

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

SUMMARY

Foreword

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

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

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

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

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

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

The quality of care received in NHS mental health trusts is broadly similar to that in acute trusts, but with an even higher level of variability within providers as well



Peter Wyman
Chair



David Behan
Chief Executive

as between them. Community services are more likely to be rated good and outstanding than inpatient services such as wards for working age adults and psychiatric intensive care units. In particular, we have concerns about the safety of acute mental health services. Problems with the physical environment frequently contributed to a rating of requires improvement or inadequate for inpatient services.

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

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

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

Our evidence suggests that finance and quality are not necessarily opposing demands; many providers are delivering good quality care within the resources available, often by starting to transform the way they work through collaboration with other services

and sectors. We cannot ignore the impact of tough financial conditions on providers – but our focus will always be on quality and we will always act in the interest of people who use services.

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

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

Summary

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

- 71% of the adult social care services that we had inspected were rated good and 1% were rated outstanding.
- 83% of the GP practices we inspected were rated as good and 4% as outstanding.
- 51% of the core services provided by NHS acute hospital trusts that we inspected were rated as good and 5% as outstanding.
- The quality of care still varies considerably, both within and between different services. We rated a minority of services as inadequate: 2% of adult social care services, 3% of GP practices and 5% of hospital core services as at 31 July 2016.
- It is a time of unprecedented demand and financial challenge for health and social care, driven by the growing numbers of older people in need of care and support, and those with complex health and care needs. By the end of 2015/16, NHS providers had overspent their budgets by £2.45 billion. Local authorities were reported to have spent £168 million more than they budgeted for, often drawing on their reserves to do so.
- Delivering high-quality care while achieving good financial management is, therefore, more important and more challenging than ever.

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

- About three-quarters (76%) of those that we re-inspected following an initial rating of inadequate achieved an improved rating: 23% went from inadequate to good and 53% went from inadequate to requires improvement.
- Almost half (47%) of those services that we re-inspected following a rating of requires improvement did not change their rating. In 8% of cases, the quality of care deteriorated so much that we rated it inadequate.
- Strong, visible leadership continues to be a major factor in delivering and sustaining high-quality services, and in making improvements.
- The best providers often had a stronger drive to improve, were focused on how to make services better for people, and were committed to collaborating with others to achieve this.

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

- On the whole, public opinion of health and care is positive. Around three-quarters (74%) of people agreed that local NHS services in general were good. Almost two-thirds (62%) of people receiving adult social care services paid for by their local authority said they were extremely or very satisfied with their care and support.
- But this is only a partial picture: between a quarter and a third were not satisfied with their care, and there are no equivalent surveys to capture the views of people who pay for their own social care, or of those who have to rely on their families or informal care arrangements.
- CQC hears directly from people who use services, and families and carers – two-thirds of their comments were to report a problem, and a third were to compliment the care they received.
- People from different backgrounds and with different needs receive variable quality of care – for example people with mental ill-health and younger people, who say their experiences of using NHS acute hospitals are not as good as others.

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

- The majority of GP practices provide a good quality of care to their patients. We have rated 83% of practices as good and a further 4% as outstanding.
- Where we have re-inspected, three-quarters of practices (153 out of 203) that needed to improve have done so. However, this means that a quarter of these practices did not improve.
- We have started to see substantial changes in GP practices, with informal and formal federations being created to achieve economies of scale in care provision and to transform the services they offer.
- We expect to see the first multi-specialty community provider being set up shortly – likely to be the first of many – that will seek to integrate provision of care more closely for population groups. We will continue to monitor their progress and support the sharing of best practice as it emerges.

