

The state of health care and adult social care in England 2017/18



Care Quality Commission

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2017/18

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Foreword

This year's *State of Care* tells a story of contrasts. It highlights both the resilience and the potential vulnerability of a health and care system where most people receive good care, but where access to this care increasingly depends on where in the country you live and the type of support you need.

Resilience is evidenced by the fact that our ratings show that quality overall has been largely maintained, and in some cases improved, from last year. This is despite continuing challenges around demand and funding, coupled with significant workforce pressures as all sectors struggle to recruit and retain staff. The efforts of staff and leaders to ensure that people continue to receive good safe care, despite these challenges, must be recognised and applauded.

But we cannot ignore the fact that not everyone is getting good care. Safety remains a real concern: 40% of NHS acute hospitals' core services and 37% of NHS mental health trusts' core services were rated as requires improvement on safety at the end of July 2018. All providers are facing the same challenges – in acute hospitals, the pressure on emergency departments is especially visible – but while many are responding in a way that maintains the quality of care, some are not.

There have been some improvements in safety among GP practices – and to a lesser extent in adult social care, although we do have some concerns about the sustainability of the improvements in this sector.

The adult social care market remains fragile, with providers continuing to close or cease to trade and with contracts being handed back to local authorities. Two years ago, we warned that social care was 'approaching a tipping point' – as unmet need continues to rise, this tipping point has already been reached for some people who are not getting the care they need. While the government made a welcome NHS funding announcement in June 2018, the impact of this funding – along with the recent

short-term crisis funding announced for adult social care – risks being undermined by the lack of a similar long-term funding solution for social care.

In this year's report, we have focused on people's experience of accessing health and care services alongside our ratings of providers. Two things are clear – that people's experience of care varies depending on where they live and what services they use; and that these experiences are often determined by how well different parts of local systems work together. Some people can easily access good care, while others cannot access the services they need, experience 'disjointed' care, or only have access to providers with poor services.

Our reviews of local health and care systems found that ineffective collaboration between services affects access to care and support services in the community, which in turn leads to increased demand for acute services. It means a struggling acute hospital can be symptomatic of a struggling local health and care system. This indicates that, although good and outstanding primary care is more evenly distributed across the country, there are geographical areas where people are less likely to get good care.

Some people may experience geographic disparities particularly acutely – people who use mental health services, for example, who are already more likely to have difficulty accessing support and who may have to travel unreasonable distances to get it. In *State of mental health care*, we reported that in some parts of the country, people with suspected dementia or an eating disorder had to wait months for specialist assessment. Our review of children and young people's mental health services found that some children and young people were 'at crisis point' before they got the specialist care and support they needed, with average waiting times varying significantly according to local processes, systems and targets. We have also highlighted the issue of inappropriate out of area placements for mental health, which vary considerably by region.

It cannot be right that people's care depends on where they live or the type of support they need. But this is not so much a 'postcode lottery' as an 'integration lottery'. In our review of local health and care systems, we found that in too many cases, ineffective coordination of services was leading to fragmented care. Funding, commissioning, regulation and performance management all conspired to encourage a focus on individual organisational performance, rather than ensuring people got joined-up care based on their individual needs. Without incentives that drive leaders together, rather than push them apart, individual providers will increasingly struggle to cope with demand – with quality suffering as a result.

There is though cause for optimism. In some places, people are benefitting from successful local initiatives and providers that are joined-up with a focus on individuals' care needs. There are examples of integrated care hubs where hundreds of people have avoided a hospital visit, and teams of care staff from different specialities work together to help people in severe pain.

Addressing the local system challenge will also mean health and social care services pooling resources to use technology to deliver common goals and improve the quality of care. There is evidence that person-centred care has been improved through technology locally. In the NHS, for example, digital monitoring devices for patients' clinical observations have saved thousands of nursing hours, e-prescribing in oncology is helping people directly, and electronic immediate discharge summaries have improved patient safety. And in primary care, the online provider market holds the potential to deliver benefits for both patients and the system as a whole.

Good, personalised, sustainable care in a local area is no longer just about whether individual organisations can deliver good care, but whether they can successfully collaborate with other services as part of an effective local system. The urgent challenge for Parliament, commissioners and providers is to change the way services are funded, the way they work together, and how and where people are cared for.

The alternative is a future in which care injustice will increase and some people will be failed by the services that are meant to support them, with their health and quality of life suffering as result.



Ian Trenholm
Chief Executive



Peter Wyman
Chair





Summary

Most people in England receive a good quality of care. Our ratings show that quality overall has been largely maintained from last year, and in some cases improved, despite the continuing challenges that providers face. Some services have improved due to the focus and hard work of care staff and their leadership teams. Others have declined in quality as providers have struggled with the challenges they face.

But quality and access to care are not consistent, and people's overall experiences of care are varied. Some people have told us about the outstanding care they received and how some individual services have changed their lives for the better. Others have told us about the poor and sometimes disjointed care they have received.

Public sentiment about health and care services remains largely positive – for example, 84% of

patients said their GP practice was fairly good or very good. However, there are real concerns, such as the one in four (25%) of people receiving NHS mental health services who did not feel they got services often enough for their needs.

This year's *State of Care* builds on our July 2018 report about the way that older people in 20 English local areas experienced care as they moved between the different services they need. We highlighted how services for many people with multiple or complex needs in these areas were not joined up around their individual needs: finding good joined-up care was sporadic and sometimes it occurred despite the lack of a systematic approach to put people at the centre of their care. We found that providers are often focused on their own corporate priorities and targets, rather than working with one another to make sure people get the best care possible.



The challenge for all local health and social care services is to recognise the needs of their local populations and find sustainable solutions that put people first. In this context, we have considered five factors that affect the sustainability of good care for people: access to care and support; the quality of care services; the workforce available to deliver that care; the capacity of providers to meet demand; and the funding and commissioning of services.

Access – In 2018, access to care varies from place to place across the country. Some people cannot access the services they need, or their only reasonable access is to providers with poor services.

Age UK estimates that 1.4 million older people do not have access to the care and support they need. In two years, the number of older people living with an unmet care need has risen by almost 20%, to nearly one in seven older people. Friends and family carers must often fill the gap, and in a recent survey three-quarters of carers had received no support to help them have a day's break in the previous 12 months.

While more than 40% of GP practices now provide access outside of their normal hours, the general practice workforce is increasingly stretched, and there was wide variation in the proportion of patients in local areas that were satisfied with the appointment times they were given, from 45% to 79%.

In the NHS, the number of patients waiting to start treatment in hospital 18 weeks after being referred rose by 55% from 2011 to 2018. Some people who need inpatient mental health care and support are having to travel long distances to obtain it, and this varies considerably depending on where people live.

Quality – The overall quality of care in the major health and care sectors has improved slightly. More than nine out of 10 (91%) of GP practices and 79% of adult social care services were rated as

good at 31 July 2018. More than half (60%) of NHS hospital core services and 70% of NHS mental health core services were rated as good at that date. The hallmark of high-quality care is good leadership and governance, a strong organisational culture that embraces learning, and good partnership working – services looking externally to work with others and share what they know.

At the same time, too many people are getting care that is not good enough. Our ratings show that, at 31 July 2018, around one in six adult social care services and one in five NHS mental health core services needed to improve, and one in 100 was rated as inadequate. Almost a third of NHS acute core services were rated as requires improvement and three in 100 were rated as inadequate.

The safety of people who use health and social care services remains our biggest concern. There were improvements in safety in adult social care services and among GP practices. But while there were also small safety improvements in NHS acute hospitals, too many need to do better, with 40% of core services rated as requires improvement and 3% rated as inadequate. NHS mental health service also need to improve substantially, with 37% of core services rated as requires improvement and 2% as inadequate.

Workforce – Workforce problems have a direct impact on people's care. Getting the right workforce is crucial in ensuring services can improve and provide high-quality, person-centred care. Each sector has its own workforce challenges, and many are struggling to recruit, retain and develop their staff to meet the needs of the people they care for.

Recruiting and retaining newly qualified GPs is a problem in a profession where there is already an ageing workforce. In adult social care, the highest



vacancy rates in all regions in 2017/18 were for the regulated professions that include registered nurses, allied health professionals and social workers. They reached 16% in the East of England and 15% in London. Vacancy and turnover rates for all staff groups are generally higher in domiciliary care agencies than in care homes. In our review of children and young people's mental health services, low staffing levels were the most common reason for delays in children and young people receiving care.

Demand and capacity – These workforce challenges are set against a backdrop of ever increasing need for care. Demand is rising inexorably, not only from an ageing population but from the increasing number of people living with complex, chronic or multiple conditions, such as diabetes, cancer, heart disease and dementia.

Demand for urgent and emergency care services continued to rise in 2017/18, with more attendances at emergency departments than ever. The capacity of adult social care provision continues to be very constrained: the number of care home beds dropped very slightly in the year, but what was noticeable were the wide differences across the country. Across a two-year period, from April 2016 to 2018, changes in nursing home bed numbers

ranged from a 44% rise in one local authority to a 58% reduction in another. Almost a third of adult social care directors (32%) said they had seen home care providers close or cease trading in the previous six months.

Providers face the challenge of finding the right capacity to meet people's needs. Services need to plan – together – to meet the predicted needs of their local populations, as well as planning for extremes of demand, such as sickness during winter and the impact this has on the system.

Funding and commissioning – Care providers need to be able to plan provision of services for populations with the right resources, so good funding and commissioning structures and decision-making should be in place to help boost the ability of health and social care services to improve. Funding challenges of recent years are well known, and in June 2018 the government announced an extra £20.5 billion funding for the NHS by 2023/24. However, at the time of writing, there is no similar long-term funding solution for adult social care. A sustainable financial plan for adult social care will be an important element of both the forthcoming social care Green Paper and the wider Spending Review.

Working together for people who need care

The challenge for every local health and care system is to come together to consider all of these factors in making sure that care organisations are joined up and strategically focused on delivering high-quality care around people's needs. Across the country, there are examples of how multiple organisations, services and care staff are coming together locally to provide person-centred care.

In Kent, an acute response team brings together social care coordinators, therapists, support group workers and volunteers with NHS specialist staff such as diabetes nurses, all in a single team to support people who have fallen ill and risk being admitted to hospital. Plymouth has coordinated a council and healthcare service that prevents social isolation and loneliness, helping people to stay

healthy in their homes. More than 1,100 people have used the service, which follows up to check on the wellbeing of people who sign up and then fail to attend.

Wakefield, in West Yorkshire, has introduced integrated care hubs. They relieve pressure on primary care as GPs can potentially just ring one number or complete one e-referral for a person with multiple needs. Once assessed and referred, people are seen by a nurse, occupational therapist, physiotherapist, social care worker, voluntary worker, housing officer or mental health worker depending on their problem. Jointly funded by the clinical commissioning group and the council, and proven to prevent avoidable hospital admissions and help people get discharged from hospital as soon as they

are well enough, the model is now being rolled out in some other areas in England.

In Berkshire, teams in primary, secondary and community care – including specialists such as

physiotherapists and psychologists – are working with expert patients to design a streamlined single service for pain management, rather than multiple isolated pathways.

Harnessing the power of technology

Addressing the local challenge will also mean health and social care services embracing new technology, with the positive effect it can have on the way services work (together and individually) and on the way the quality of care can be improved for people. For example, in the NHS, digital monitoring devices for patients' clinical observations have saved thousands of nursing hours, e-prescribing has led to reduced waits for pharmacy services, and electronic

immediate discharge summaries have improved patient safety.

Some adult social care services use clever ways to harness technology to improve people's lives. One care home is using innovative assistive technology – including eye-gaze or 'head mouse' software – to enable young people with a physical disability to express their views, control their living environment and maximise their independence.

Better person-centred care is possible

People's experiences depend on both the care they receive from individual services and the way that different services work together to understand and respond to their needs. People's needs should be the focus of local health and social care systems. For good care to be sustainable, it is no longer just about individual organisations succeeding or failing.

When services work together with an understanding of the needs of their local populations, it is more likely that people will get the best care possible, when they need the care and in the best environment that suits their needs. Among such people is Tracey, who has used mental health services and was treated for multiple health problems including cancer and diabetes. Tracey said her care staff made her feel "valued" and "important". She summed up her feelings about her care like this:

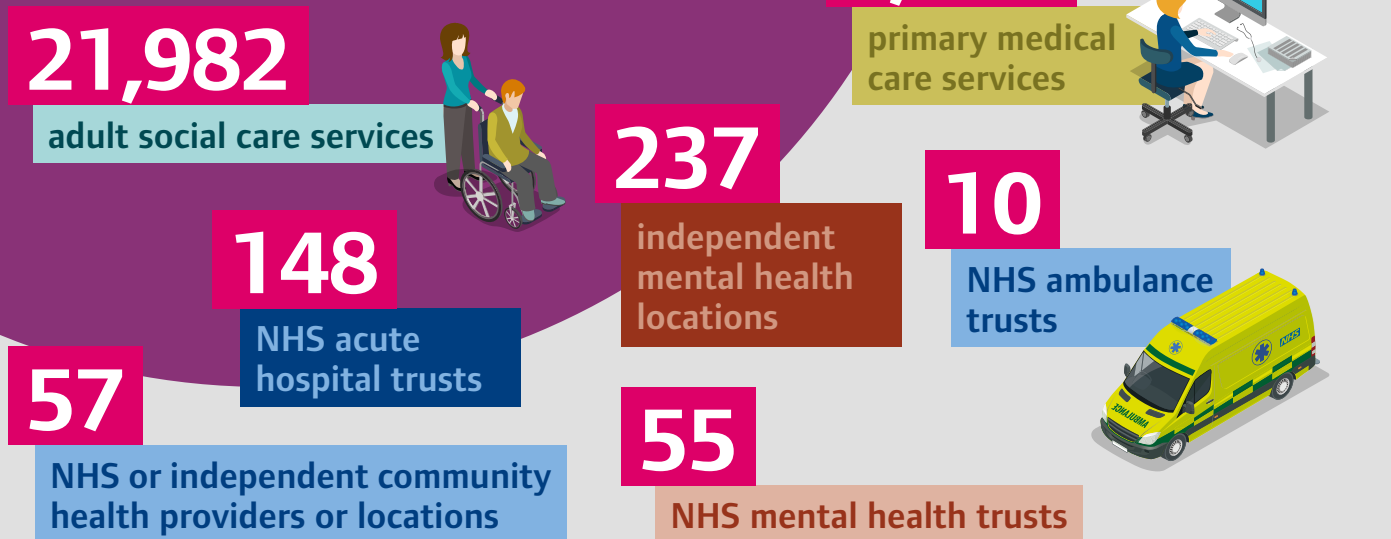
"It's been almost as if all these different places, all these different departments, have all worked – in my particular case, in my particular situation – together, like holistically."



Data used in this report

This report sets out the Care Quality Commission's (CQC's) assessment of the state of care in England in 2017/18. We use our inspections and ratings data, along with other information including that from people who use services, their families and carers, to inform our judgements of the quality of care.

To present as contemporary a picture of quality as possible, the data on inspections and ratings in this report are for CQC ratings published as at 31 July 2018.



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

- Quantitative analysis of our inspection ratings of almost 30,000 services and providers (as set out above), drawing on other monitoring information including staff and public surveys, and performance.
- Qualitative analysis of CQC inspection colleagues' experiences of inspecting services this State of Care year. This analysis was conducted to explore factors associated with quality, including what leads to deterioration, supports improvement and helps to maintain quality. It informs part 1 of the report and our chapters on the sectors we regulate. It was based on:
 - Thematic analysis of 28 interviews with senior members of CQC's inspection directorates (CQC deputy chief inspectors and heads

of inspection) and 10 focus groups with inspectors and inspection managers from adult social care, hospitals, mental health, and primary medical services inspection teams.

- Qualitative case study analysis of 15 services that had declined from a rating of good to requires improvement or inadequate since 1 April 2017 and four locations that had maintained a rating of requires improvement since 1 April 2017. This analysis comprised inspection report analysis and interviews with lead inspectors. High-level findings from this analysis were used to inform interviews and focus groups with inspection teams.

^a Dental practices are not rated, and data on these is for the year to 31 March 2018.

- Qualitative analysis of nine interviews with Experts by Experience who had used, or cared for someone who had used, a range of health and social care services this State of Care year. This analysis aimed to understand personal experiences of care in England and informs part 1 of the report and our sector-based chapters. Data has been anonymised and any names used in the report are pseudonyms.
- Qualitative analysis to inform our chapters on Deprivation of Liberty Safeguards (DoLS) and equality in health and social care:
 - The analysis detailed in our chapter on DoLS is based on 12 interviews with inspectors and inspection managers with particular knowledge and interest in DoLS and/or the Mental Capacity Act. A case study analysis of four services that had demonstrated good or improved practice in DoLS and the MCA since 1 April 2017 was also carried out to provide further evidence of the factors associated with quality in this area.
 - For our chapter on equality in health and social care, we conducted a case study analysis of four adult social care services identified as displaying one or more areas of good practice in relation to person-centred care for lesbian, gay, bisexual and transgender people. We also carried out secondary qualitative analysis of a sample of NHS hospital trust inspection

reports and a sample of responses to new-style provider information returns (PIRs). These analyses focused on the implementation of the Workforce Race Equality Standard (WRES) and adherence to the Accessible Information Standard (AIS).

- We interviewed a further nine members of the public (including Experts by Experience) to understand common experiences of people when they move between different health and social care services.
- The analytical findings have been corroborated and in some cases supplemented with expert input from our chief inspectors, deputy chief inspectors, specialist advisors and analysts to ensure that the report represents what we are seeing in our inspections.
- All interviews and focus groups took place from March to June 2018.

Where we have used other data, we reference this in the report and, unless otherwise stated, it relates to the year ended 31 March 2018.

Equality in health and social care

Our chapter on equality (page 106) looks at whether everyone has equally good access, experience and outcomes from health and social care. Alongside *CQC's Annual report and accounts*, it is how we fulfil our public sector reporting duties under the Equality Act 2010.

Deprivation of Liberty Safeguards (DoLS)

We have a statutory duty to monitor the use of DoLS and to report annually to Parliament on their implementation. We have a wide set of powers that allow us to protect the public and hold registered providers and managers to account. We are also one of the 21 organisations that form the UK's National Preventive Mechanism, which carries out regular visits to places of detention, and we monitor DoLS in these settings.

