including:

- The waiting area for children in the emergency department, while small, was designed in a way that responded to the needs of all children visiting the service.
- The commitment of midwifery staff to develop effective midwifery services for women from the King's Lynn area. Midwifery staff rotated throughout the service to maintain their knowledge and skills.
- Relatives and staff told us the paediatric team were well organised and effective, providing a good service for the children and families of the King's Lynn area.

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

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