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

- Many care homes, home care agencies and other adult social care services are providing good quality care (71% rated good and 1% rated outstanding).
- Of those services rated inadequate that we re-inspected, more than three-quarters (399 out of 520 initially rated inadequate) had improved enough to receive a higher rating. This means that nearly a quarter of these re-inspected services did not improve.
- Half of services rated as requires improvement that we re-inspected (904 out of 1,850) had no change to their rating. In 153 cases (8%), we found that the care had become inadequate.
- Until recently, the growth in demand for care for people with greater care needs had been met by a rise in the number of nursing home beds. However, this bed growth has come to a halt in the last 16 months.
- We have seen profit margins reducing – both due to pressures on fees that funders of care are able or willing to pay, and cost pressures that include the impact of the national living wage. We have seen examples of large providers starting to hand back home care contracts that they think are uneconomic and undeliverable.
- While so far the sector has been more resilient than some anticipated, we are concerned about the fragility of adult social care and the sustainability of quality.
- This is concerning for the continuity and quality of care of people using those services, and for the knock-on effects across the whole health and care system: more emergency admissions in A&E, more delays for people ready to leave hospital, and more pressure on other services.

6. Hospitals are under increasing pressure

- While many hospital core services were rated good or outstanding, especially services for children and young people (63% rated good and 4% rated outstanding) and critical care (57% good and 8% outstanding), some need to improve, including urgent and emergency services (38% rated good and 5% rated outstanding) and medical care (39% good and 5% outstanding).
- The difficulties in adult social care are already affecting hospitals. Bed occupancy rates exceeded 91% in January to March 2016, the highest quarterly rate for at least six years.
- More than eight out of 10 NHS acute trusts were in financial deficit at the end of 2015/16 and steps have been taken to address these. Our analysis shows that better ratings are associated with a better median year-end financial position (a smaller deficit or even a surplus).
- Overall, the quality of care received in NHS mental health trusts is broadly similar to that in acute trusts. There is a high level of variability within mental health providers as well as between them – community services are more likely to be rated good or outstanding than inpatient wards such as those for working age adults and psychiatric intensive care units.

7. While we are seeing some improvement, we are concerned about the sustainability of quality

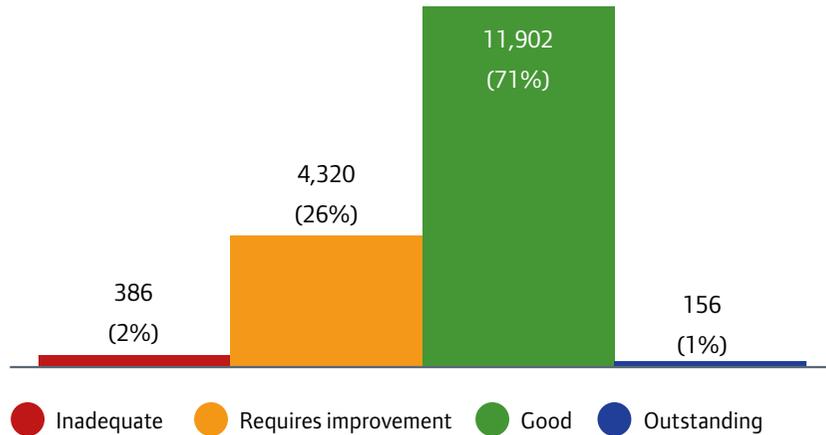
- Maintaining quality while demand increases and budgets are under pressure is going to be challenging, even for the best-led services.
- Some providers are navigating the demand and financial pressures by starting to shift towards new models of providing care.
- All parts of local health and care systems – commissioners, providers, regulators and local people – need to work together to help transform local areas.
- Working with our partners, CQC will offer the system whatever support we can to make the changes necessary to ensure high-quality care into the future.