Part 1

THE STATE OF CARE IN ENGLAND



1. How people experience care today

Most people in England, when they are able to access it, receive a good quality of care. In 2017/18 this quality has, overall, been maintained. Some services have improved due to the focus and hard work of care staff and their leadership teams. Some have declined in quality as providers have struggled.

On balance, across the country, there has been more improvement than deterioration, and for some people, this means they now receive a better quality of care than they did before.

This is not true for everyone. Quality and access to care are not consistent, and people's overall experiences of care – especially as they move

between services – are varied. Often, people have a poor experience of care because services are not joined up and not organised around their individual needs.

While people can receive a good quality of care from individual services – for example, a visit to their GP or regular visits from care staff in their own home – getting good care at the right time and in a way that meets their specific needs is hit or miss for too many people. This is especially if they need to use a combination of care providers – an increasingly likely occurrence for many people, as they live longer and with more complex health and social care needs.

What people have told us

Understanding people's experience of care is central to understanding the state of health and social care in England. There are a number of surveys that track how people feel about the care they receive, and together these help to describe people's experiences.

In the 2016/17 national survey of people who receive adult social care, 65% of people said they were extremely or very satisfied with their care and support, and 70% said they felt as safe as they wanted. Less than half (45%) of respondents said that they had as much social contact as they liked.¹

Eighty-four per cent of GP patients said in 2018 that their experience of their GP practice was very good or fairly good. There was some variation in this across the country, with percentages in different clinical commissioning group areas ranging from 72% to 93%. Two-thirds of patients (66%) were very or fairly satisfied with the GP appointment times available to them; 17% were very or fairly dissatisfied. Almost all patients (94%) said that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment.²

Among people who receive NHS mental health services, three-quarters (75%) felt that they had

seen services often enough for their needs, and 72% said that in the previous 12 months they had had a formal meeting with someone from NHS mental health services to discuss how their care was working.³

To illustrate how people experience care, we asked our Experts by Experience (people with particular experience of different types of care service) to tell us what it is like from their point of view to receive health and care today. They explained both where they enjoyed good care and where things have not worked well, in different parts of their journeys in an often complex health and social care system.

The people we spoke to were quick to praise the people and services that care for them, despite their challenges. **Tracey** has a history of mental health issues and has been treated for breast cancer and diabetes. She told us about her care for multiple health problems, and said her care staff made her feel "valued" and "important".

"You don't just feel that you're a number, that you're a file ... I've felt valued and I've felt ... I don't mean self-important, but I've felt important, I've felt as though I'm

a human being: 'This is the situation, this is what we can do to help you; let's get together and see what we can do to help'."

Tracey mainly experienced very good care where services showed a personalised approach. However, she pointed out that sometimes this was despite a complicated system.

"The amount of change and the amount of bureaucracy that there is, some of it necessary, I'm not saying it isn't... but to work within those guidelines, but still provide a person-centred service is a skill and my experiences of the people that I've come in contact with over a considerable number of conditions... those experiences have been really good."

Andrew was first diagnosed with clinical depression more than 10 years ago. He said what mattered was "people who cared about the patients".

"Good quality care is the staff caring about what's wrong with you in the first instance, being seen in a timely amount of time... within a certain period – whether it be six weeks, three weeks, a month – and sticking to that."

David has experienced varied quality of care, particularly as a patient using mental health services as an inpatient and in the community. He is also a carer. For David, involvement in decisions about his care was of central importance. He described his desire to have choices in his care and to feel that he was working with staff to find solutions.

"I'll tell you the best positive experience out of it all was, when I got handed back over to my GP... I was taking [medication] for a number of years and my GP would then schedule, like every two to three months, an appointment to sit down and talk about how my last two or three months had been. And also, at the end, they would say, 'Do you feel that the dosage is right, do you need to go down, do you need to go

up?', and leave that in my hands... leave that decision with me, rather than saying, 'I think you need more medication'...

"I was in control of my life, it helped me along the road to recovery."

"I'm hoping that the future will be more co-productive with staff and patients and I think the future is having patients... where possible, take the lead on their care."

Melissa looked after her mother until she went to a nursing home and cared for her son, who had Down's Syndrome and sadly died a few years ago. She is also a carer to her sister and brother-in-law, who both have dementia. She told us about her experience of primary care.

"The GPs themselves are very understanding, very patient and very caring with my sister and brother-in-law. I am their appointee. So if there's anything they're concerned about at all they will give me a ring."

"It makes me feel brilliant because I think well somebody does care... you're not having to fight for everything, that is the main thing... most of the time, well most of my life for both my mum and my son I've had to fight for anything we've needed."

But she also told us being a carer could be a "horrible experience", when health and social care staff failed to listen to her concerns or support her in caring for her family member.

"I felt I'd been dismissed and it was nothing to do with me. That was the feeling. I'm trying to care for this person and the way the psychologist spoke to me was well, you know, it's nothing to do with you! How can you care for somebody if you're being told it's nothing to do with you? And it was just such a horrible experience I don't think I'll ever forget that."

Tracey has recently been diagnosed with diabetes, and described going for an endoscopy and colonoscopy. She told us that there had been a number of problems with her referral. She was given a 14-day referral but was initially sent an appointment she couldn't make. When she tried to rearrange, she was told that she would have to go back to her GP as there was no suitable appointment available in the 14-day period.

"She sort of said, 'Oh, well your doctor's told me you've got to be seen within a fortnight. I'm afraid you've gone past that time now; you'll have to go back to your GP.' And I thought, 'Whoa, just a minute. If I'm in that fortnight, even though I can't go in the fortnight – it's a few days out of that – and yet you're saying I've got to go back to my GP.' I didn't say this over the phone; I'm just sort of... it's only when I thought about it afterwards and I thought, 'But what if there is something wrong?'"

Getting access to good care is crucial, and this depends on many factors, including where you live.

Paul has experienced a number of health and social care services, and he was also carer for his ex-wife. He has diabetes, atypical high-functioning autism and a history of using mental health services.

Things changed for him because he moved home. He described how happy he was with the mental health services he needed when he lived in a city. But he lost that access to a support network and has been unable to find an autism support service in a more rural location.

"... for mental health it's better that the services are there all the time, but generally they're not... [the] autism services in the city, they were there all the time... you know one month that they're going to be there, the next month or next year..."

"Autism services should exist everywhere... [with] diabetes, you don't have, you know, that there's a diabetes service

in the city, but there isn't one in the country... there's one everywhere... nobody says, 'Oh, we can't afford to provide diabetes services everywhere', because they know if they don't do it, it will cost more money and it's unethical to leave people suffering without help..."

"I've moved to somewhere which is more rural and less funded. And in the city, the autism services, they're like one of the top two or three in the country, so now I've got what other people get, rather than what the top quality stuff is. And the top quality stuff is what we need."

Andrew struggles with access to mental health services. When he was first diagnosed with clinical depression he was referred to a psychiatrist by his GP. It took almost two years to get an appointment for specialist help and during this time he had little support. More recently, his experience has continued to be convoluted.

"... the GP referred me to the psychiatric mental health team and they said, 'Yes, we can see you', so I got to see... not a doctor, not a psychotherapist, but a psychiatric social worker, who was very nice."

"And he said, 'Right, what you need to do is ring the counselling services'... for some reason, the system's changed, where the mental health team don't do their own counselling. I don't understand why not."

"[I was asked] 'Do you want a review of your state of mental health and do you want that done by your GP and your medication done by your GP or do you want me to refer you to the psychiatrists here?'. I said... I'd rather see the psychiatrists here than let my GP do it."

"I got an appointment with a psychiatrist within a month of going... that was

brilliant. Three days before my appointment, the psychiatrist left. I was put on the waiting list and I'm still on the waiting list."

People's experience of health and social care services in England can be affected if care providers do not have the right staff or enough staff to offer high-quality care. We have reported about the way workforce issues affect quality in previous years, and different parts of the NHS and social care services are still struggling to recruit and retain the staff they need.

David told us that quality ultimately depended on the staff.

"...these are the people that are delivering your care, these are the people that you see every day, more than your own family, more than your own friends... these are the people that you more or less live with.

"It's down to the people that are running the service because they're the ones that the quality kind of depends on... and if they don't run a tight ship, then it's going to be poor, isn't it?"

Speaking about her experiences of working with domiciliary care staff when her son was alive, **Melissa** said that sometimes care staff did not turn up when they were expected and there was no phone call.

"If you've got somebody with a learning disability [then] a profuse apology means nothing. To them they just didn't come and they don't know why. And then my son used to say 'they don't like me'. So it can have a knock-on effect with the person."

A high level of staff turnover and issues with staff training also caused problems with her mother's care. This made her feel responsible for ensuring her mother was properly cared for.

"Especially with my mum who couldn't speak because of her condition, it was difficult to know and to get to know staff to find out who understood her and

who didn't... again it was made difficult because staff changed so much..."

"I mean yes she was my mum and yes I knew her really well, but I don't think they'd had appropriate training to be honest."

Deprivation of Liberty Safeguards

More than 850,000 people currently live with dementia in the UK and this is projected to increase to one million by 2025. People who are not able to make some or all of their own decisions at the time they need to be made, due to a lack of mental capacity (such as those living with dementia), are protected and empowered by the Mental Capacity Act 2005 (MCA). The Deprivation of Liberty Safeguards (DoLS) are part of the MCA and both work together to provide an empowering legal framework that balances safety and freedom through best interests decision-making, the right to representation, and advocacy arrangements.

We continue to find varied practice in the implementation of DoLS and the MCA. For example, some services use overly restrictive practices because they lack understanding of the legislation. Delays in local authorities assessing and authorising DoLS applications also remains a major issue.

Strong leadership and governance, a positive organisational culture, adequate staffing levels and embedding staff training are important factors in supporting good DoLS and MCA practice.

It is important that system partners and providers continue to work together to improve and develop the delivery of the DoLS scheme in its current form, to protect people when they are deprived of their liberty, and to support their families and carers.

Read more on DoLS in part 2 

"[I felt] terrible because I knew mum had to be there because I couldn't cope with her. So that was really awful and that's why I went every day... I needed to know that she was being looked after at least at some point of the day when I was there."

For Melissa, services needed to be "honest as to whether you can deliver that service or not" and "honest about the level of staffing you've got and what will happen if there's anybody off sick or whatever".

Some of the people we spoke to cited temporary staff and short-term contracts as detrimental to the quality of care they receive. **Paul** says that whoever is providing services, for the staff "the money and the infrastructure needs to be there for them to have enough training to understand things like mental health".

"...most of the staff there are temporary, they're on like a six months or one-year contract, you know, so they don't get any training, you know – or they

do get training, but by the time they know anything, they're gone."

"... with the budget cuts, they're concentrating on the front line, which means the training doesn't happen. But it's another thing where it's a false saving because if the care planning is poor and the training is poor, they're going to have more emergencies."

People's experience of care can be affected by the capacity of their local system – including GPs, community health, mental health services, hospitals and adult social care – to provide care that is centred on them as individuals.

Where care providers have collectively considered the needs of their local population, and they have strong planning in place, people's experience of care can be better. The Experts by Experience we spoke to told us about the way they receive care and some of the issues they have seen or they perceive. Often this is about moving between services.

Equality in health and care

There is evidence that some inequalities in experience are slowly reducing. Improvements in person-centred care and values-led cultures in services play a big part in advancing equality and inclusion. Innovative new technology is also being used to help improve equality, for example through enabling disabled people to communicate their needs.

But overall progress is slow and there is potential for more improvement. We still have concerns about the experience of people in some equality groups, particularly people with a learning disability, mental health condition or dementia who need to use acute hospital services and people from Black and minority ethnic groups using acute mental health inpatient services. For change to happen, leaders need to proactively

tackle equality issues and engage with staff and people using services. And still too few adult social care services carry out specific work to ensure equality for people using their service.

Some longstanding issues need national action. More work is needed to implement the Accessible Information Standard to improve communication with disabled people using health and social care services.

Some gaps in access to services and in health outcomes for people are widening. This cannot be addressed by providers alone. One solution is for local areas to use 'population health' approaches to improve access and outcomes for particular groups, such as older people. At the same time, they need to take account of the diversity of the needs and experiences of older people.

Read more on equality in part 2 

Paul told us that discharge and care planning should focus on “putting the patient first”.

“I think the carer discharge planning... it’s a bit of a tick-box exercise and there’s boxes missing from the tick-box.

“... if somebody has no medical need to be in the hospital anymore and say they’re living in a care home, if the hospital’s ready to discharge them, the care home has to take them, you know and arrange for funding it. I think they should be putting the patient first, rather than the funding. They need to sort out where the patient goes and then the procedure can kick in to how it gets funded... I think that should all be formalised.”

Andrew, with his experience of using multiple health and care services – as well as being a carer – believes “commissioners don’t know what local people need” and a “lack of communication” is the problem.

“[Commissioners] see what the government tells them about what people need and say, ‘Oh, we’ll put a contract out for that’, even though nobody in the area will know what the contract is about.

“[They] don’t know what they want because they’re not talking to the people who need certain services, which is the people at grass roots... [They say] ‘Oh, what’s the latest thing... oh yes, we’ll put out a contract for that’... everything’s down to communication.

“... local people need to be involved, whether it’s charities or health services or clinical commissioning groups, they need to know what each one’s doing.”

For health and social care in a local area to be sustainable, there needs to be the right provision in place and sufficient capacity to support people to stay well in the community or move smoothly

through the system. This all depends on having staff with the right skills, in the right place.

The stories of our Experts by Experience tell us something about how the capacity of a system to cope with demands locally can manifest itself on the front line. Some of those we spoke to think that staff – particularly in adult social care – are inadequately paid and trained. And in some cases, they told us that they think this leads to staff not being adequately rewarded for doing a good job.

Karen is the main carer, with her husband, of her 35-year-old son, Sam. Sam has Down’s Syndrome and lived with his parents for most of his life until December 2017 when he moved into a residential care home. Karen says she has “grave concerns for the future”. She no longer gets a carers allowance but has to care for her son “a lot”. For Karen, staff support, training and management are really important in ensuring high-quality care.

“... teach people how to care properly, give them a qualification and a decent wage and you know, that’s all it needs really, isn’t it? And then you get the right people in the homes and then, you know, it’s like anything: train them well, monitor well, appraise well, reprimand when it’s not good enough. There’s ways of doing it without losing staff... we all have to retrain.”

“... if you want somebody sitting in an office doing the paperwork, that’s fine, because there is a lot of paperwork... but you need somebody else to be popping in throughout the week at different times, to be actually working with the clients, with the staff, to see where the faults are, to monitor the staff. I mean I would have always thought a good manager would be popping in at any time to see what’s going on, not disappearing early because her dog’s got to go to the vets and what have you.”

People need health and care that revolves around them, not the other way round

In July 2018, we published *Beyond barriers: How older people move between health and social care in England*. This report, commissioned by the Secretaries of State for Health and Social Care, and for Housing, Communities and Local Government, focused on how people aged 65 and over experience the health and social care system in 20 local authority areas.⁴

Many older people in England have complex care needs that usually require more than one service. Their experience of care depends on how well different services work together with and for them, and their families and carers. This is focused on three outcomes:

- Maintaining their own health and wellbeing, in their own home, with the care and support needed to be able to do this.
- If they need further help, knowing how and where to get high-quality care and accessing it quickly and easily.
- When they no longer need intensive support, to return to their own home quickly or to move as seamlessly as possible into a new home if that is what is needed.

The same is true for other people as well: people with a long-term health condition such as diabetes, people with a mental health condition, people with a learning disability – to name a few. People may get high-quality care at individual services, but they could have improved health outcomes and a better experience in the health and care system. With improvements in life expectancy in the UK continuing to slow down, and in some cases stopping, they need services to work together to provide care and support to keep them healthy and well, to enable access to high-quality care quickly when they need it, and to help them to return home as soon as possible.

In the latest GP patient survey, four in five people with long-term conditions (79%) said that they received enough support from local services or

organisations to manage their conditions. But this means one in five people (21%) do not get enough help. And one in 10 people with long-term conditions (10%) have had an unexpected stay in hospital in the last 12 months due to their condition.⁵

High-quality care and a good experience for people using services depend on the way the whole system works around people and their needs. An approach from all organisations (NHS, social care, commissioners, councils and more) to understanding and responding to the individual needs of people is essential in a local area to achieve better outcomes for individuals and local populations.

When people are moving between different services, they may receive excellent care at individual stops in a typical care pathway. For example, the GP practice might be responsive to someone's needs, and provide effective and caring treatment. But this must link up with any hospital care or social care that's needed. People often get lost in the system – stuck in gaps between services – and it can occur between any number of different combinations of services, and in any direction (for example, between primary care and mental health services, or between a care home and a hospital).

Where possible, people want to be supported in the communities they live in, and for health and care services to work together to meet their daily challenges to keep well.



2. The challenges for local areas in ensuring high-quality care

For good care to be sustainable, local health and social care systems and the organisations within them should be joined up and strategically focused on delivering high-quality care around people's needs. This means ensuring that:

- People can access the care and support they need.
- The quality of care that people receive is of high quality.
- There are enough capable and confident people within the workforce to deliver good care.
- There is capacity among services to fully manage the needs of local people.
- Sufficient funding is in place and commissioning of services is focused on the needs of local people.

Access to care and support

Access to high-quality care is of fundamental importance to everyone who needs it. Whatever the quality of care that is delivered, it means little to people if they are not able to access it in the first place.

Access to good quality health and care is not equal for all types of care, or all groups of people. Some groups of people have unmet needs, particularly those who are socially excluded or in vulnerable circumstances.

Availability of care and support to maintain people's health and wellbeing

In our reviews of local systems, we saw many initiatives that were helping older people to access care and support when they needed it and in the communities they lived in, and helping to maintain their health and wellbeing.

However, latest estimates from Age UK show that 1.4 million older people do not have access to the care and support they need. In two years, the number of older people living with an unmet care need has risen by almost 20%, to nearly one in seven older people.⁶

Person-centred care: Preventing loneliness

In Plymouth, the public health prevention budget was small, but it continued to fund a befriending service. Local health and care leaders recognised the role it played in preventing social isolation and loneliness.

