Care Quality Commission

# The state of health care and adult social care in England 2016/17

## Primary medical services

STATE OF CARE

## 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.

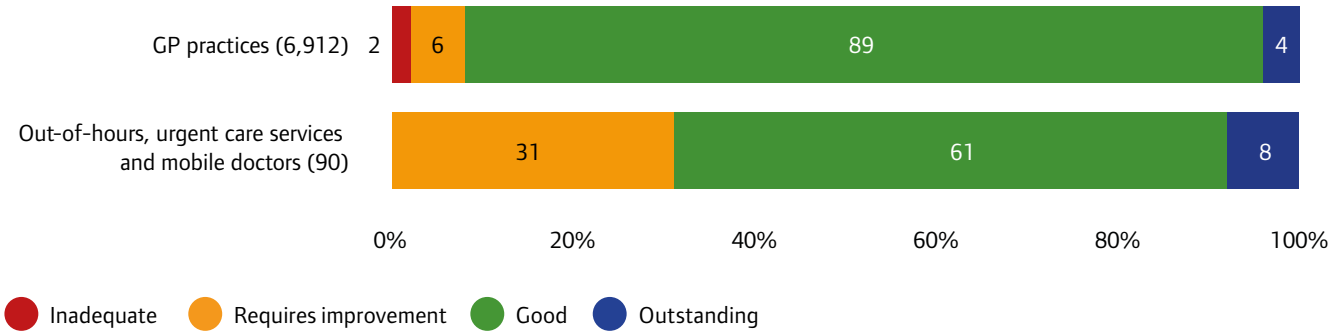
We also inspect all registered health services that provide services to children, and focus our inspections on where we believe there is the greatest risk. Our Children's Services team provides expert child safeguarding advice in our regulatory inspections and carries out a programme of specialist inspections.

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

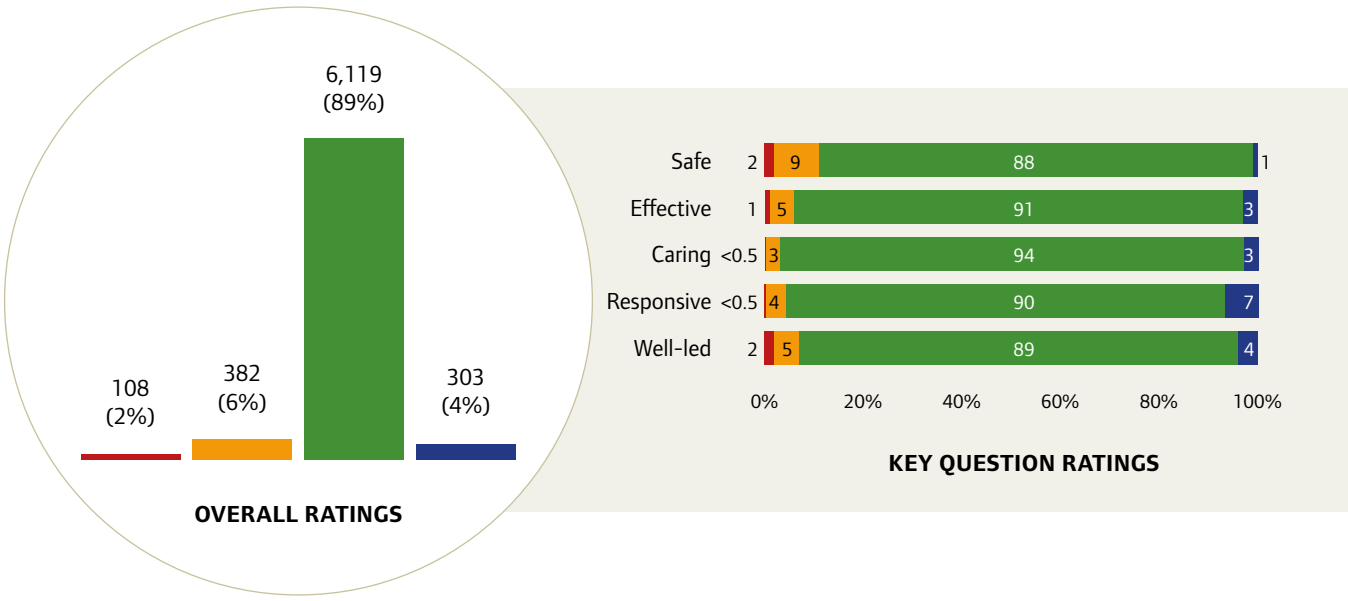
Regulation of primary care is tailored to each different type of service. We do not give a rating to all types of service but, overall, we have found that the majority of providers are meeting regulations, which means that people are receiving good quality care (figure 2.18). As discussed in part 1, 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).