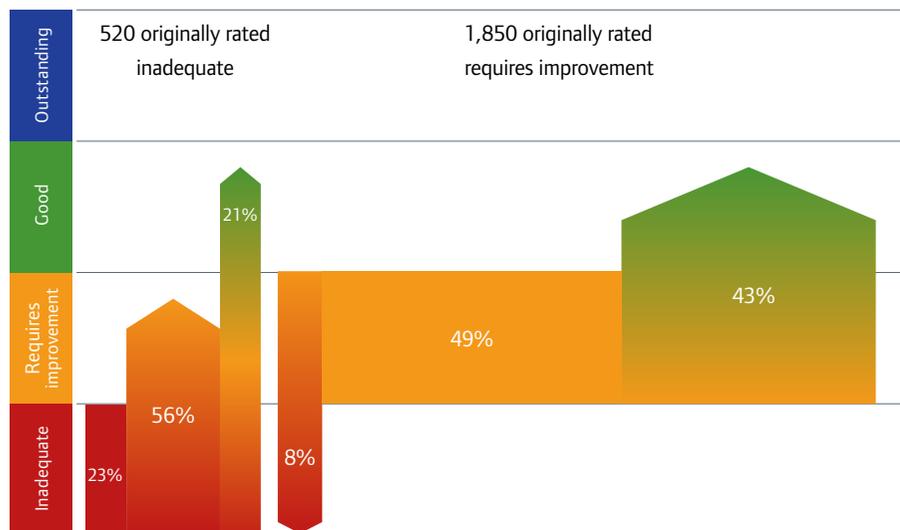
Adult social care

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

The majority of adult social care services were rated as good (71%) or outstanding (1%)



Three-quarters (77%) of the services that we rated as inadequate, and then re-inspected, improved



Strong, visible, person-centred culture

ClarkeCare Limited, Suffolk

ClarkeCare Limited (Suffolk) is an outstanding service providing care to people in their own homes. It supports people recovering from an illness or operation as well as people living with life changing conditions such as dementia, multiple sclerosis and Huntington’s disease. When we inspected in September 2015, the service had a strong, visible person-centred culture. A relative said how their family member “looked forward to [the care workers’] visit”. They put this down to the care workers giving them “a sense of importance,

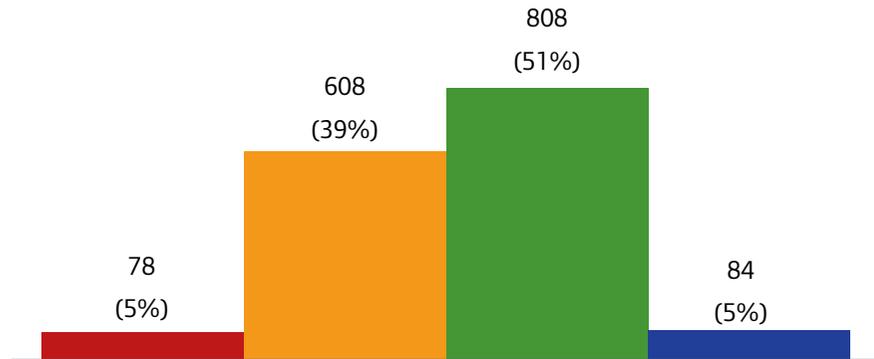
[since the family member] makes the decisions” which validated them as a person, making them feel they were “worth something”. Another spoke about how well they “matched their staff” with people and provided examples such as shared interests, which enabled them to “sit and chat, to take the [person’s] mind off what is going on”. One of the people using the service told us, “I’ve struck lucky with the carers. They are lovely, I can’t fault them, everyone is so nice, I feel when something is good I should sing their praises.”



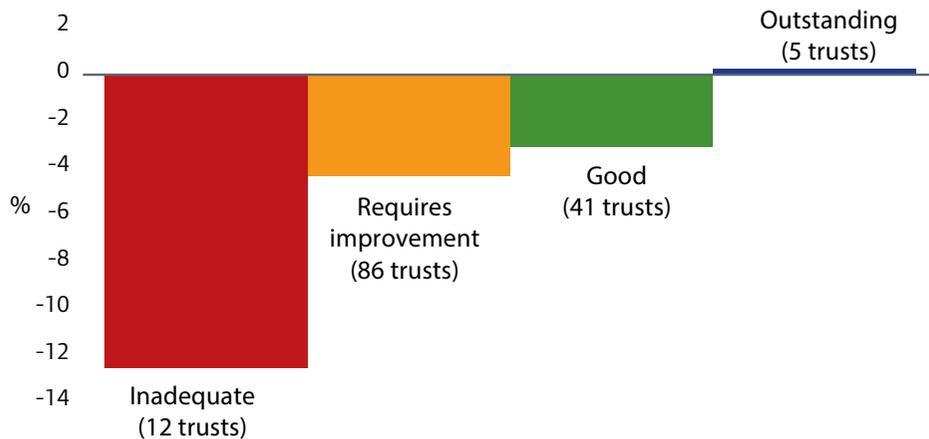
Acute hospitals, community health services and ambulance services

- 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.