The service provided support to more than 1,100 people at the time of our review. It proactively followed up people who failed to attend regular sessions, to ensure they were safe and well.

People we spoke with were extremely positive about the service; some had been using it for more than 15 years and stressed the important role it played in maintaining their health and wellbeing. One person told us, "It provides company for me, with bingo and trips out. It's a part of our local community and integrates with other things like the church and the theatre."

Of the 1.4 million people affected, Age UK estimate that there are more than 300,000 who need help with three or more essential daily tasks such as getting out of bed, getting dressed or going to the toilet. The study found that more than half of the 300,000 people received no help at all from paid carers or family and friends.

Compared with 2010/11, fewer people are eligible for publicly funded social care in England in 2018/19, with the financial thresholds for accessing social care (the amount a person can have before being required to contribute to their care) staying unchanged and therefore going down by 12% in real terms.⁷

Adult social care provided by local authorities can broadly be categorised into short-term support and long-term support. One of the purposes of short-term support is to provide care that is intended to maximise the person's independence and help prevent them needing long-term social care support. The latest data from NHS Digital (for 2016/17) shows that spending on this type of social care rose by less than 1% from 2015/16, or around £5 million.⁸ In comparison, spending on long-term support increased by £539 million (around 4% in cash terms).

The ONS Family Resources Survey 2016/17 shows that informal care remains a considerable component of care provision, with around 8% of people reporting that they provide some level of informal care, and that this falls disproportionately to women.⁹ And NHS Digital data shows that informal carers continue to absorb the bulk of the pressure: 77% said they had not received any support or service that allowed them to take a break of between one and 24 hours from caring in the last 12 months.¹⁰

Social care provided in people's homes plays a key role in supporting older people to remain independent. Although the number of organisations providing domiciliary care continues to grow, they continue to report higher job vacancy rates than care homes. Skills for Care, the leading source of workforce intelligence for adult social care in England, reported that in 2017/18, the overall staff

vacancy rate in adult social care was 8%; specifically for domiciliary care staff it was 10%.¹¹ Skills for Care estimates that there are 110,000 job vacancies in adult social care at any one time.

General practice is usually a person's first point of contact for medical care, and provides the majority of contacts between the NHS and people. It plays a central role in the early identification and management of health problems and preventing people from needing hospital care.

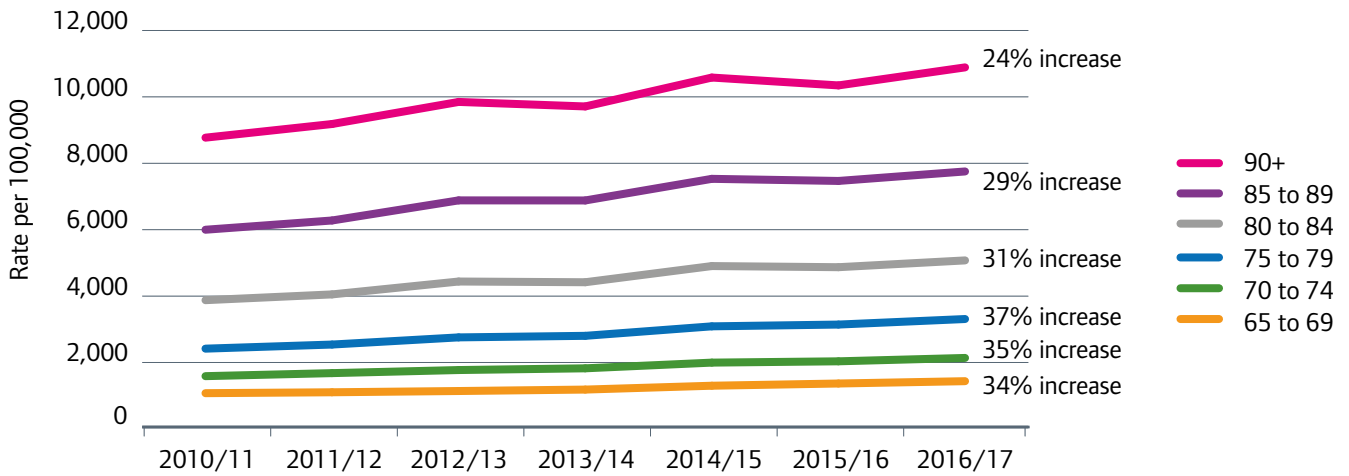
The national drive to provide seven-day services has been recognised in general practice, and extended access is rising substantially.¹² Clinical commissioning groups (CCGs) are required to provide extended access to GP services for 100% of their populations by October 2018.¹³ In March 2018, 40.9% of GP practices across England that responded to NHS England's survey of extended access said they offered full provision outside of core contractual hours, an 8.5 percentage point increase on the previous survey in September 2017.

This means that almost four in every 10 (22.6 million) people registered with a practice have access to a GP appointment outside of core working hours.¹⁴

But the general practice workforce is stretched, with a larger workload and the number of GP full-time equivalents falling from 34,592 in September 2015 to 33,890 in December 2017.¹⁵ These pressures may be affecting people's access to their GP practice. Satisfaction with GP services among the general public in most of the UK has fallen to its lowest level for 35 years.¹⁶ There is wide regional variation in the proportions of patients in each CCG who were satisfied with the GP appointment times they were given, ranging from 45% in Corby CCG to 79% in Nottingham West CCG.¹⁷

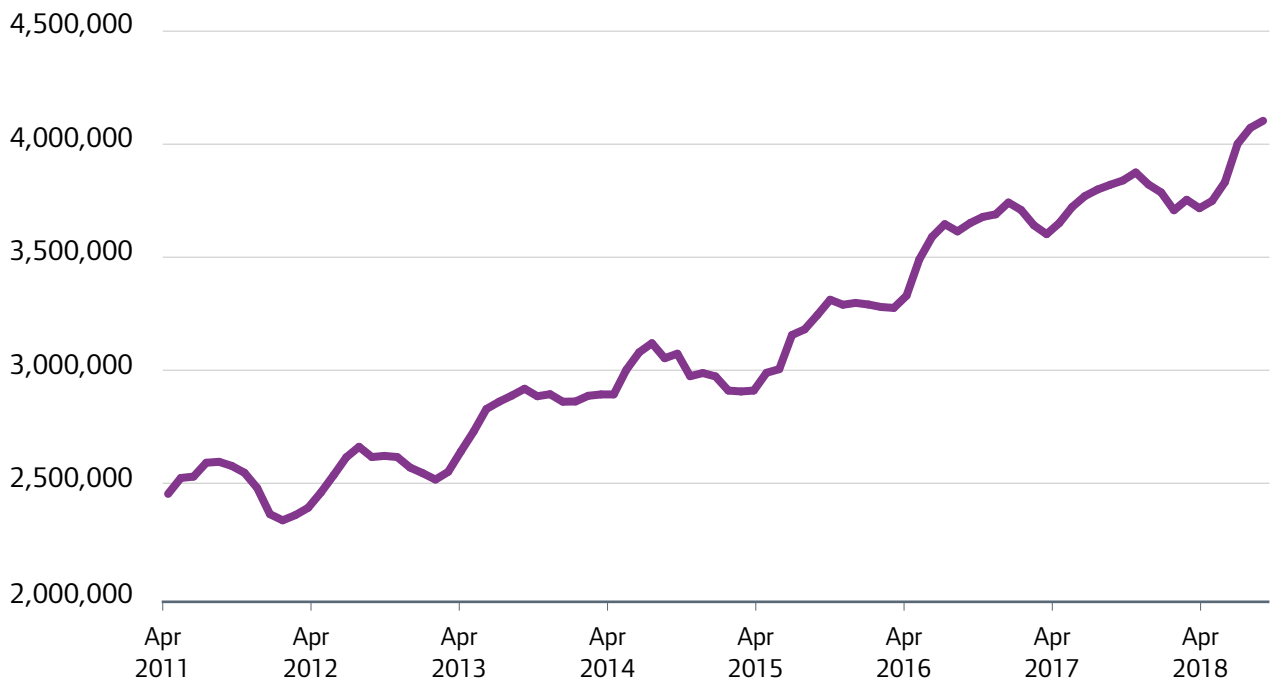
Inadequate access to GPs can lead to people relying on emergency services or reaching the critical point where they cannot access suitable care in the community. Across our reviews, older people told us it could be difficult to access their GP. Access to primary care support out of hours was also critical, but we found that people's access to this support varied, and in some areas was not adequate.

Figure 1.1 Rates of avoidable emergency admissions for older people, 2010/11 to 2016/17



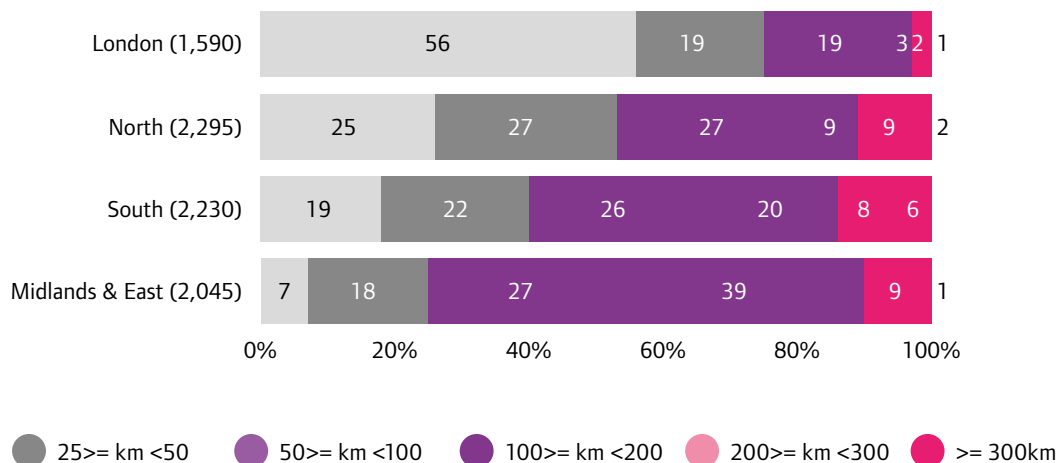
Source: NHS Outcomes Framework 3a – emergency admissions for acute conditions that should not usually require hospital admission. Rate has been indirectly standardised to take into account demographic differences.

Figure 1.2 Number of patients waiting to start treatment on the 18-week referral to treatment time pathway, April 2011 to June 2018



Source: NHS England, Referral to Treatment (RTT) waiting times, England.

Figure 1.3 Mental health patients allocated to inappropriate out of area placements, by distance and region, March 2017 to February 2018



Source: NHS Digital, Out of area placements in mental health services.

Access to community health services (such as community nursing and therapy services) is also vital. However, nationally, capacity in community health is challenged. From 2009 to 2017 there was a 40% fall in the number of full-time equivalent community matrons and a 44% drop in the number of district nurses. At the same time, the number of nurses caring for adults in hospitals increased by 8%.¹⁸

From 2010/11 to 2016/17, the rate of emergency hospital admissions for older people (numbers of people with the condition per 100,000 older people in the population) has steadily increased for conditions (for example kidney and urinary tract infections, flu, pneumonia, upper respiratory tract infections and angina) that would not usually require hospital admission. Each age group over 65 years showed at least a 24% increase over this period (figure 1.1).

The total number of NHS patients still waiting to start treatment in hospital on the 18-week pathway at the end of the month continued to rise in 2017/18, and increased by 55% overall from April 2011 to March 2018 (figure 1.2). These waiting times vary across different regions.

In mental health care, the vast majority of times that people were sent outside their area for care and treatment were inappropriate, in that it was deemed that the best care would be close to home but there was no bed available locally: between 94% and 100% of all occasions in 2017/18. Looking at the distance travelled for patients in each region, more patients in the Midlands and East of England had to travel further for a bed (48% travelled more than 100 km (62 miles), while the South region had the highest percentage (6%) who were placed more than 300km (186 miles) away (figure 1.3).¹⁹

People with a learning disability living far away from their families in inappropriate settings has long been an issue. The cross-system Transforming Care programme has led the way in developing and implementing high-quality community services for people in their own area. This is a challenging programme to implement at the speed required, but in June 2017 NHS England announced further funding to support local Transforming Care Partnerships in this work, to build on a 13% reduction up to that date in the number of people who were living inappropriately in inpatient settings.²⁰

In March 2018, we published *Are we listening?*, our review of children and young people's mental health services. We reported how children and young people can struggle to access appropriate support for their mental health because they do not meet the eligibility criteria to be accepted into mental health services.²¹

In our fieldwork, we found that inappropriately high eligibility thresholds can sometimes create an unhelpful barrier that prevents children and young people getting the right support at the right time – particularly if alternative sources of help are not available. Because eligibility criteria are often applied after a child or young person has been referred to another service by their GP practice or school, children and young people may have been waiting for some time before they are told their needs cannot be met by the service they have been referred to. Too often, we found that children, young people, their parents, families and carers have to be at the point of crisis before being able to access the right support.

Navigating services and support

All the local areas we reviewed had a range of services to promote the health and wellbeing of older people and their carers in the community. Yet people were not always able to access the support they needed because they didn't know where to go. People sometimes found accessing services complicated and confusing. Even people working within an area were not always knowledgeable about the services available to make referrals to the right service, in a timely way.

Many local areas had developed specific services to help people navigate the system, called single points of access: one point of contact from which people could be referred to the most appropriate team, based on their needs. These varied in terms of who could use them – some could not be accessed by members of the public directly, and some could not be accessed by all health and care workers. They also varied in the range of services that they could refer a person into.

Alongside the development of single point of access services, the role of primary health care teams in providing signposting and information is still critical. We saw systems successfully embedding signposting within practices. There was the introduction of specialist coordinator roles (sometimes called community connectors or care navigators) to help people access support and services in the community.

We found social prescribing initiatives in various stages of development. Social prescribing is a means of enabling GPs and other frontline healthcare workers to refer people to services in their community instead of offering only medicalised solutions.

Equal access and choice

In our reviews, we found variation in the access to and availability of services. This depended on where people lived and was a result of disjointed organisation, funding and delivery of health and care services.

Some people living in large rural areas did not have access to services, and had to travel long distances, with poor transport links. In urban areas we also

Person-centred care: Life coaching

Wealden in East Sussex has a jointly funded NHS and council health coaching service, with local GPs prescribing community activities from the council's not-for-profit leisure operator, including coffee mornings, singing workshops and walking groups. More than 80 patients have benefitted from expert coaching and many have improved

mental health, reduced isolation, increased physical activity, lost weight or reduced their medication requirements. Twenty-nine patients who regularly visited their GP in the six months before receiving coaching reduced these visits by 61% in the six months after.

Source: NHS England

saw that the availability of services could differ from one part of a city to another. Where you lived could determine the type of preventative support you received, such as extended access to GPs or enhanced GP support to care homes.

Personal budgets and direct payments are a mechanism to allow people to have choice and control over the support and services they receive. We found that in areas where there was good access and support to manage direct payments, this allowed people to take control of their care. We found examples of people using personal budgets and direct payments for dementia day services and other community-based support.

Nationally, personal budgets and direct payments for social care and health are not widely accessed. In 2016/17, 17.6% of older people accessing long-term social care support across England were receiving direct payments,²² and 9,127 adults received a personal health budget (an amount of money to support a person's health and wellbeing needs) in 2017/18 (of which 4,784 received direct payments).²³

There is wide variation in uptake of direct payments and personal health budgets across the country. This variation was apparent in the areas we visited. In several areas, one in four older people received direct payments for social care. In others it was one in 20.²⁴

Access to urgent care and support

Sometimes people experience a health crisis and might need urgent support from a variety of services – this might be a physical or mental health problem or a social crisis, but it is something that profoundly affects a person's ability to function or to remain independent.

In mental health, crisis resolution home treatment teams (CRHTTs) exist to provide intensive support for people in mental health crisis outside of hospital. They are charged with working to reduce the need for admission to hospital and with 'gate-keeping' admissions for which there is a national threshold of 95%. This means that in at least 95% of admissions, the patient should already have been assessed by the crisis team to determine if their admission could be prevented and, if not, the team should have been involved in the final decision to admit the patient. During 2017/18, CRHTTs reported that the level of gate-keeping these admissions was maintained above 98% in all four quarters nationally, but there was a great deal of geographical variation: for example from January to March 2018, while a level of 100% was achieved in 117 CCG areas, it was less than 95% in 20 CCGs, with the lowest being 81%.²⁵

NHS acute hospitals are under continued strain. The percentage of beds occupied in acute hospitals is higher than it has ever been. Our analysis estimates that, in April 2018, only 16 of the 152 local authority areas in England had bed occupancy rates

Person-centred care: Helping people to stay out of hospital

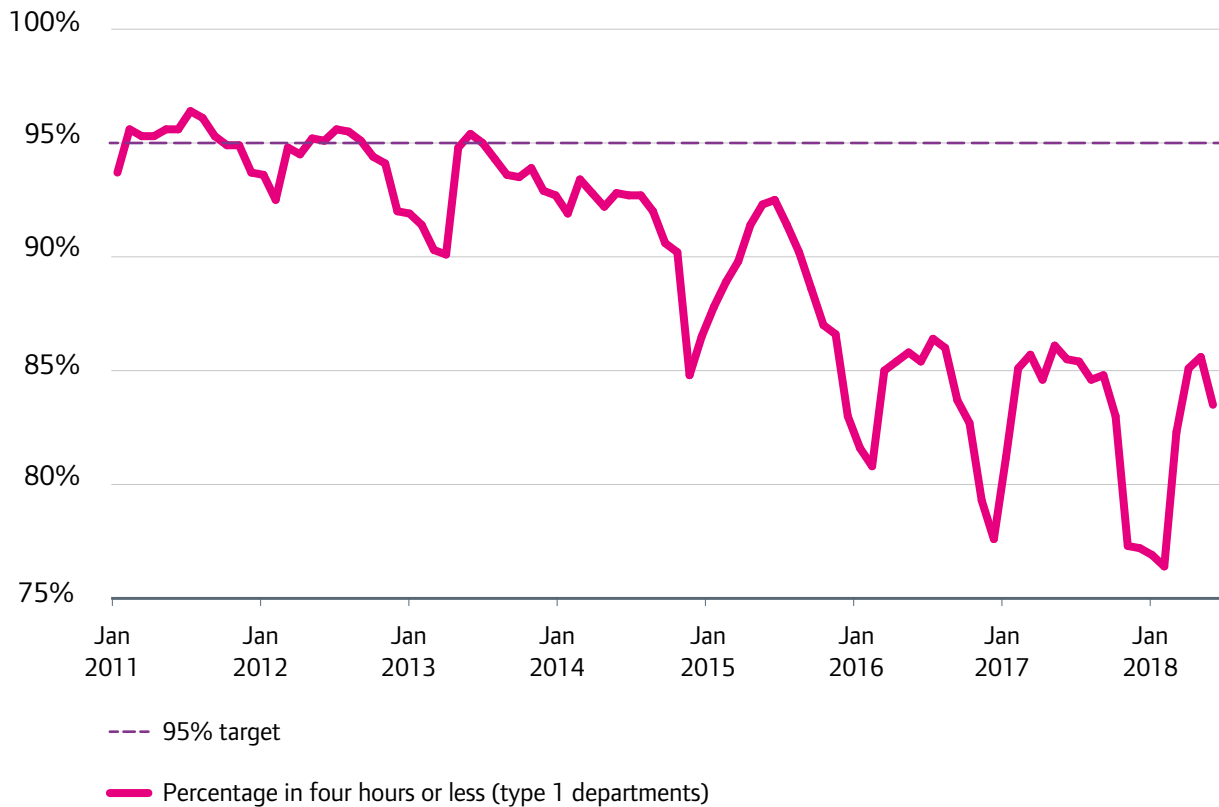
A service launched in Thanet, part of Kent and Medway STP, is improving care and reducing demand on the local hospital. The Thanet Acute Response Team is a partnership between the county council, NHS organisations and local Age UK. It brings social care coordinators, therapists, support group workers and volunteers alongside NHS specialist staff, such as diabetes nurses, into a single team to support people who have fallen ill and risk being admitted to hospital. Instead,

the team treats and cares for them in their own home or in the community.