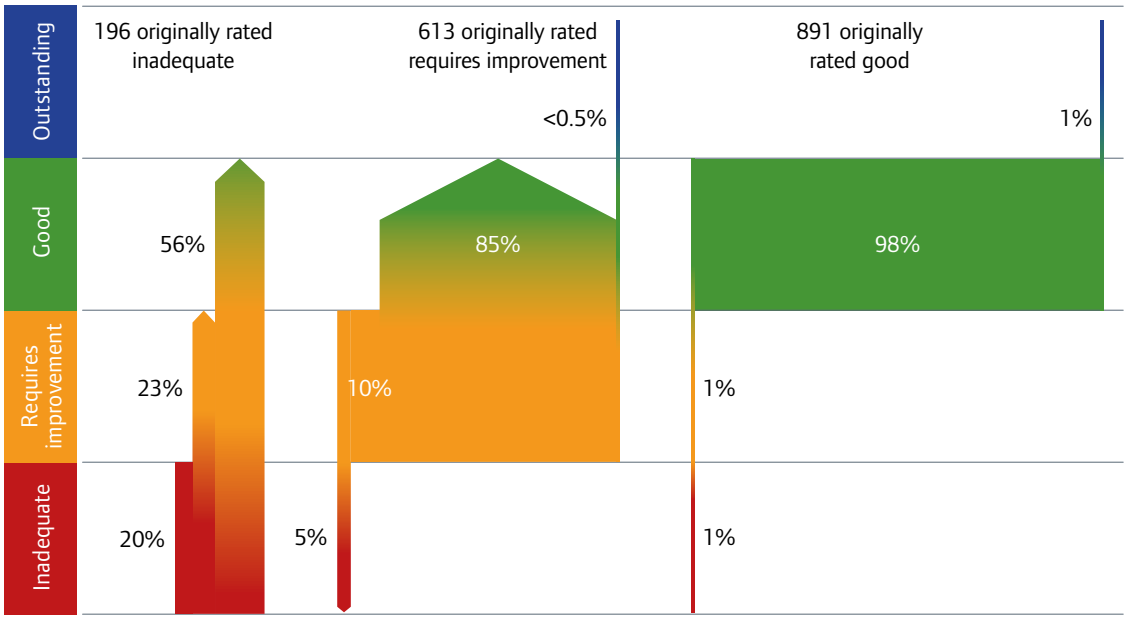
The improvement seen on re-inspection was driven largely because the leadership in improved practices acknowledged that there were problems in the practice. They were willing to learn from the findings of the inspection, motivated to change, keen to learn from what was wrong and keen to access support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

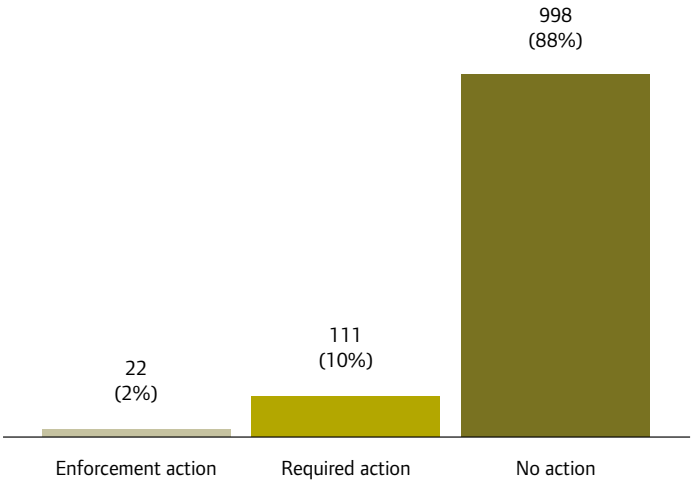
CQC carried out an unannounced inspection focused on the safe key question after we received concerns. We found significant concerns around the cleanliness of the practice in general and risks around a lack of medical emergency equipment and out-of-date medicines.

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.

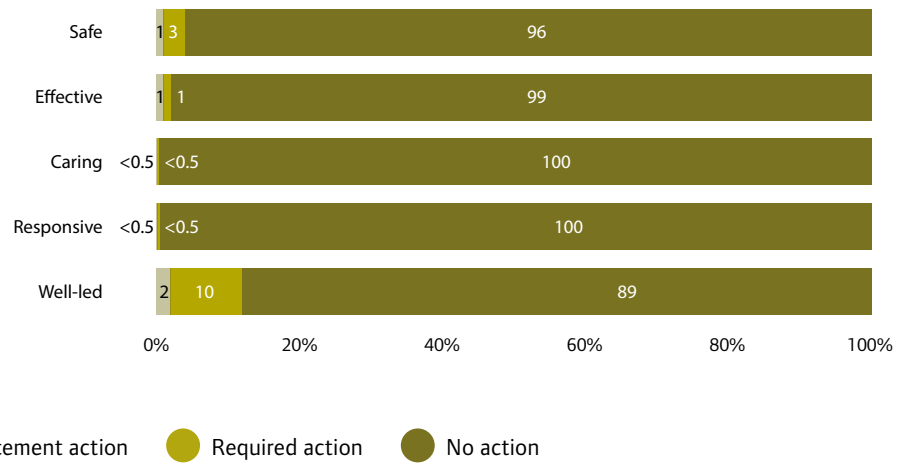
When we re-inspected, we found the practice met all five key questions. It was evident the practice had worked as a team to implement changes to provide safe care and treatment, and the practice manager had supported staff with training and development. The provider and staff appreciated the continued 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.