More than half of NHS acute core services were rated as good (51%) or outstanding (5%)



NHS acute trusts with higher ratings tended to be better at balancing their budgets (or have smaller deficits)



Left hand axis is the median financial outturn for 2015/16 as a percentage of operating income

● Inadequate ● Requires improvement ● Good ● Outstanding

Inspirational leadership

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 Infirmarys 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:

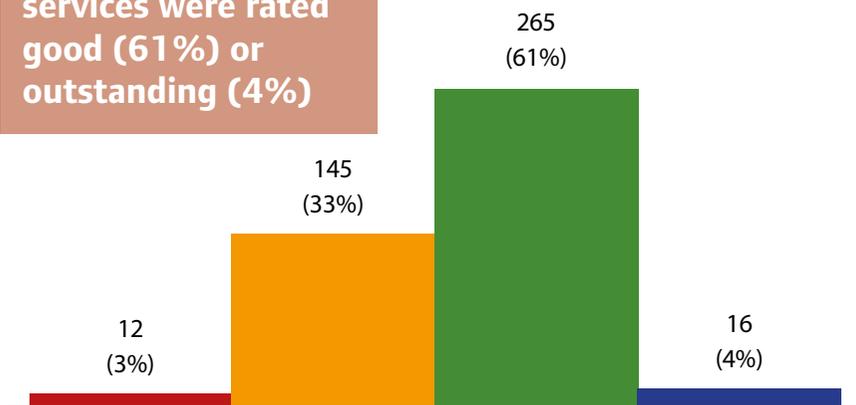
- Inspirational leadership and strong clinical engagement had ensured that a recent reconfiguration of services had been managed effectively.
- There was strong integration of all services between the hospital and community, particularly in end of life care services.
- Staff delivered compassionate care, 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.



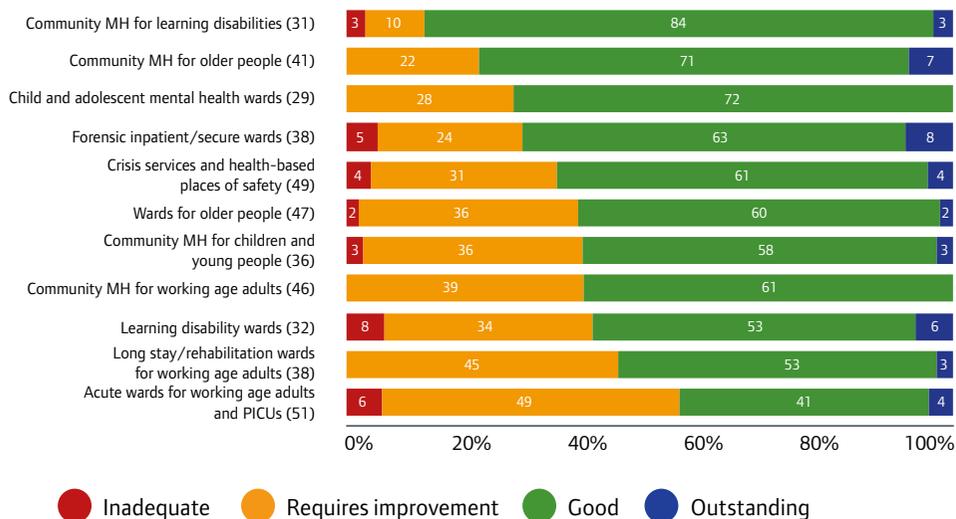
Mental health

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

Two-thirds of NHS mental health core services were rated good (61%) or outstanding (4%)



We inspect and rate 11 core services for mental health. These are the ratings for NHS core services



Collaboration with local stakeholders

2gether NHS Foundation Trust, Gloucestershire

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

2gether was viewed as innovative, notably for working with schools and in other local organisations to raise awareness of mental health and the profile of mental