It is the first time that the different staff groups have worked together in this way in the area. It is estimated that the service allowed 200 people to stay out of hospital last winter, improving health outcomes and relieving pressure on local health and social care services.

Source: NHS England

Figure 1.4 Monthly performance against the A&E four-hour target in major A&E departments, January 2011 to July 2018



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

below the 85% level. This strain is felt further during surges in demand, such as the winter months.

Performance against the four-hour target in emergency departments has continued to decline – there has been a long-term trend of deterioration and a year-on-year decrease in performance. Over winter 2017/18, it dropped to its lowest level for at least seven years in major A&E departments (figure 1.4).

System leaders in some areas told us that planning for surges in demand is now needed all year round, not just for winter. Regardless of the time in which a system comes under pressure, a system’s resilience is dependent on the organisations within it, working together to plan and deliver effectively, as a

system. In May 2018, we published *Under pressure: safely managing increased demand in emergency departments*, a report providing practical solutions from staff working in emergency departments.²⁶

In response to pressures in hospitals, the areas we visited have implemented various approaches to reducing avoidable admissions. These varied from introducing community-based rapid response services (for example, hospital-at-home services) to streaming services in the emergency department, set up to point people to the right support when they do not require emergency admission.

Some areas had established links between hospital front door staff and local voluntary, community

and social enterprise services, helping people to quickly access social support. We also saw 'care navigators' in emergency departments, and community matron in-reach services that could point people to appropriate community care. Links between emergency departments and community-based services are important – we saw people being admitted to hospital with social needs, such as a breakdown in support at home, rather than medical reasons because support was not available in the community.

Support to return home as soon as possible

When a person is cared for in hospital, for their wellbeing and the best opportunity for recovery, services caring for that person should be joined up in the way they support them to return home, or in some cases settle them into a new home such as a nursing or care home.

If services are not well planned or coordinated, people can experience delayed transfers of care (DTC) from hospital. This can have a substantial impact on people's health and wellbeing.

There has been a drive to reduce these delays: the Department of Health and Social Care required the reduction of DTC to 3.5% of occupied hospital beds by September 2017.²⁷ Nationally, DTC fell throughout much of 2017 as a result. At the close of 2017/18, 18 of the 20 local systems we reviewed had managed to reduce their rate of delayed transfers, and two had fallen below the national average. There is still wide variation across England in the rate of delayed transfers.²⁸

Throughout our reviews, we were told that the pressure on local systems to reduce delays in hospital discharge has almost overwhelmed other health and social care priorities. We saw that system leaders had implemented various measures to achieve this, and frontline staff were working hard to reduce delays.

While this reduction in delayed transfers of care is positive, we found examples where the focus on DTC had compromised the safety of people moving through services. This included people being moved

out of care settings before arrangements such as equipment, medicine or transport were in place for the person to return to their home.

There are many different reasons why people experience delays to the discharge process. For example:

- availability of staff
- availability and coordination of medicine
- availability of care provision (including in intermediate care, in care at home and in care homes)
- coordination of assessments
- availability of transport
- access to equipment and adaptations.

Much of the health and care delivery system is already in operation 24 hours a day and seven days a week. But this is not uniformly implemented or coordinated. A lack of seven-day services creates delays. For example:

- Social care providers may be less likely to accept discharges at weekends.
- There could be a lack of seven-day access to equipment and medicine.
- Community health services may not be available to support people in their own homes.

A focus on DTC alone does not fully address problems that people sometimes face when they need to access ongoing care, wherever that care may be. For example, someone leaving hospital, but who is not well enough to return to their own home, may struggle to access a residential home. This may constitute a delay, but getting to the heart of the problem is not always straightforward.

In our work, we found that older people's access to care can be problematic at different stages of their step-down care. We have seen that a strong multi-disciplinary approach, involving people's families and carers, can help a more effective discharge from hospital. Ward-based social workers and strong coordination with community and primary care services make a difference for people. Various people

are involved in someone's discharge from hospital, so coordinating their assessments is important.

Information sharing and communication on discharge underpins safe and effective care – we can see that the timeliness and accuracy of shared information was crucial. We heard that people were frequently sent home from hospital without accurate or sufficient information for their ongoing care needs – and sometimes without their medicine, which was a risk to their safety.

To improve people's movement through different kinds of care, some services use a trusted assessment model. This is where someone is authorised by the various care services involved in a person's care to make an assessment about that person's care needs. We saw different interpretations of the trusted assessor model in different systems. Some had dedicated trusted assessor roles, whereas in others there were agreements between services to share assessments. In the systems we reviewed, the model was in early stages of development and there was not the level of understanding between services to implement this model quickly and at scale. From feedback we received from social care and in our reviews, it was clear that some providers lacked confidence in the assessments carried out in hospitals.

Choice and control is important for people when they are moving between care services. For example, discharge from hospital can be a life-changing time for some people, so access to the right services or the new home that meets their needs is vital. From our work, we are aware that some older people are offered poor quality services or end up living far away from their families and friends. People described their experience to us – one person waiting in hospital for a social care package told us it was like being in a "holding pen" with 40 other people who had similar needs.

People should not be in hospital for any longer than they need to be – their access to ongoing care should be smooth. We have seen established 'discharge to assess' care pathways working well for people, but these are not without risk. Without sufficient capacity, people can be sent home and not

receive their assessment soon enough, which can cause distress and harm.

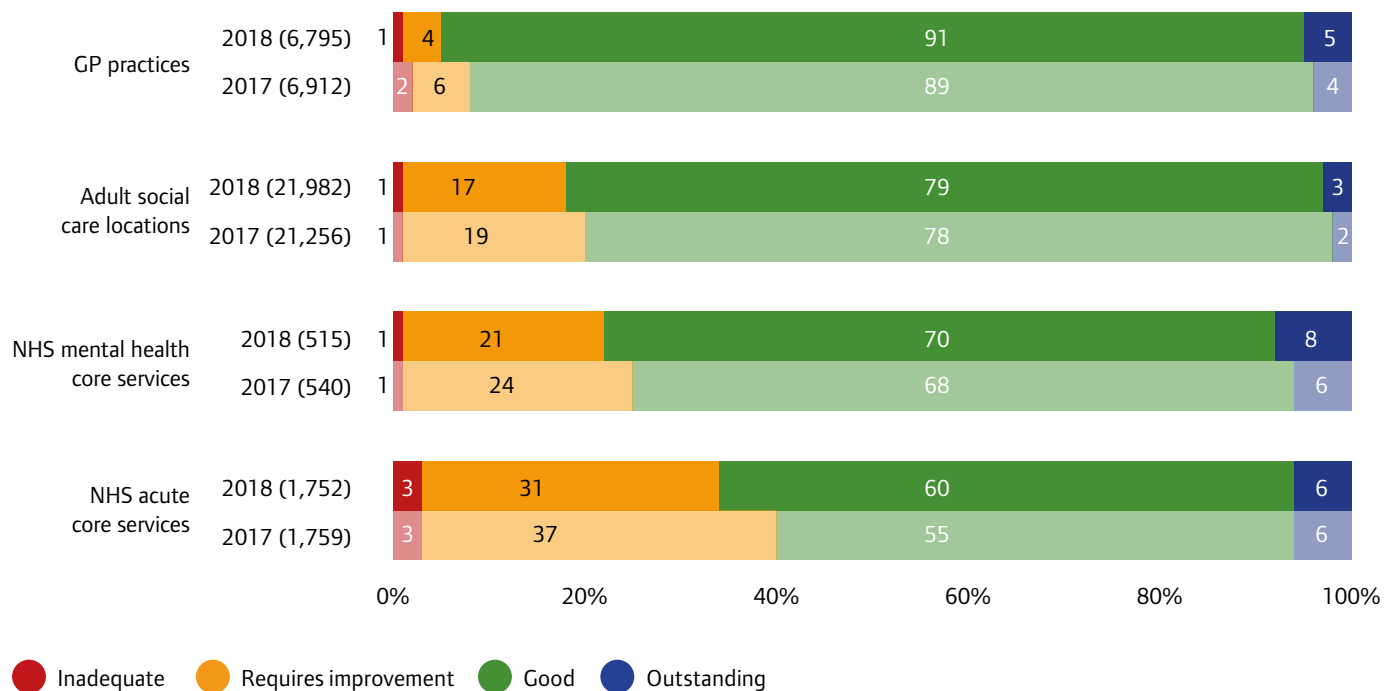
Access to intermediate care can have a positive impact for people – an audit in 2015 showed how more than two-thirds of people who used intermediate care after a hospital stay did not ultimately need to move to a more dependent care setting.²⁹ Access to reablement and rehabilitation services can make a significant positive difference for people – there is wide variation in access to these services. Of those older people who received these services following discharge from hospital in 2016/17, 82.5% were still at home 91 days later. However, only 2.7% of older people discharged from hospital received these services in the first place.³⁰

Unpaid carers are a critical and valuable part of any high-quality local health and social care system. The Office for National Statistics estimates the cost of replacing unpaid carers with paid carers at £57 billion per year.³¹ Unpaid carers are at the heart of many people's support network when they need to access step down care. Aside from providing care themselves, unpaid carers help people to navigate the system – they often help people to access services they need and coordinate their care and support.

Some local areas have taken proactive steps to identify and support carers. We heard about GP practices that gave carers priority access to appointments and that flu vaccinations were offered at carers groups. In one system, GPs and practice nurses could 'prescribe' carers a social, leisure or health break.

When speaking to carers we were told that voluntary, community and social enterprise organisations and carers' centres provided what was described as "invaluable guidance and support". Working as the key point of contact for carers, they helped people to navigate the system to access carers' assessments, services, and practical and financial support.

Figure 1.5 Main sectors, overall ratings, 2017 and 2018



Source: CQC ratings data, 31 July 2017 and 2018.

Quality of care services

The overall quality of care in the major health and care sectors has improved slightly (figure 1.5). As at 31 July 2018:

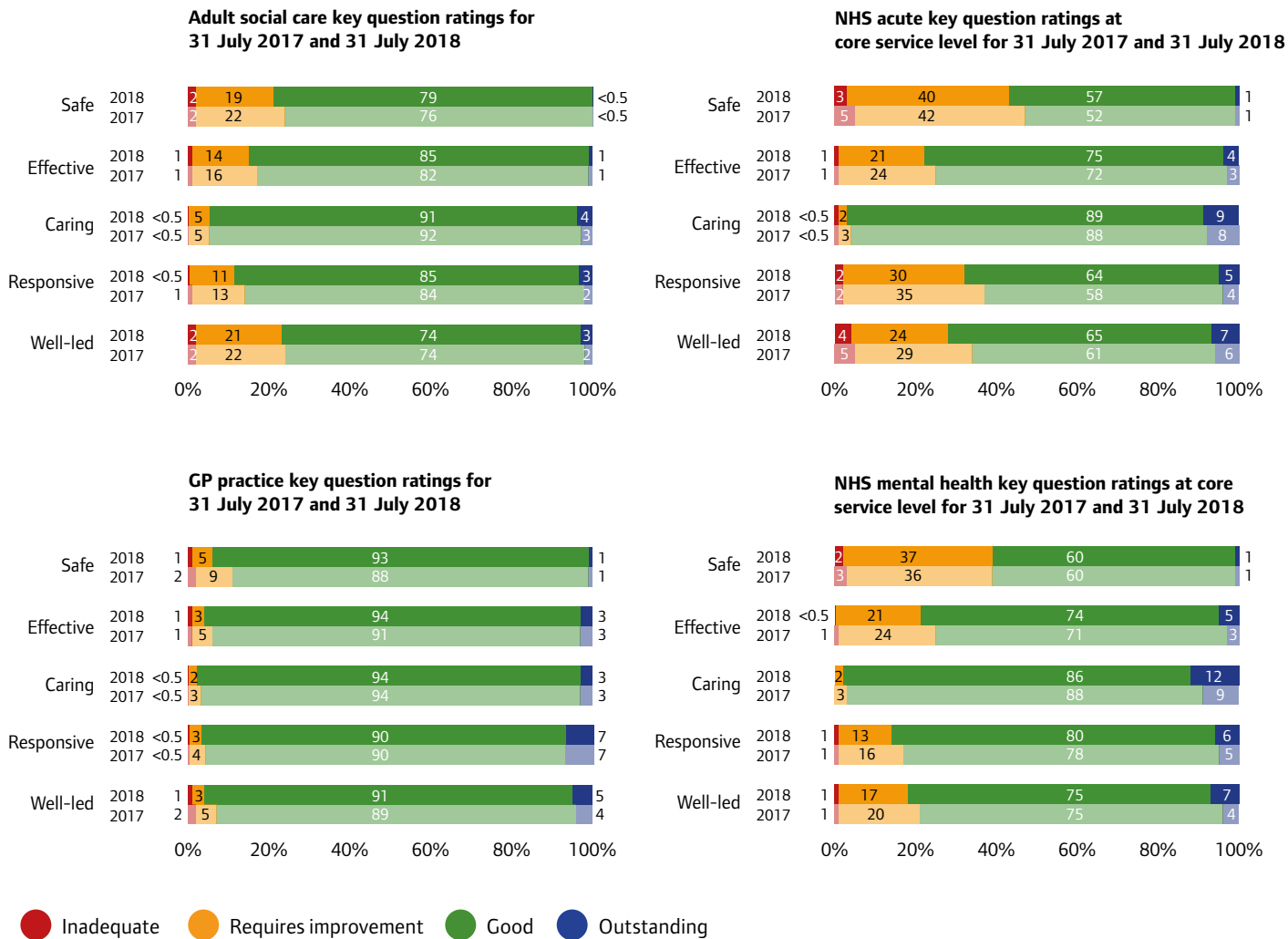
- 91% of GP practices were rated as good, compared with 89% as at 31 July 2017
- 79% of adult social care services were rated as good, compared with 78%
- 60% of NHS acute core services were rated as good, compared with 55%
- 70% of NHS mental health core services were rated as good, compared with 68%.

There were also small increases in the proportion of GP practices, adult social care services and NHS mental health core services rated as outstanding.

The safety of people who use most health and social care services remains our main concern. The issues that affect the safety of people include poor safety systems and processes for managing medicines or determining staffing levels in adult social care, safety cultures in NHS acute hospitals that are not always effective and consistent, and concerns about the safety of ward environments in NHS mental health hospitals.

However, we have been pleased to see improvements in safety in some sectors. Among GP practices, 93% were rated as good for safety at 31 July 2018 compared with 88% rated as good at 31 July 2017 (figure 1.6). In adult social care services, 79% of services were rated as good for safety compared with 76% last year. In NHS acute

Figure 1.6 Main sectors, key question ratings, 2017 and 2018



Source: CQC ratings data, 31 July 2017 and 2018.