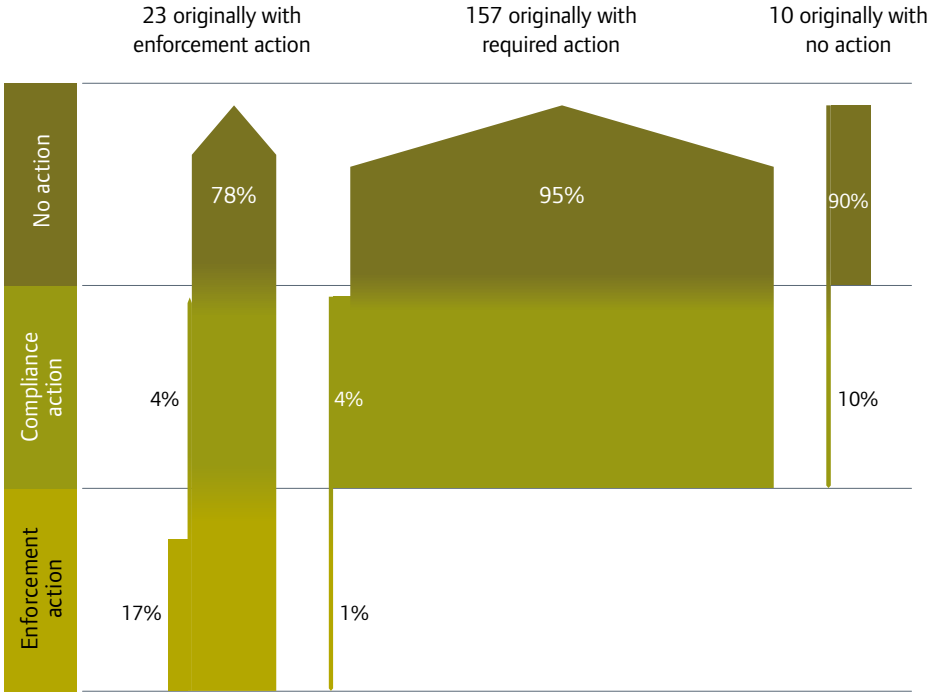
The regulation relating to good governance was the most often breached: 105 practices required action and we took enforcement action in 16 practices. This was often a result of the leadership of a practice not being properly engaged with the processes that are needed to ensure safety. For example, although 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.)

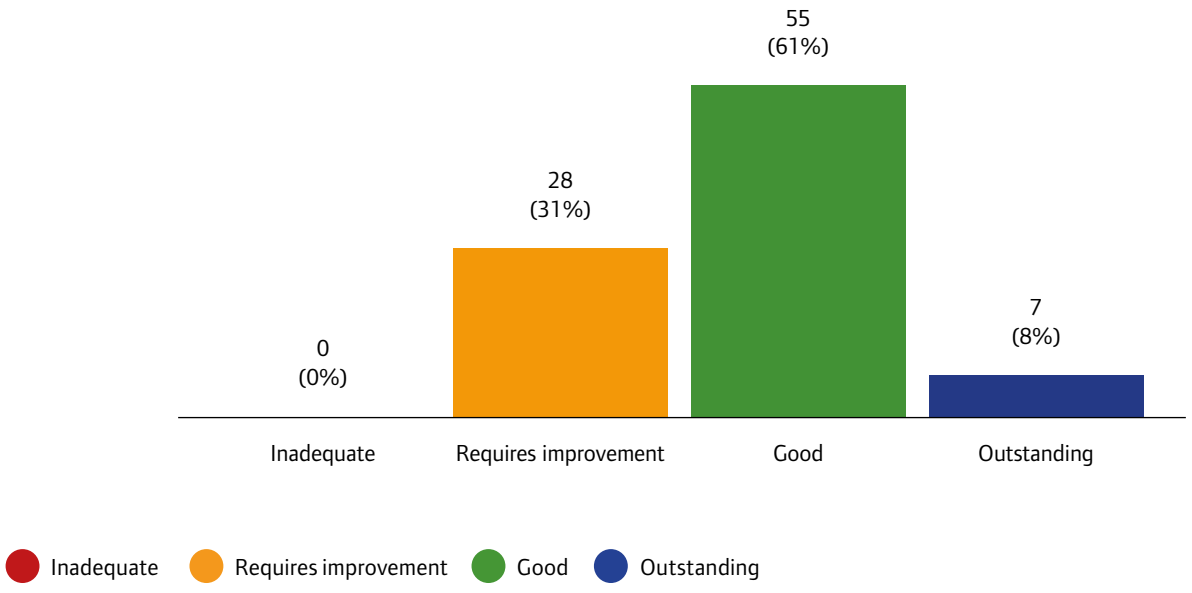
We completed all inspections of GP out-of-hours services and urgent care centres in March 2017 and rated the majority of providers (61%) as good overall, with a further 8% rated as outstanding (figure 2.24). Where the quality of care fell short of what patients should expect, our inspections showed that 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.

Care Quality Commission

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