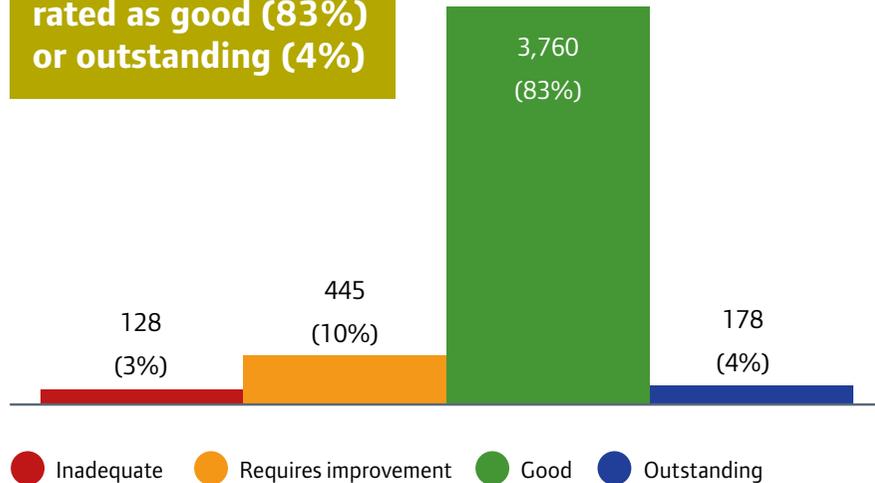
health services. It was seen as an example of good, joined-up thinking – not just seeing a patient, but also seeing the person in their entirety. Inspectors highlighted its focus along care pathways and across a range of providers to ensure there were no out of area placements for adults. This ensured bed availability and transitions between services were monitored and managed well. Inspectors thought that this had a huge impact on bed availability, as support systems keep people healthier in the community.



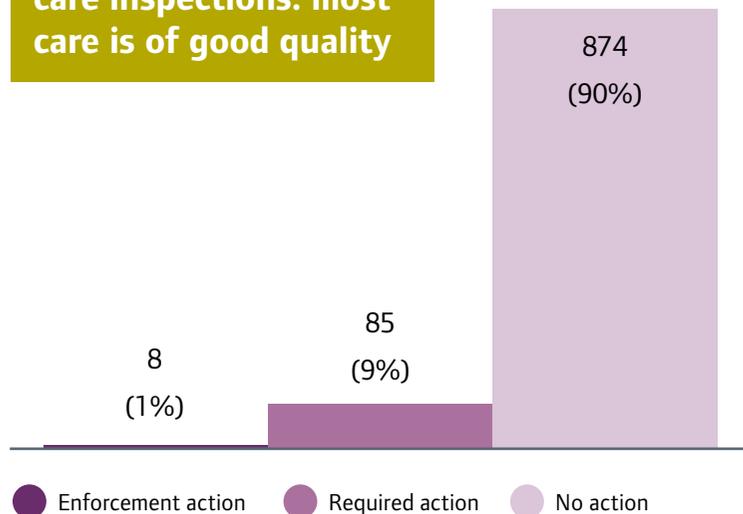
Primary medical services

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

The vast majority of GP practices were rated as good (83%) or outstanding (4%)



Outcomes of dental care inspections: most care is of good quality



Compassionate care for homeless people

Bevan House, Bradford, West Yorkshire

Rated outstanding in all areas of our inspection, Bevan House is an exemplar in meeting the needs of people in all the population groups that we identify.

This practice serves homeless people and people in temporary or unstable accommodation, refugees, people seeking asylum and others who find it hard to access the health and care they need.

After the CQC inspection, it was described as "one of the best practices in England". Among the many positive examples of its work, inspectors commented on staff at the practice, who were described as "motivated and inspired" to offer kind and compassionate care.

Risks to patients were assessed and well managed. And the practice

has improved access to services in numerous ways.

An example of extending access is its street medicine team, which holds mobile outreach clinics in city centre locations for vulnerable people. There is also a late night (until 11pm) clinic for female sex workers, as well as an early morning clinic, in liaison with a local women's support team.