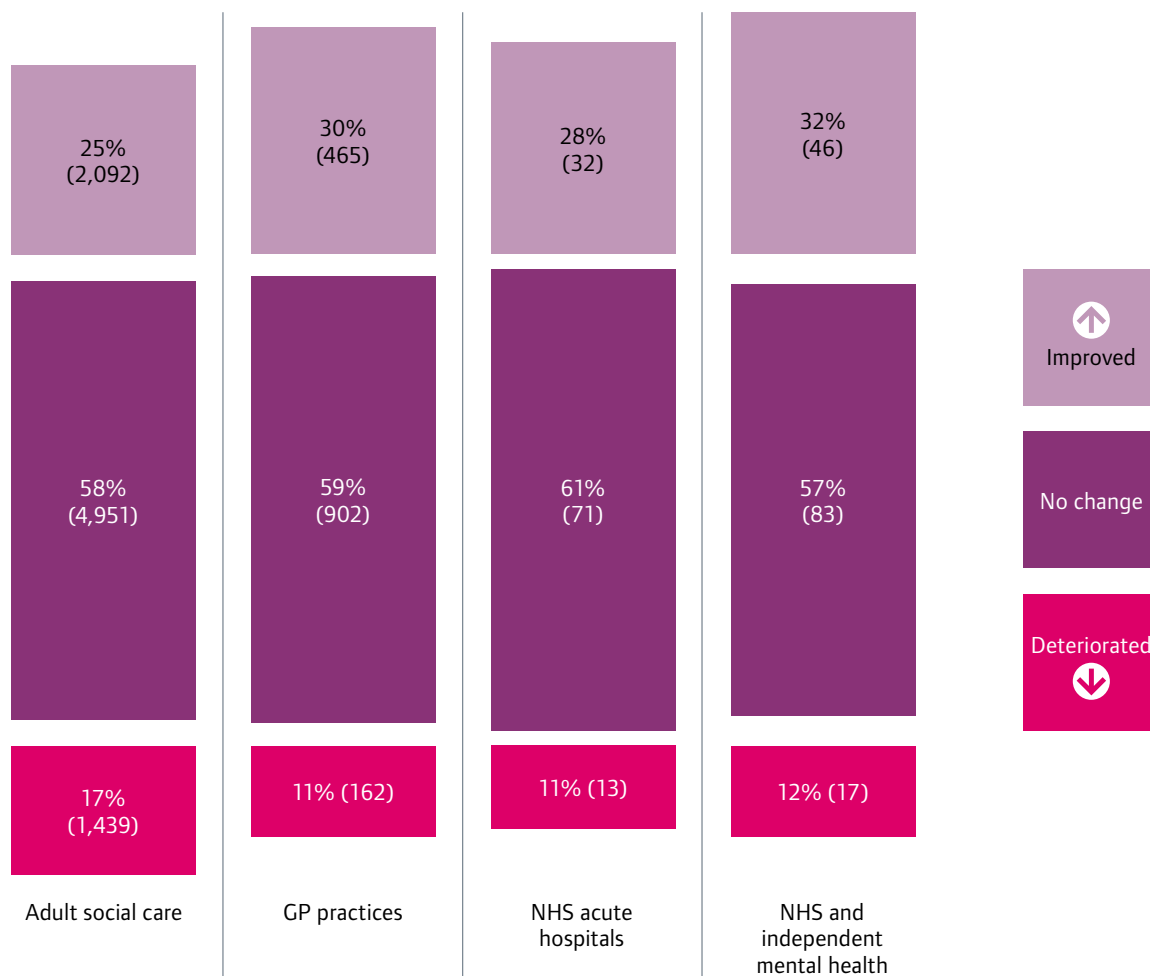
hospitals, 57% of core services were rated as good compared with 52% last year.

We are pleased that the majority of people in England continue to receive care that is good or outstanding. At the same time, it is clear that too many people received a quality of care that is not good enough. As at 31 July 2018, around one in six adult social care services and one in five NHS mental health core services needed to improve, and one in 100 was rated as inadequate. Almost a third of NHS acute core services was rated as requires improvement and three in 100 were rated as inadequate.

The overall ratings picture only goes so far in describing the quality of care in England. There is a great deal of complexity that affects this snapshot of ratings, which includes what happens when we re-inspect (does the service improve, deteriorate or remain unchanged?) and, particularly in adult social care, the impact of services leaving the market and new services entering.

The most common result of re-inspection is an unchanged rating. For example, figure 1.7 shows that in the year to 31 July 2018, across the main sectors we regulate, approximately 60% of re-inspected locations retained their original rating.

Figure 1.7 Overall re-inspection results published in the year to 31 July 2018



Source: CQC ratings data 1 August 2017 to 31 July 2018

Of those services whose ratings did change, we saw more improvement than deterioration – for instance among GP practices, 30% of re-inspected practices improved while 11% deteriorated.

However, as we explore in more detail in the sector chapters in part 2 of this report, the propensity of services to improve will vary depending on their original rating. Services originally rated as requires improvement are much more likely to improve than those originally rated as good. In adult social care for example, just over half of re-inspected services originally rated as requires improvement were able to improve in the year to 31 July 2018, compared

with 7% that deteriorated to inadequate (part 2, figure 2.4).

Among re-inspected adult social care services originally rated as good, however, almost a quarter saw their rating deteriorate – 22% to requires improvement and 3% to inadequate; while, perhaps unsurprisingly given the standards expected of outstanding services, only 4% improved their rating from good to outstanding. These patterns are similar (although not identical) in the other sectors.

We are also seeing some geographical variation in re-inspections. For example, among re-inspected (up

to 31 March 2018) adult social care locations first rated as requires improvement, 58% improved in the North West region compared with 67% in the West Midlands. Meanwhile, among GP practices this figure ranged from 79% in London to 93% in the North West.

For adult social care services originally rated as good that were re-inspected in the same timeframe, only 17% deteriorated in London compared with 23% in Yorkshire and the Humber. Among GP practices, this figure ranged from 2% in the South West to 11% in the East Midlands.

There are many reasons why the quality of care that people receive may improve or decline. We have analysed the factors that underpin changes and variation in quality.

Some of these are external factors – the availability of a diverse and skilled workforce, the increasing demand on all health and social care services, and the funding that is available and how that funding is used to commission care for people. We explore these factors on pages 38 to 47.

There are also internal factors: the quality of leadership of a service and its governance, the culture within a service and how leaders engage staff and the people who use their services.

And there are factors that cross organisations: the extent to which services work in partnership to meet the needs of local people.

Leadership and governance

Capable, high-quality leaders create a workplace culture that enables and supports high-quality care. The quality of management, at all levels, is a key factor in whether the service performs well or poorly and whether it can improve from a less than good rating.

Well-embedded and effective governance processes make it easier for senior leaders to monitor quality and risk. These processes allow a service or provider to identify any emerging issues and tackle them before they become problems.

Having these mechanisms in place will also go some way to enable a service to manage external pressures

or an unexpected change, such as a key member of staff moving on.

A change of management or changes within leadership teams can have a significant impact on the quality of a service, particularly in smaller organisations. The loss of a skilled and knowledgeable manager can have a serious detrimental effect on how well a service runs and the quality of care provided, particularly if succession planning has not been implemented or is of poor quality, or if the replacement manager is not as skilled. Equally, a change in leadership can be a springboard for improvement where managers have been ineffectual or where relationships have broken down.

The relationships between leaders are important too, whether between different levels of management (for example, between board directors and ward leaders) or between peers (for example, partners in a GP partnership). If these relationships are poor, there are often negative consequences for people working at and using the service; if they are good, showing trust and mutual respect, there is more likely to be a positive workplace and a higher quality of care.

An outward-looking leadership approach can also help to support improvement. Our experience of inspecting services tells us that leaders who demonstrate a willingness to learn from and engage with other services, and who acknowledge problems and resolve to tackle them, can be more likely to make positive change to the quality of services.

Culture, engagement and inclusion

We have repeatedly seen that a positive workplace culture, based on meaningful values and an engaged workforce, creates a more person-centred approach to care.

The culture of a service is closely linked to leadership. Leaders at all levels are important to setting, changing or maintaining the culture of an organisation. There can be pockets of poor culture in a generally good organisation (and vice versa). Linked to this is where organisations have, or lack, a culture of learning from problems and an ability to recognise the need to change practice.

A poor culture can lead to staff members not feeling empowered or supported to think beyond the boundaries of the immediate requirements of their own roles. This can be a manifestation of a fearful staff group and a divided workplace, where staff feel disconnected from the organisation as a whole.

Where the culture is good, this affects both staff and people using the service in positive ways. Staff feel empowered and engaged to deliver person-centred care.

There is an association between good and outstanding practice and a focus on equality and inclusion for both people using services and for staff. Equality and inclusion is often embedded into the culture of organisations where good practice is found. Where this happens, leadership teams make considerable efforts to support staff in areas such as training, health and wellbeing, and welfare. And a focus on equality and inclusion for people using the service often goes hand-in-hand with a focus on equality and inclusion for staff.

The delivery of person-centred care is closely linked to a consideration of equality and inclusion for people using services. Our experience of inspecting services, particularly in adult social care, tells us that organisations that demonstrate a commitment to delivering care that is tailored to the needs and wants of individuals tend to also embed equality and diversity into their day-to-day provision of care. Those who do this well involve people who use services and ask them how they want care and support to be provided. This in turn means understanding and recognising the make-up of their local population and what they need.

Partnership working

Partnership working can be an important driver of improvement. Proactive leadership in particular is a key factor, with leaders needing to display an openness to learning from others.

We have seen a link between services that are outward looking and open to developing and improving relationships with partners and sharing learning, and the provision of high-quality care. On

the other hand, services that struggle are sometimes insular and not willing to learn from others.

The amount of support from system partners varies across sectors as well as within sectors across different service types, and this reiterates the need for local areas to work as one to support improvement. Relationships with commissioners are particularly important. Positive engagement with CCGs and local authorities can be central to overcoming problems within services, and commissioner-led support networks can help services to improve.

Working in partnership with people using services can support the provision of high-quality care. We have seen the benefits of adopting a collaborative approach between community groups and health sector organisations to try to understand and meet the needs of the local population. Identifying gaps in provision and working with partners to plan and deliver local solutions can lead to more responsive, timely experiences of care.

Improvement and deterioration

Where we have seen the quality of care improving or deteriorating, it is linked to the themes that we have identified above. In the following examples these themes – leadership and governance, culture and engagement, partnership working, workforce

challenges, increasing demand, and funding and commissioning – often come together in different ways to influence the extent to which providers are able to deliver good-quality care.

Improvement examples

Primary medical services

Following an inspection, **Litcham Health Centre** at King's Lynn in Norfolk needed to improve how it reported significant events and assessed risks to patients, staff and visitors, and also improve measures for infection control and prevention.

A re-inspection found significant improvements and some examples of outstanding practice, such as a specialist community support team and an innovative system to monitor patient outcomes.

The GP partners recognised some operational weaknesses, and so a surgery management advisor came in one day a week to help. To overhaul the governance and management, two practice managers were also brought in. The starting point was to address the key issues of policies and procedures, training and the building environment. The practice managers met every department to introduce the policies and tell staff where to find the information. There is now a log for significant events, which are acted on straight away and discussed at a weekly practice meeting.

Another new initiative is the 'patient passport' system. Patients have a smartcard that links to the data held on the practice's system. Scanned at reception when a patient arrives, the patient passport alerts staff if any outstanding tests are due or if additional clinical input is needed. The

patient passports are directly linked with local hospital data and allow the extended healthcare team to access the patient's key medical information outside of the practice.

The practice also holds a weekly meeting to review patients who have been admitted to hospital, and checks their records to see the reasons why.

Adult social care

We inspected **The Potteries** care home in Poole, Dorset, which found a need for significant improvements. The home's ratings improved each time following two re-inspections.

A unit manager stepped up as interim manager and then successfully applied for the permanent role. To support the improvement work, the home's head office provided an operational support manager and other resources. The company also stopped new admissions during the improvement.

A major issue for the service was lack of staff continuity, as it relied heavily on agency staff. At one point, agency workers were covering 600 hours of care a week. It was decided in the best interests of residents and staff to end the reliance on agencies and a recruitment and retention programme was implemented.

When internal communications were poor, staff sometimes received mixed messages from managers. One way this was addressed was by

introducing a short daily managers' meeting at 10am, with the notes posted in staff rooms and fed back through regular team meetings. The manager also has a daily 'flash' meeting at 3pm to get updated on issues on each floor.

From the start, staff were encouraged to share ideas about improvements. They felt more valued and can now nominate colleagues for monthly staff awards.

The Potteries has a customer relations manager, who works with external networks such as dementia support groups, memory clinics, the Women's Institute and church groups. It has teamed up with local schools and the Young People of the Year charity to help recruit about 60 local students as 'befrienders'. Residents look forward to the regular visits, and enjoy chatting with the students over tea and cake – often reminiscing about their younger years.

The Potteries has good links with the local authority, having a mix of local authority and private paying residents. There are also now better links with local GP practices and district nurses.

Acute health care

In less than three years, the **University Hospitals of Morecambe Bay NHS Foundation Trust** demonstrated a remarkable improvement journey from special measures.

This trust – with three hospitals – set out a plan for improvement based on principles including better staff relationships and ensuring they had the right partnerships in place to support what they wanted to do.

Recognising its problems – including low morale, staff shortages and unmet training needs – the trust embarked on a cultural change, to “get everyone on the same page” and to “get people to think and act differently”.

The trust acknowledged it needed to improve on safety. The leadership engaged with staff and was purposeful in looking outwards to influence change. They got involved with GPs and asked

the local population for participation to help improvement, and that is something the trust is still doing today.

With clear priorities and its improvement plan in place, the trust came out of special measures and just over a year later it achieved its good rating.

Mental health care

In under two years, **Somerset Partnership NHS Foundation Trust** was able to improve its mental health services, particularly its community mental health service for people with a learning disability or autism, which have improved remarkably.

Workforce involvement was instrumental in improving the service, and leadership at the trust level was a key factor.

Staff have described the importance of a team leader's “visibility, transparency and commitment to involving staff in the improvement plans”. Staff had previously said they did not feel involved in change, and an inspection cited an example where psychologists were tied-up doing assessments to see if people could get income support, rather than providing counselling or therapy services.

To improve the service, a culture change was needed. We saw that new leadership offered a “positive and inclusive attitude”, not a blame culture. The trust had looked externally for ways to improve, visiting another trust to see good practice, and getting advice from the national development team for inclusion. Closer working with the local council and Healthwatch was included in the improvement actions, including developing a single point of access for people who need help.

The trust told CQC it no longer sees improvement as a “CQC-led” action. Staff want to improve further and they are using a person-centred approach to care in their further improvements.

Deterioration examples

Mental health care

Internal and external factors, potentially manageable in themselves, can combine to cause deterioration in the quality of care provided by a service.

One independent hospital we inspected was providing adult low secure forensic services, as well as child and adolescent psychiatric intensive care units (PICUs). On an inspection, we found that the quality of care provided for children and young people had deteriorated since our previous inspection.

The deterioration was largely confined to the children and adolescent PICU service. NHS England stopped placing young people at the hospital, and the children and adolescent mental health services PICU wards closed permanently.

Staff in the child and adolescent service did not possess the experience, skills and competencies to safely manage the complex behaviours of young people in their care, and systems for maintaining the quality of care broke down.

Staff morale had deteriorated – there was insufficient support for the people who worked there; there were also inadequate staffing levels for managing the complex needs of patients. Problems combined (national staff shortages and the high costs of living locally) and safety on the PICU ward had become a major concern, with high numbers of serious incidents.

Following these issues, we re-inspected the service and found that substantial improvements had been made.

Adult social care

A care home with a history of poor inspection ratings was inspected five times in three years – its rating went up and down during this period. A consultancy took over the management of the service for the registered provider, and the registered manager had made improvements.

However, by April 2017, the location had deteriorated. At this time, some people were at risk of unsafe care and care had become task-based rather than person-centred. Poor management and leadership were at the heart of the problem. The registered manager had been replaced by a succession of peripatetic managers, which led to instability in management and poor staff support. With limited oversight of the service, there was little action taken when problems were identified.

Although there was an advanced tool to work out accurate staffing levels, we found that there were not enough staff to provide safe, effective and responsive care. As a result, staff were rushed and stressed. The culture of the service became entirely task-based as staff worked hard to provide essential physical care but had no time for meaningful engagement with people.

Set in a wider context of workforce issues in adult social care, the service also had problems with the recruitment and retention of staff, particularly registered nurses. As a result, the home relied heavily on agency nurses, which affected the consistency of care people received. These problems can be seen to have been related to low wages, the inability to recruit staff locally and a lack of public transport.

Following these issues, we re-inspected the service and found that substantial improvements had been made.

Acute health care

An acute NHS trust we inspected was facing increasing demand and it was not able to increase capacity to meet the demand. There were problems with the flow of patients through the hospital, resulting in long waiting times and frequent use of escalation areas, as well as staff training and staffing levels.

The trust was subject to other external factors. An upcoming merger caused pressures, and a nearby hospital was put into special measures (increasing demand on its neighbouring hospitals). Also, this was in a local area with too few residential care beds.

In addition, the trust's relationships were sometimes strained with the CCG and other stakeholders.

Patients at the hospital were feeling the impact of some of these problems. Some were deprived of their liberty without necessary safeguards, there were delays to assessment and treatment, and increased incidents of patient harm were observed.

Primary medical services

Deterioration in leadership was at the root in a medium-sized GP practice that we inspected, caused by a breakdown in the partnership arrangements.

There had been two GP partners, but one went on long-term leave. This left the remaining partner to take full responsibility for the leadership of the practice, but they did not have enough managerial experience to do this.

The isolation experienced by the remaining GP partner was apparent. It had an impact on the service and the GP's own health and wellbeing.

To make matters worse, the practice manager was due to leave and the communication between the outgoing practice manager and remaining GP partner was strained. The result was that neither had taken ownership for tasks that went beyond the day-to-day service delivery – for example, not attending to audit, reviewing and updating policies and procedures, and organising staff records.

Following these issues, we re-inspected the service and found that substantial improvements had been made.

Workforce planning

Health and social care bring together the two biggest workforces in England, combining to make the country's largest industry. In 2017/18 there were about 1.47 million people working in adult social care³² and about 1.2 million working in the NHS in England.³³

Capacity within the health and social care workforce is a significant and ongoing challenge – many health and care organisations are struggling to recruit, retain and develop their workforce to meet the needs of people they provide care for.

As we reported in our local systems review, each sector has its specific challenges:

- **Adult social care:** Challenges in recruiting and retaining care workers and nursing staff were common, and were affecting systems' ability to meet people's care needs in care homes and in the community.
- **General practice:** An ageing workforce, coupled with challenges in recruiting and retaining newly qualified GPs meant that the workforce was unstable in places and impacted on people being able to access their GP.
- **Acute medical care:** Shortages were reported across staffing groups and could particularly affect urgent and emergency care.
- **Community health:** Shortages in community nursing were affecting the delivery of responsive, seven-day care. A lack of allied health professionals was affecting the timeliness of people's discharge from hospital and step-down care.
- **Social services:** A lack of social workers could mean that they were working with high case-loads of people with complex needs, and having an impact on the timeliness of support for older people.
- **Ambulance services:** The shortage of paramedics was affecting the ambulance services' ability to respond to emergencies in a timely way.

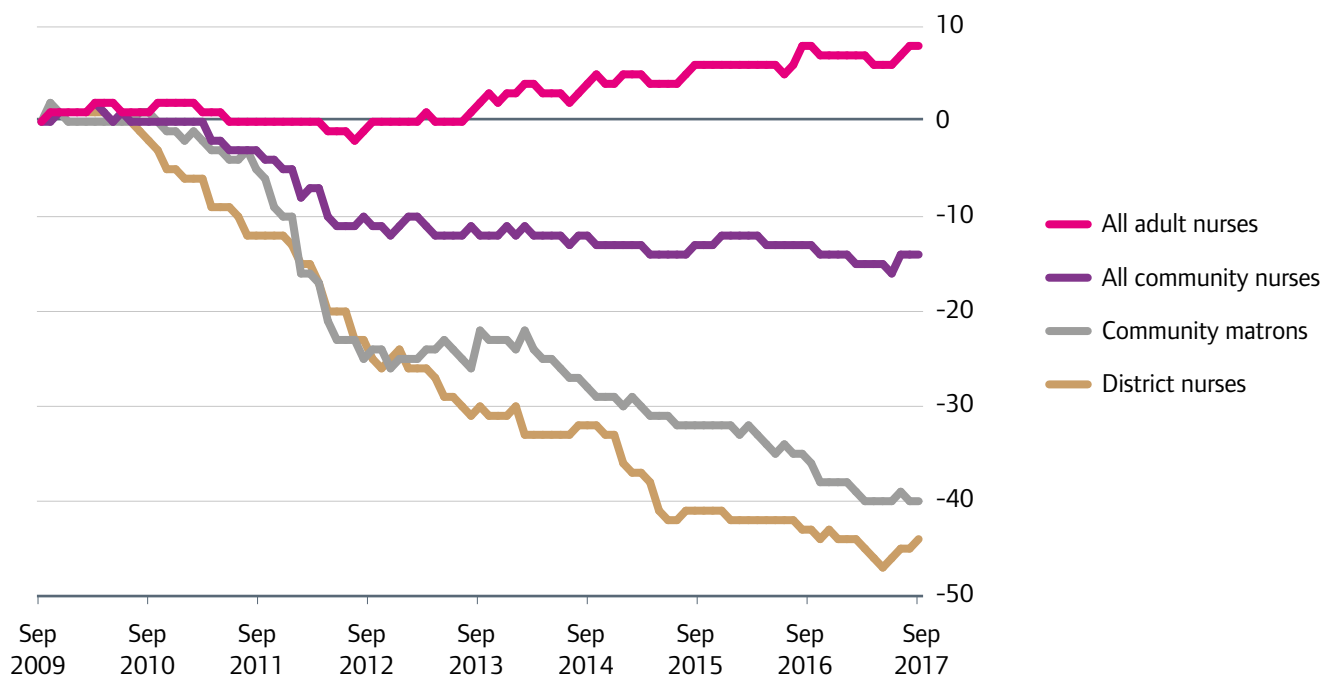
From 2009 to 2017, there was a 40% fall in the number of community matrons and a 44% drop in the number of district nurses (figure 1.8). During the same period, the number of nurses caring for adults in hospitals increased by 8%, although this was in the context of a rise in demand of about a fifth; in that period total monthly non-elective general and acute admissions increased by 21%, monthly GP referrals rose by 17% and monthly first outpatient attendances (general and acute) rose by 23%.³⁴

The referendum vote to leave the European Union adds to the uncertainty in health and care in the challenge to recruit and retain staff. There has been a sharp fall in the number of first registrations with the Nursery and Midwifery Council from nurses and midwives from EEA countries (9,389 in the year to March 2016 compared with only 805 in the year to March 2018). During the same period, there has been a sharp rise in the number of EEA nurses and midwives leaving the register (1,981 in the year to March 2016, 3,962 in the year to March 2018). This was only slightly offset by a rise in the total number of nurses and midwives from outside the EEA.³⁵ This suggests that we are already seeing an impact on nurse staffing ahead of Brexit in March 2019.

In adult social care, the highest vacancy rates in all regions in 2017/18 were for the regulated professions that include registered nurses, allied health professionals and social workers. They reached 16% in the East of England and 15% in London. Vacancy and turnover rates for all staff groups are generally higher in domiciliary care agencies than in care homes.³⁶ This fundamental recruitment and retention challenge – alongside issues for the sector of geographical and funding disparities – is echoed in a forthcoming King's Fund report on domiciliary care.

In primary care, there has been a continuation of the trend towards part-time working by GPs, with the number of full-time equivalent (FTE) GPs continuing to fall from September 2016 to September 2017 (from 34,495 to 34,091 while the total headcount has risen from 41,865 to 42,145). Using the ONS

Figure 1.8 Percentage change of NHS full-time equivalent nurses, September 2009 to September 2017



Source: NHS Digital, NHS Hospital and Community Health Service (HCHS) monthly workforce statistics - Provisional Statistics.

mid-year population estimates, the number of FTE GPs per 10,000 people peaked in 2009 at 6.91 and is now 6.13. Regionally, there is a wide variation in the number of FTE GPs per 10,000 registered patients, from 4.6 in London, Greater Manchester, and Lancashire to 5.4 in the South West.³⁷

In *Are we listening?*, our review of children and young people’s mental health services, we reported that staffing shortages are a significant barrier to high-quality care. Low staffing levels were the most common reason for delayed access to children and young people’s mental health services. We heard that high levels of staff turnover and reductions in funding for services contributed to staffing shortages and a large number of vacancies. Services found that it took a long time to recruit appropriately-trained staff to vacant roles, and some posts – such as managerial roles or part-time jobs – were particularly difficult to fill.³⁸

Difficulties associated with staff shortages created further challenges. For example, staff could not improve their skills and expertise because there were not enough other staff to cover their normal duties while they were training. The increased workloads caused by staffing shortages also put more pressure on people working in services, which in turn affected their own health and wellbeing. Staff could get ‘burned out’ and some people wanted to leave the mental health profession – which, in turn, would further exacerbate the staffing shortages that had caused increased workloads and affected people’s morale in the first place.

Staffing was also a particular area of concern when we looked at how NHS emergency departments were coping with the extra demand they are facing. In our report *Under pressure*, we highlighted our concerns about the wellbeing of staff working under considerable pressure in clinically high-risk

environments. This is made worse by shortages of key staff in many departments. A number of our inspections found that many emergency departments were failing to meet the recommended 16 hours a day consultant cover, as recommended by the Royal College of Emergency Medicine.³⁹

Some trusts were using staff modelling tools to look at nursing staff numbers. For example, we found the 'safer nursing care' tool had been adapted for emergency departments to establish the number of permanent nurses and healthcare assistants employed. This led to an increase in nursing staff numbers, following a successful recruitment programme.

However, nursing staff levels remained a challenge and many trusts continued to use a high level of bank and agency staff to maintain planned staffing levels both in the emergency department and also in inpatient escalation areas. Often there were not enough suitably qualified, skilled and experienced nursing staff in these areas.

In many cases, different local services are competing with each other to recruit from the same pool of skilled and qualified staff. While some local systems were working proactively to develop career pathways and raise the profile of the health and care sector, the competition from other sectors, such as retail or hospitality, was making recruitment and retention of paid care staff a significant challenge.

To enable health and care staff to build skills, knowledge and experience, some systems are developing accreditation style 'passports' that are recognised across health and social care organisations, allowing staff to easily move across health and social care roles. Nursing associate roles are being developed in several systems, some allowing for rotation across the hospital, community and social care.

We have seen examples of staff working safely beyond the boundaries of their traditional roles – for example, paramedics supporting out-of-hours primary care services to provide home visits, reducing pressures on general practice. Through the effective deployment of advanced nurse practitioners in urgent care centres, medicines could be prescribed

without having to wait for a GP, considerably reducing delays.

In Oxfordshire, we saw some GPs had employed nurses or paramedics to do many regular patient reviews and some visits that would normally be carried out by GPs. In York, there were nurse associates rotating around the NHS trust, community care and adult social care – and the Yorkshire Ambulance Service NHS Foundation Trust had offered placements to nurse associates.

We also visited Bracknell Forest. Here we found multidisciplinary care workers, including a social worker working in the emergency departments to prevent avoidable admissions and to improve patients' onward care. Frimley Park Hospital had a senior nurse in place in A&E who would, alongside an initial assessment, also offer patient education with a focus on self-care.

In Manchester there was GP support in an A&E department until 10pm – they saw six to eight patients per hour. We saw the same in East Sussex, with GPs in emergency departments in Brighton and Eastbourne Hospitals. In Hartlepool, enhanced care paramedics also prevented avoidable admissions, treating people at the scene and referring them to GPs, out-of-hours services or NHS 111.

▶ Building a more sustainable care home workforce

Effective partnership working has enabled Wakefield to begin planning a more sustainable care home workforce. A 'passport' for care home staff and investment in training and development will help the local system to create 750 jobs a year by 2025, a 50% increase in care home workers from the current 14,250 to 21,000, to meet the needs of a projected 22% of people aged over 65.

Source: NHS England

In Coventry there was an urgent primary care assessment service, where an advanced nurse practitioner-led service accepted referrals. Also aiming to prevent unnecessary hospital admissions, we found that people in crisis in Cumbria could be routed to a 'hospital at home' team or an acute assessment unit, where they could be seen by a GP or advanced nurse practitioner, or get help in a frailty service.

Having the right number and mix of skilled, permanent staff in an organisation's workforce is a key driver of high-quality care. The ability or inability to achieve this can be one of the main factors behind providers' improvement or deterioration in quality and ratings.

National staffing shortages in some areas of care, as well as the relative attractiveness to potential employees of different types of service in different locations, contribute to the challenges that services face – even in otherwise high-performing organisations. The employment market is extremely competitive, and we often see high levels of turnover and staff movement.

Shortages of qualified staff can have a substantial impact on the quality of care, with some roles and specialties facing more severe shortages than others. High reliance on agency, bank and locum staff can often be a characteristic of poor performing services.

The geographical location of a service can affect its ability to recruit and retain staff in a number of ways. The cost of living in an area can be an important factor in services' ability to recruit staff – particularly in areas surrounding London, as they have a high cost of living but do not attract London weighting. We have seen on inspection that some providers can find it more difficult to recruit if a service is in a particularly rural or isolated location.

While national and local workforce issues are usually beyond the control of individual organisations, leaders can make a substantial difference to the quality of care by how they plan and manage the deployment and training of staff.

Ultimately, the development of a comprehensive local workforce strategy will bring together the ways that organisations work together and the ways that care staff work together. This includes new roles such as physician associates, nurse practitioners and healthcare assistant apprenticeships that some organisations are developing in response to the workforce pressures, alongside new career pathways that will bring health and social care organisations together.

Capacity of providers to meet demand

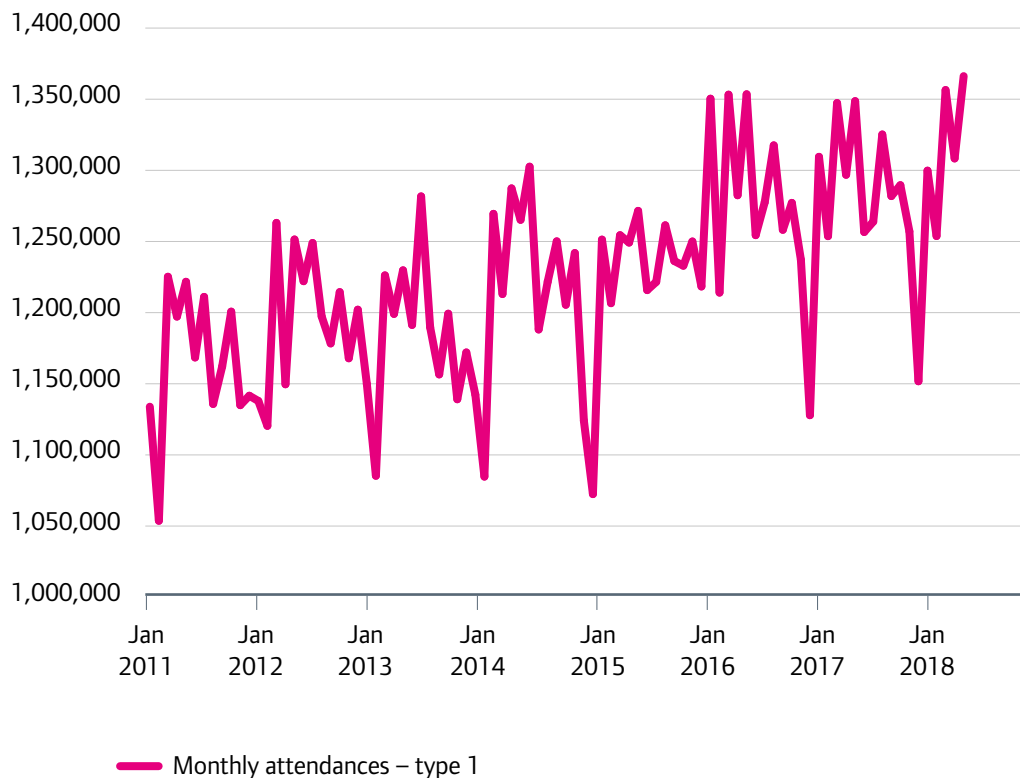
England's health and adult social care services face a formidable challenge. Older people are more likely to use health and social care services and they are the fastest growing demographic. The number of people aged 90 and over living in the UK in 2016 was the highest ever: 571,245, compared with 416,368 in 2006.⁴⁰

Demand is rising inexorably not only from an ageing population but from the increasing number of people living with complex, chronic or multiple conditions, such as diabetes, cancer, heart disease and dementia. The total number of years people can expect to live in poorer health is steadily growing.⁴¹

Demand for urgent and emergency care services continued to rise in 2017/18, with more attendances at emergency departments than ever. There were

15.4 million attendances at major A&E departments in 2017/18, a 9% rise on 2011/12. Figure 1.9 shows that July 2018 actually saw the highest monthly number of attendances since at least January 2011, nearly 1.4 million. However, it is in the winter when, although the number of attendances tend to be lower than in the summer, hospitals really feel the pressure as more people attend with complex needs that require admission to hospital. In January 2018, almost 31% of attendances at major A&E departments resulted in admission, the highest proportion since at least January 2011, and the Health Foundation has reported that the total number of emergency admissions grew by 42% in the 12 years to 2017/18.⁴²

Figure 1.9 Monthly attendances at major A&E departments, January 2011 to July 2018



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

The capacity of healthcare services to meet the increase in demand is being felt across the sector. The number of cancelled operations hit a five-year high in the final quarter of 2017/18 (figure 1.10).

The capacity of adult social care provision continues to be very constrained. From April 2017 to April 2018, the number of nursing homes decreased by a further 1.4%, with a drop of 0.2% in the number of nursing home beds (347 beds) (figures 1.11 and 1.12). The number of residential homes decreased by 2.4% during the same period, also with a reduction of 0.2% of beds (418 beds). In contrast, the number of domiciliary care agencies has continued to rise since April 2017, by 4.3%.

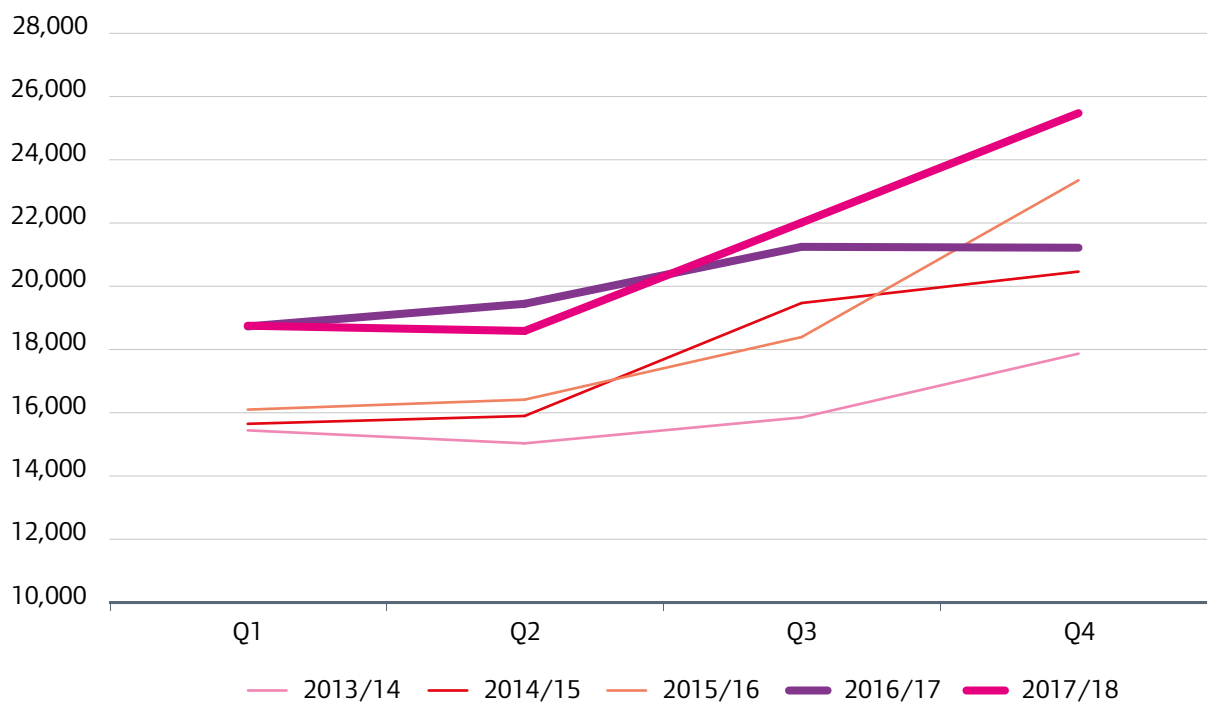
At a local level there was a great deal of variation in these trends. Looking at the change in nursing home beds for example, over a slightly longer period from April 2016 to April 2018, the range was from a 58% loss to a 44% rise. The 32 local authorities with

more than a 10% loss in nursing home beds were dominated by those in the North East, London and the West Midlands, with 17 coming from these areas. These also tended to be areas with lower proportions of people paying for their own care independently (figure 1.13). Of the 19 areas that gained at least 10%, nine were in the South East, South West, and East of England, where higher proportions of people fully fund their own care.

In some cases, it appears that nursing homes may be re-registering as residential homes, possibly due to difficulties in recruiting enough nurses. Some of the areas with the highest nursing home bed loss also saw some large rises in the numbers of residential home beds.

The demand for services is changing, and this is affecting organisations' capacity to meet the requirements of the people they are caring for. This manifests itself differently across the sectors, but

Figure 1.10 Operations cancelled for non-clinical reasons, by quarter, 2013/14 to 2017/18



Source: NHS England, Quarterly monitoring of cancelled operations.

overall services are seeing people with a higher level of need and more complex, multiple conditions than before.