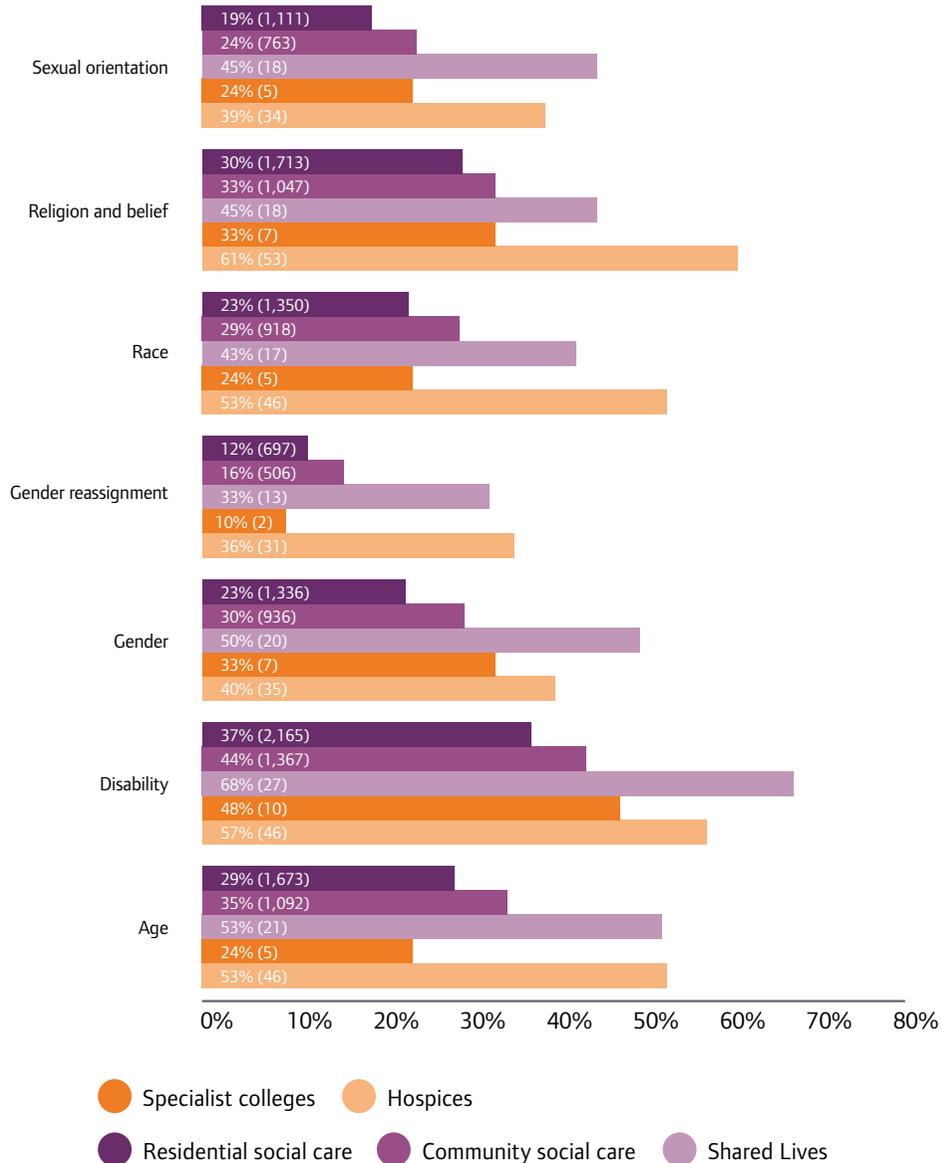
Among inspectors' findings, they noted how patients were given 'cold weather packs' consisting of gloves, socks, a hat and scarf, water and a bar of chocolate. Several staff told the inspection team that on winter mornings they would take a pack to people they had noticed sleeping rough on their way to work, and encourage them to come to the surgery. A similar and appropriate pack was available for the summer.