Socio-economics, demographics and geography also play a role in shaping demand on services. These will be different in different areas. For example: inner city services may have higher levels of deprivation, and a population that faces more barriers in accessing services and therefore is more likely to present with complex health problems; services in some more affluent areas may serve a larger population of wealthier retired people who have different expectations from their local services; community nurses, home care staff and ambulance services in rural areas have large areas to cover, meaning staff have to travel further to provide care.

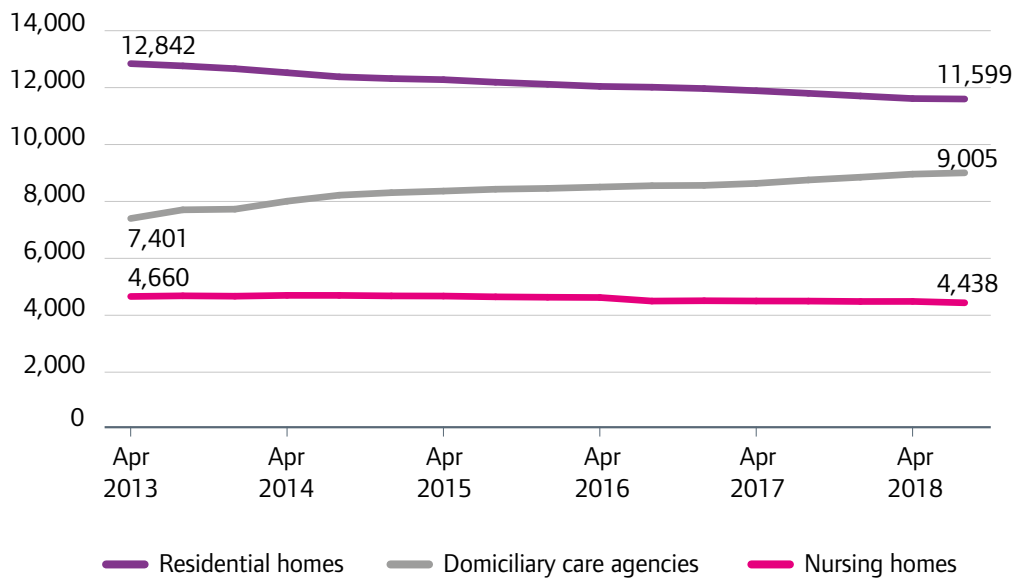
Surges in demand triggered by other poor performing services can lead to deterioration in the quality of care. For example, secondary and primary care

services can be sensitive to changes in the local health economy. When services close, are rated as inadequate or enter special measures, the impact is often felt across the system, with hospitals, GP and urgent care services having to respond to a sudden influx of patients without the benefit of increased resources.

Stretched capacity, limited resource and demand for inpatient beds can lead to patients being treated in inappropriate places, reaching crisis point before they access care or being discharged too early. This is a particular issue for those with complex needs such as people with a learning disability, mental health condition and/or long-term condition.

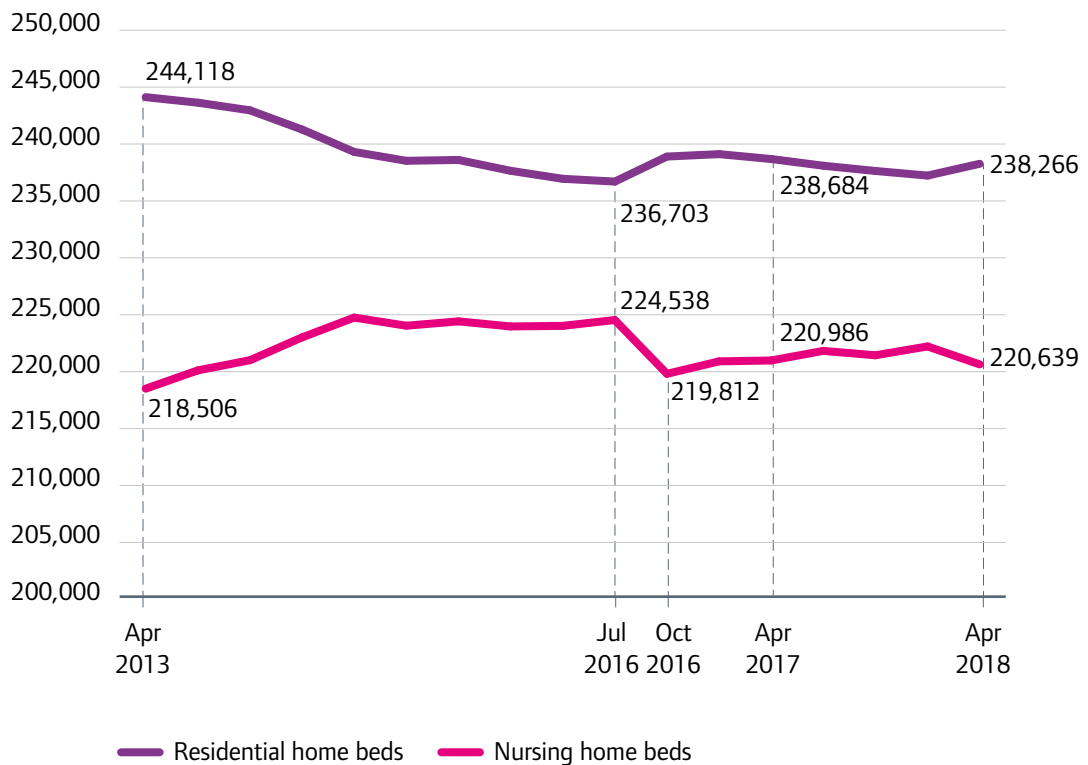
In adult social care and independent health care, a business drive to fill beds combined with pressure from commissioners to take on people with more complex needs can be a risk for the quality of care.

Figure 1.11 Number of adult social care locations registered with CQC, April 2013 to April 2018



Source: CQC registration data.

Figure 1.12 Care home beds in locations registered with CQC, April 2013 to April 2018



Source: CQC registration data.

However, while increasing demand on services can make it harder to maintain the quality of care, we have seen services that have developed ways to cope with demand or been able to improve despite system pressures. It is important that services do not use the increases in demand as an excuse for providing

unsafe care. The responsibility remains to work with the system to understand local population needs, to manage services effectively, to make any internal changes required to improve the quality of care, and to adopt proactive and creative approaches to overcome challenges raised by increasing demand.

Funding and commissioning of services

Across all sectors, funding and commissioning structures and decisions have an effect on the provision of high-quality care, and on the ability of underperforming services to improve.

The financial challenges facing care providers in recent years are well documented. Age UK in its report *Behind the Headlines* reported that from 2009/10 to 2016/17, the average spend per adult on social care fell 14%, from £439 to £379, and from 2008/09 to 2013/14 more than 400,000 fewer older people received social care as eligibility criteria tightened in response to reduced resources.⁴³ In addition, Age UK reported how the amount of home care provided by councils fell by more than three million hours since 2015. Recent annual increases in NHS spending have averaged 1.1% a year (2010/11 to 2014/15), compared with an average annual increase of 3.7% since the start of the NHS.⁴⁴

In June 2018, a long-term NHS funding plan was announced. This promises that, by 2023/24, the NHS England budget will increase by £20.5 billion in real terms compared with today.

For health and social care to plan collectively as a system for the long-term, funding security is required across both sectors. Some extra funding for adult social care has been enabled by the government through channels including the adult social care precept, the Improved Better Care Fund and two grants from central government. These added up to an extra £2.3 billion in 2017/18 and much smaller additional amounts in the following two years.⁴⁵

In its latest annual budget survey, the Association of Directors of Adult Social Services (ADASS) acknowledged that this additional funding has enabled many councils to considerably reduce the numbers of people delayed in hospital and to balance budgets nationally.⁴⁶

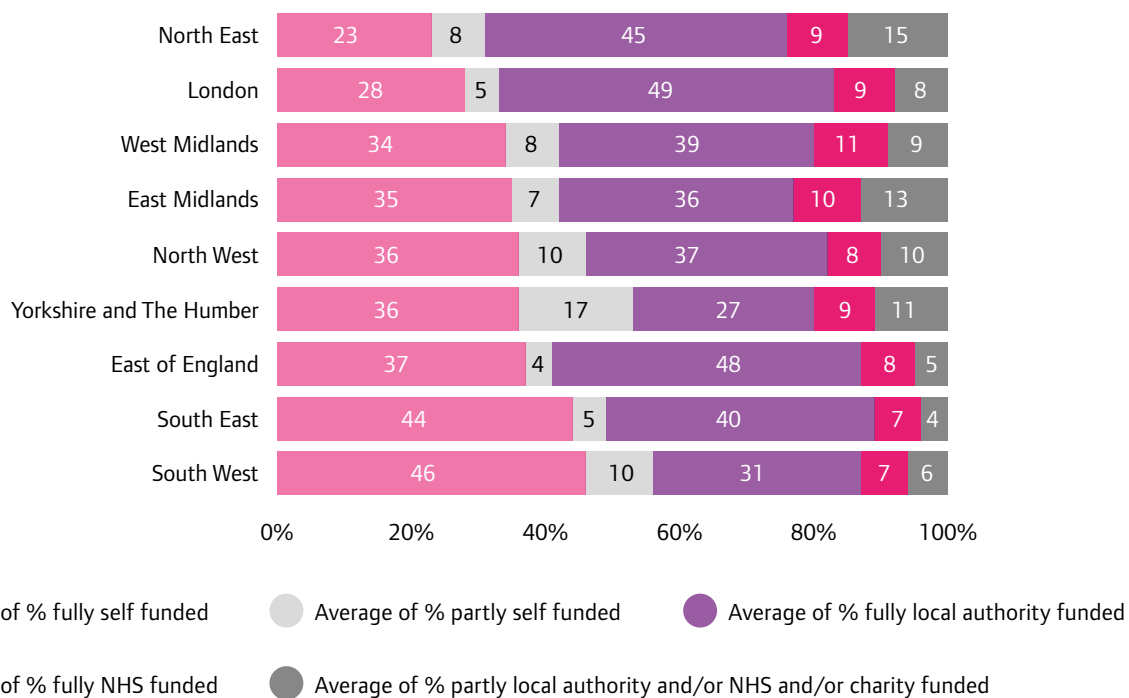
However, ADASS warned that this was a short-term injection of funding and, despite it, fewer older and disabled people with more complex care and support needs were getting long-term care. The area of greatest concern to councils is the increasing cost of care packages for growing numbers of people, both older and younger adults with complex needs, and their families.

This adds to the fragility of the social care market, in particular home care. In the budget survey, 32% of directors of adult social services said they have seen home care providers closing or ceasing to trade in the last six months, affecting 3,290 people (although this compares with 39% affecting 5,670 people in the 2017 survey). Twenty-nine per cent reported that contracts had been handed back by home care providers, affecting 2,679 people in the same period (again a slight improvement on the previous year, when 37% reported this, affecting 3,135 people).

More than three-quarters of directors (78%) were concerned about their ability to meet the statutory duty to ensure market sustainability within existing budgets. Moving towards prevention and early intervention was an important priority for councils, to support a reduction in demand for long-term health and social care. However, ADASS warned that, as budgets reduce, it is becoming harder for councils to manage the tension between prioritising statutory duties towards those with the greatest needs and investing in services that will prevent and reduce future needs.

These concerns inevitably have an impact on providers of adult social care, many of whom are in the private and voluntary sectors. Across the country there are substantial variations in the proportion of people using services who are funded by their local authority, the NHS or charities, and those who pay

Figure 1.13 Distribution of non-specialist care home funding source by region, November 2017



Source: CQC, residential adult social care provider information returns. Figures are based on responses from individual providers, averaged across each region.

for themselves fully or partially. Our data suggests that the areas with the lowest reliance on self-funded care are the North East and London, with the South West and South East at the other end of the scale (figure 1.13). In the current funding climate, the areas with the highest reliance on public funding are likely to be considered least financially sustainable by adult social care providers.

It is also intuitive that areas with more self-funders are likely to have lower general rates of unemployment, which in turn may affect providers' ability to recruit in those areas. We have found a weak but statistically significant correlation between low unemployment and high care home vacancy rates at local authority level.

At the time of writing there is no long-term funding solution for adult social care. A sustainable financial plan for adult social care will be an important element of both the forthcoming social care Green Paper and the wider Spending Review.

In July 2018, we reported on the way health and care systems work for older people. We concluded that sustainable funding reform that addresses social care and the NHS together is needed, to remove the barriers that prevent social care and NHS commissioners from pooling their resources and using their budgets flexibly to best meet the needs of their local populations.

Our analysis shows that relationships with commissioners are central to supporting improvement. The way in which individual services are supported and managed by clinical commissioning groups (CCGs) and local authorities can have important implications for the quality of care.

Proactive and strategic approaches to planning and managing commissioning across local systems create the condition for good, joined-up pathways of care and effective system working. However, gaps in commissioning and funding can have significant impacts on other services.



Services across adult social care, primary care, acute health care and mental health care operate within a complex commissioning environment. The manner in which services combine multiple funding contracts, from public and private sources, can be challenging. In general, there is regional variation in the amount of money available to provide health and social care services, and in some specialist areas, there is uneven distribution of commissioning budgets. We have seen through our local systems review the impact of this variation on people's experiences of care. Long-term the variation in commissioning and funding will have an impact on all services in an area.

Federated GP practices – saving hospital attendances and money

The 14 multi-specialty community providers (MCPs) bring together networked or federated GP practices to operate on a large enough scale so they can provide a wider range of services outside of hospitals and include GPs, hospital specialists, nurses, community health services, psychologists and social workers.

For example, in Dudley the team has reduced the average length of stay for non-elective admissions, with an estimated 9,600 bed days saved between April 2014 and August 2016 with an associated cost-saving of £2.1 million. A combination of population health management, community engagement, supporting self-care and patient activation, flexible use of estates across the entire system, a positive culture of continuous improvement and proactive community-based approach to urgent care have been identified as success factors.

As well as this, pharmacists, working alongside teams in local GP practices, have helped reduced mortality from hypertension.

Source: NHS England

Re-thinking nursing care

In Staffordshire, the county council has commissioned two new dementia centres of excellence – the services will be registered as care homes with nursing and will provide specialist care and support with an “in-reaching” nursing model.

Accord Housing Association has been awarded the contract by the council, and the contract includes the transfer of three existing council care homes into Accord's management. Once developed, staff and customers from the existing care homes will move into the new residences, the first of which is due for completion in November 2018.

This care and nursing model has been developed in conjunction with the council and local CCG, with input from local clinical partners. This model ensures that people can be cared for within the service up to the end of their lives.

Among various local issues, the model aims to tackle issues with recruitment of good quality nurses and access to a multi-skilled workforce, and to enable the best clinical care for people with dementia, who often have multiple health conditions and complex care needs. Care staff will receive training to enable them to undertake a range of low-level monitoring and screening, supporting frontline staff to identify early signs of illness.

Accord describes its approach as “rethinking nursing care” to offer care that is different to the traditional nursing model, building on the learning of the NHS vanguards to influence its care offer.

The plans include in-reach specialist nursing, providing planned and 24-hour responsive clinical input. Clinical staff will reflect the spectrum of people's needs, from registered nurses to specialist palliative care nurses. Formal contracting arrangements will be in place for each of the providers and an overarching partnership agreement between all the providers, the council and the CCG.

3. Working together to meet people's needs

In chapter 2, we explored the five areas that need to be considered together to ensure that people can continue to receive good quality care: access to care and support, the quality of care that people receive from care services, workforce planning, capacity of providers to manage the needs of local people, and funding and commissioning of services.

It is clear that across the country there is substantial variation in all of these areas. As a result, while most people receive a good quality of care, there are some people who do not receive the same quality of care as others, and many people struggle to get timely access to care and support at all.

There is no easy answer to the question: which areas of England are performing better than others? The challenge for every local health and care system is to consider all of these factors in making sure that care organisations are joined up and strategically focused on delivering high-quality care around people's needs.

Challenges for different population groups

Our review of the way older people move between health and social care services showed that while people may often use individual, high-quality services, their experience of care is sometimes poor. This is influenced by a wide range of local factors.

One thing that is clear from our work is that nationally, there is no such thing as one recognised 'system'. And locally, there is not one systematic approach to the process of commissioning and providing health and care services that is universally used or followed by health and care providers across different local areas.

For any group of people, the system of care and support that surrounds that group or issue will be unique. For children and young people's mental health, for example, the system that should be there to support them locally is different from the system that helps older people get out of hospital. If you have diabetes and the complications that arise from

diabetes, the system that should be there to support you is different from the system for if you have dementia. Moreover, each 'system' revolves around the specific needs of those people and the pathways of care they need.

We asked representatives of our inspection teams for their thoughts on the challenges facing different groups of people, and on the areas that each different local system needs to address:

- **People with a learning disability**– There are some concerns about continued inequalities in health and social care provision for them. For example, the deaths reviewed by the Learning Disabilities Mortality Review show that the median age of death for people with a learning disability is 23 years younger for men and 29 years younger for women compared with the general population, and that these deaths are often for entirely avoidable reasons.⁴⁷ Correctly diagnosing a person's health conditions plays an important part in this. People with a learning disability have on average four times more symptoms that are unexplained compared with others.⁴⁸

The extent to which people with a learning disability experience joined-up care varies, and this can be related to a lack of understanding about their needs and how to meet them, for example approaches to communicating with people with a learning disability and understanding of the Mental Capacity Act.

Commissioning the right care is a challenge. CQC has moved away from registering services and models of care that have been proved to be ineffective for people with a learning disability, autism or challenging behaviour, but there remain a significant number of these services operating in the adult social care sector.

GPs play a crucial role in identifying those with a learning disability and their carers in order to provide proactive management and coordination of their care needs. Where people with a learning

disability need to access secondary care, acute care has a responsibility to ensure that learning disabilities are recognised, reasonable adjustments are made and people with a learning disability are supported. Schemes such as the “This is me passport” can be effective in identifying patients with additional needs and in helping staff to understand their individual needs.