Equality in health and social care

- We continue to see variation in the access, experience and outcomes for people in equality groups using health and social care services.
- The link between equality for staff working in services and the quality of care is now well-established. Providers need to reduce the difference in experiences and outcomes for their staff and to learn from best practice, such as through the NHS Workforce Race Equality Standard.
- People in particular equality groups are more likely to get their specific needs and preferences met if they are involved in planning their own care and the service delivers more personalised care.
- Action on equality also needs to be taken at a service level. This requires leaders to embed equality into working practices to achieve good quality care for all, including those who are often less-considered by services such as lesbian, gay, bisexual and transgender people using adult social care services.
- Good practice in equality means that services are more likely to be rated good or outstanding for being responsive.
- Equality in health and social care cannot be achieved by providers alone. The whole system needs to be involved, including through commissioning and joint working such as Sustainability and Transformation Plans.

Adult social care services that reported work on equality



Addressing equity of experience from board to ward

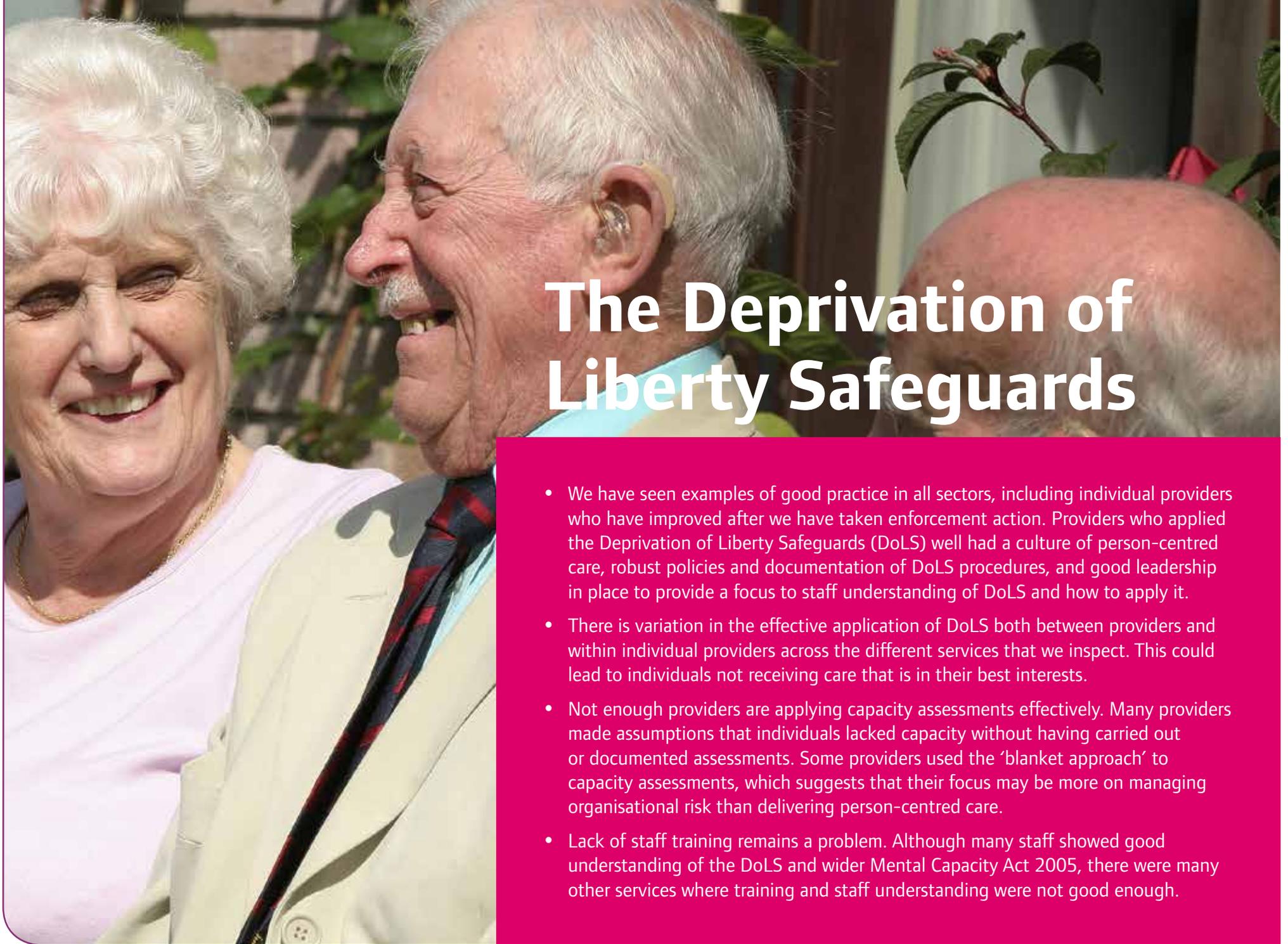
Mersey Care NHS Foundation Trust, Liverpool

We inspected Mersey Care NHS Foundation Trust and rated it as good in October 2015. We found that the trust was committed to equality across all protected characteristics and was piloting the use of a human rights-based approach. The trust was using the NHS Equality Delivery System effectively. It had an equality and human rights steering group, chaired by a non-executive director. Coordinators were in place across the trust to oversee how local action plans were implemented for each service. There had been visible effects on frontline services, for example:

- The trust had been awarded a Navajo Merseyside and Cheshire LGBT Charter Mark for recognition of its approach to lesbian, gay, bisexual and transgender (LGBT) people.
- A human rights-based approach in

older people's services had resulted in developing a person-centred assessment tool incorporating the values of human rights law. We saw this being used on the ward.

- People had good access to interpreting services. The dietary requirements of people were met, with a choice of food available that was appropriate to different religious and cultural needs.
- There was an active learning disability advisory group that promoted the involvement of people using the service and used human rights principles. The group had produced a booklet about human rights for people with a learning disability.
- The trust had been improving its recording of incidents of discrimination for both people who use the service and staff.



The Deprivation of Liberty Safeguards

- We have seen examples of good practice in all sectors, including individual providers who have improved after we have taken enforcement action. Providers who applied the Deprivation of Liberty Safeguards (DoLS) well had a culture of person-centred care, robust policies and documentation of DoLS procedures, and good leadership in place to provide a focus to staff understanding of DoLS and how to apply it.
- There is variation in the effective application of DoLS both between providers and within individual providers across the different services that we inspect. This could lead to individuals not receiving care that is in their best interests.
- Not enough providers are applying capacity assessments effectively. Many providers made assumptions that individuals lacked capacity without having carried out or documented assessments. Some providers used the 'blanket approach' to capacity assessments, which suggests that their focus may be more on managing organisational risk than delivering person-centred care.
- Lack of staff training remains a problem. Although many staff showed good understanding of the DoLS and wider Mental Capacity Act 2005, there were many other services where training and staff understanding were not good enough.

42%

increase in DoLS applications in 2015/16

73%

of applications approved

Improved training

One provider had made significant progress in implementing DoLS and the wider MCA since our last inspection. Previously, we had reported staff “not really knowing what it [DoLS] was”. When we re-inspected, we found that training had been completed, assessments of people’s capacity to consent to necessary arrangements

were being made, and authorisation was now appropriately sought from the local authority. The manager in charge of the service said that the main driver for improvement in their handling of DoLS applications was the increased understanding across the service that they had fostered through training.

Focused on solutions

A woman with strong religious beliefs was admitted to a care home. The home applied to the relevant local authority to deprive her of her liberty, in her best interests. This was authorised under DoLS. While being deprived of her liberty, the woman had a strong desire to continue to practise her faith. The care home tried different options, consulting with a family member (who was also her Lasting Power of Attorney for health and welfare) to minimise the possible restrictions on her human rights, despite the need for authorisation. However, the lady concerned was distressed by each option and did not find them suitable. A best interests meeting was held to find a solution. A decision was made that attempted to minimise her anxiety about “strangers”

taking her to church and that also gave her more freedom to live as she wished. The care home and the woman’s daughter involved the church community, and the lady is now picked up by the minister at the care home and taken to church for a communion service. She is accompanied by a carer, who does not wear a uniform, reducing the likelihood of her being singled out among the congregation. To minimise as far as possible restrictions on her human rights, the provider, together with her Lasting Power of Attorney for health and welfare, sought ways to enable her to attend her church as she wished to do. This has enabled her to continue to practise her faith as she wishes, has increased her happiness and has had a positive effect on her wellbeing.

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