- **People with mental health conditions** – The landscape of mental health care is fragmented, which makes the experience of navigating health and social care services particularly challenging. Access to services is variable, and the extent to which mental health is prioritised as part of local strategic plans also varies. There are capacity issues, including a lack of specialist mental health staff and a shortfall in the availability and quality of mental health services, including crisis services. This can lead to unmet need and people being placed far from home, making it harder for effective local system working.

We have previously highlighted that access to children and young people’s services is particularly problematic. Children and their carers are often required to travel long distances to get the right support, and general paediatric wards can find themselves caring for children with mental health conditions until an appropriate placement can be found.

People with both mental and physical illnesses face particular challenges; these needs are often not treated together, and physical health services may not always identify or take into account people’s mental health needs. And those with mental health conditions can face specific problems when accessing secondary care services, particularly emergency services. Some staff can lack the appropriate skills to manage the complex needs of those suffering from a mental health condition. It is important in this case to identify the mental health needs of patients on admission and make proactive efforts to safeguard their privacy and dignity.

- **People with long-term conditions** – To support effective pathways for people with long-term conditions, it becomes very important to prevent

health problems from escalating to avoid admission to hospital. This needs to be underpinned by adequate support for unpaid carers.

Relationships and partnership working are particularly important in creating effective pathways for people with long-term conditions. All parts of the health and care system need to work together. For example, many if not most people receiving adult social care will have multiple long-term conditions and therefore adult social care needs to work with primary and secondary health care to ensure joined-up pathways and care coordination.

Challenges in accessing high-quality care

People living in different areas have different chances of getting high-quality care. For example, in some places people will be close to good mental health services and GP practices, but in other areas people may struggle to find a good nursing home with capacity to care for new people, or need to travel a long way to find a good hospital.

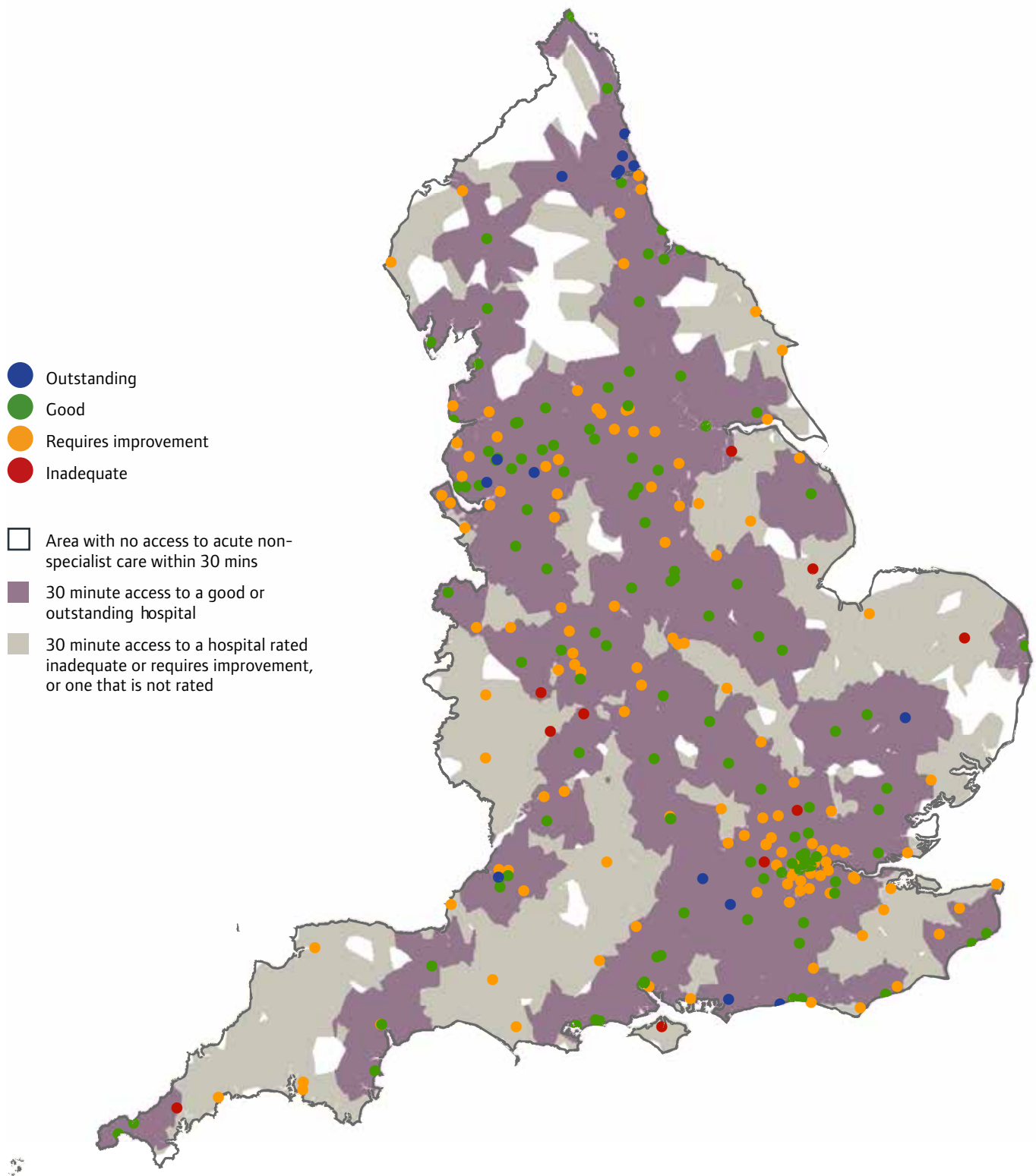
To explore this further, we have analysed how close people are to care services that are rated as good or outstanding. Figure 1.14 shows how this map looks for NHS acute hospitals.

This map helps to highlight how good care is not evenly spread across the country. Local health and care systems need to look at how they meet the needs of all their local people, and ensure that people are able to access the services they need.

In the course of our work, we can see that some local areas are starting to do this. People in some parts of England are benefitting from successful local initiatives – individual projects and ways of delivering health and social care services that are making a difference for local populations. Sometimes these are specific solutions for local issues and sometimes they may be good initiatives that may be workable in other places too.

The examples in this report give a snapshot of the work going on in different parts of the country to ensure that people can receive care that is based on their needs, and not the needs of the organisations that provide it.

Figure 1.14 Areas of England within 30 minutes' drive time of NHS acute hospitals rated as good or outstanding, July 2018



Source: CQC ratings data, 31 July 2018. The patterns may be affected by unrated hospitals, which tend to be smaller sites offering fewer services. Sites will also be unrated where trusts have been reconfigured and hospitals now come under a new trust that is yet to be rated.

Harnessing innovation and technology

Technology is playing an increasingly important role in improving outcomes for people who need care, and often we see how it is helping providers to be more joined up in the way they work.

Imperial College Healthcare in London is using digital monitoring devices that capture patients' clinical observations and vital signs at their bedside. About 5,800 nursing hours were saved in the first 18 months of this technology's deployment – nurses' time collecting (manually) and recording observations was halved. At Royal Papworth Hospital, e-prescribing has led to reduced waits in its pharmacy service and better infection control. More timely and accurate information sharing is happening through emailed patient discharge summaries.

The use of e-prescribing in oncology is making a difference for people in many places, including Sunderland and Southampton. And technology is also helping providers to be more efficient: in Hull

and East Yorkshire, electronic immediate discharge summaries have improved patient safety and the instant communication of patient information is estimated to have released about 23,000 staff hours annually (estimated non-cash yearly saving of £235,000).

Some services are using technology well to resolve local or geographic issues and help patients with access to care. Cumbria Health on Call provides urgent care services spread across the county, which includes a very large rural area. Its out-of-hours services were the first to be rated as outstanding in April 2017.

The service has been using telehealth appointments and this had reduced the average waiting time for a consultation with a clinician from 146 minutes to 32 minutes. Telehealth appointments offer the option of using specialist medical cameras at a local base to enable a doctor to assess patients, rather than patients driving long distances to a hospital or a doctor driving to their home.

Person-centred care: Independence through technology

We have seen adult social care services using clever ways to harness technology that can improve people's lives. A care home in Gloucester uses innovative assistive technology to enable young people to express their views, helping them control their living environment and maximising their independence.

Elizabeth House is part of the National Star Foundation charity and it is rated as outstanding by CQC. It cares for men and women with a physical disability and/or learning disability or autistic spectrum disorder.

At this service, CQC inspectors saw that staff were constantly looking for ideas on how to improve people's quality of life. This was helping to enhance young people's communication and independence, making sure individuals' lives were as full as possible.

People received an IT access assessment so that the right hardware and software solutions

were there for each young person to access computing in the most appropriate way – the right keyboard, the right mouse or alternatives, or on-screen keyboards that could be used via eye-gaze or 'head mouse' technologies. Young people with complex communication needs could control a mouse pointer using their eye or head movements and this worked for communication, education and enjoyment.

One young person with limited mobility and range of movement was supported to use computers and was authoring a book on disability rights, sharing their experience with the help of staff.

We saw that young people were very confident in using a variety of assistive technologies, on their own terms, developing their independence and autonomy in areas such as self-care, domestic tasks, mobility, communication, leisure, sensory and other therapeutic activities.

This service was working closely with North West Ambulance Service; in 93% of cases requiring ambulance attendance, the patient avoided admission to hospital.

In the NHS, technology is directly and indirectly helping improved person-centred care. Luton and Dunstable University Hospital has digitised 1.25 million paper records. As well as reclaiming 750 square metres of hospital space for clinical use, technology has saved the cost of delivering 1,000 paper records to outpatient clinics every day. Savings of at least £2 million are expected.

Good use of technology is also linking up the NHS with adult social care. Led by the North of England Commissioning Support Unit, a care home 'bed state tool' is a web-based portal that means clinical and nursing staff can instantly see the current state of care home bed availability locally. This has helped reduce the number of delayed transfers of care between hospital and some adult social care settings – it also helps free up hospital beds and reduces pressure on A&E.

Better person-centred care is possible

Most people are still getting good care, despite the pressures on providers. Overall, the quality of care

for people in England has improved slightly over the last year. But this not reflected in everyone's experience of care, and not everyone is able to access the care that is available.

People's experiences depend on both the care they receive from individual services and the way that different services work together to understand and respond to their needs. Many, especially older people and an increasing number of others, have more complex care needs that require attention from multiple health and care services. Those services need to wrap care around the individuals.

Among the people who talked to us for this year's *State of Care* report was Tracey, who was treated for multiple health problems including cancer and diabetes. While Tracey's experiences of accessing services and receiving treatment have not always been perfect, she summed up her feelings about her more recent experiences of care like this:

"It's been almost as if all these different places, all these different departments, have all worked – in my particular case, in my particular situation – together, like holistically...the counsellor's from the lymphoedema service, the nutritionist

Joined-up care for better pain relief

Patients in West Berkshire suffering high levels of pain had their wait for specialist appointments reduced from nine months to one, thanks to an Integrated Pain and Spinal Service created by the local CCG and NHS trusts. Before this service, care for patients living with chronic pain could be disjointed, with each provider managing their own care episode in isolation from other healthcare colleagues. This often meant patients had to repeat information to different parts of the system, and make multiple and unnecessary visits to consultants or outpatient departments.

Teams in primary, secondary and community care, including specialists such as physiotherapists and psychologists, worked with expert patients to design a streamlined single service, rather than

multiple isolated pathways. Patients are now assessed and receive the most appropriate care earlier on in their treatment plan, and the system also offers more support to patients to self-manage, including back and pain management classes to promote exercise.

The number of patients making relevant appointments has reportedly fallen by a third under this approach. Waiting times for outpatient appointments have fallen from between seven and nine months to around four weeks, with 92% seen in six weeks. The local system aims to reduce pain-related multiple attendances by at least 50% each year, and anticipates a 5% reduction in related day case procedures.

Source: NHS England

is from the diabetic service, the general surgery and the endoscopy department, that's a completely different service, then the hospital, that's not even in the same location and the mammogram's not in the same location. The standard of care, in my experience, has been excellent."

People's needs should be the focus of local health and social care systems – the organisations should be joined up locally and strategically focused on delivering high-quality and sustainable care around individuals. For good care to be sustainable, it is no

longer just about individual organisations succeeding or failing. It means working together, focused on access to care, quality, workforce, capacity, and funding and commissioning.

Joined-up care can lead to better outcomes for people of all ages. When services work together with an understanding of the needs of their local populations, it is more likely that people will get the best care possible, when they need the care and in the best environment that suits their needs. Some local areas are starting to work this way.

Person-centred care: Integrated care hubs

Integrated care hubs in Wakefield, West Yorkshire, relieve pressure on primary care, as GPs can potentially just ring one number or complete one e-referral for a person with multiple needs.

Once assessed and referred, people could be seen by a nurse, occupational therapist, physio, social care worker, voluntary worker, housing officer or mental health worker, depending on their problem. In six months, the Hubs have seen almost 2,000 people including 636 urgent referrals.

In the Hub, a mixed social care and healthcare team sit together with coordinators in one office and triage referrals to the right place or person. An urgent care team sits with them and can go to any patient needing rapid care, for example providing mobility equipment that day which may prevent them needing to go into hospital.

The model means patients who may otherwise receive fragmented care, with multiple referrals and handovers, can be seamlessly supported with health and social care needs. It's a model being rolled out in other areas of the country with Dorset and Luton and Bedfordshire sporting similar teams.

Jo Webster, West Yorkshire and Harrogate Clinical Commissioning Group Lead and Chief Officer at NHS Wakefield CCG, said: "People only want to tell their story once and then they want a solution. Many elderly people don't have a single medical

condition or social care problem, they need a package of help that meets their needs and what we've done in Wakefield and in other areas is to provide that.

"If someone has fallen for example and might be living on their own and socially isolated, they can be referred into the Hub for support with all of these factors, which may be impacting on their health and wellbeing."

Funded jointly by £5.9 million from the NHS Wakefield CCG and Wakefield Council, the Hubs are proven to prevent avoidable hospital admissions and help people to be discharged from hospital as soon as they are well enough.

The Hubs are supported by a Late Visiting Service run by community matrons who see mainly elderly, house-bound patients needing an urgent same day home visit. People get seen sooner in the day, preventing health problems getting worse and enabling the patient to stay at home and avoid a hospital admission.

In eight months, the Late Visiting Service has seen almost 400 people and prevented many of these from going to hospital. Community matrons can also refer into the Hub if the person they visit needs extra support for other health, wellbeing or social care issues.

Source: NHS England



Part 2

THE SECTORS WE REGULATE

Adult social care



**Hospitals, community health services
and ambulance services**



Mental health care



Primary medical services



Equality in health and social care



The Deprivation of Liberty Safeguards





Adult social care

Key points

- More than four-fifths of adult social care services were rated as outstanding (3%) or good (79%), whereas 17% of services were rated as requires improvement and 1% as inadequate. There are now 605 services rated as outstanding – nearly 250 more than when we reported last year.
- Staff continued to care well for people, with 91% of services rated as good and 4% rated as outstanding for the caring key question. By contrast, 2% of services were rated as inadequate and 21% as requires improvement for well-led.
- There was variation in ratings between different types of adult social care service, with 4% of community social care services rated as outstanding, 86% rated as good, 10% rated as requires improvement, and none now rated as inadequate. This compares with 3% of nursing homes rated as outstanding, 69% as good, 25% as requires improvement, and 3% as inadequate.
- Of the 396 services that were originally rated as inadequate and have been re-inspected since 1 August 2017, 89% improved their rating.
- Providers and managers of improved services have worked hard to make care better for people. They used their poor rating as a wake-up call and their inspection report as a “roadmap to improvement”. They prioritised person-centred care, supported their staff and sought help from system partners.
- Improvement is challenging for many services. Of the 3,031 services that were originally rated as requires improvement and have been re-inspected since 1 August 2017, 42% failed to improve and have retained this rating. A further 7% dropped to a rating of inadequate.
- Problems with management and leadership support can exacerbate pressures in the system and have a substantial impact on the quality of care people receive.

Helen's story

Helen lives in supported living accommodation, which means she can live as independently as possible but receives support several times a day to help her with things like doing her hair and cooking meals. Helen has a learning disability and a mental health condition.

What does Helen think is good about her care?

Helen likes being given choice about her care and the flexibility of the service. This helps her take control of her care. For example, Helen chooses when she goes to bed and stays up late when she wants.

Helen recognises the importance of having the right staff in place for good quality care:

"I know it's not an easy job. But to work in care you've got to be passionate about what you do, and you've got to be there for the people using the service."

What does Helen think needs to improve?

Recently, Helen has started attending a slimming group, but there are not enough staff on site to take her on a Monday evening. She says,

"It's okay, but it puts pressure on other people, such as my mum and dad, taking me there."

Helen also feels that agency staff are not a good use of money because they are more expensive and can lack skills. For example, one agency worker was not qualified to administer medicine at night and had to be supervised. Having agency staff in her home sometimes made her feel uncomfortable, as she did not know them and they did not understand the support she needed. For example, Helen manages her own medicines, but when agency staff were in the home they took this control away from her.

"Agency staff are a bit like having a stranger to talk to on the first day and you can't really sort things out properly. I wish they'd asked me first instead of taking over."

Introduction

Adult social care services provide vital support and can help people stay independent through a range of services at home, in the community or in a care home. However, services continue to be under pressure because of a number of challenges.

Funding remains an issue. The Local Government Association estimates that adult social care services in England face a funding gap of £3.5 billion by 2025.⁴⁹

Demand for care is increasing:

- The number of people over 85 needing 24-hour care in England is projected to almost double to 446,000 between 2015 and 2035.⁵⁰
- This demand is likely to vary by region. Using population projections from the Office for National Statistics, the Institute for Fiscal Studies has highlighted that increases in the older population over the next 18 years are likely to be

very unevenly spread across the country. Some areas will expect hardly any increase and others will expect increases of almost 8% in the share of the population over 75.⁵¹

- The number of working-age adults with long-term care needs, such as those with a learning disability, has also increased.⁵²
- Age UK has calculated that the number of older people in England who do not get the care and support they need to carry out essential everyday tasks, like going to the toilet or getting dressed, has risen to a new high of 1.4 million. This is a 19% increase since 2015.⁵³

Choosing care

A recent CQC survey of 1,000 adults across the UK found that choosing care for themselves or a loved one is one of life's most stressful decisions. For example, 70% of people found choosing care in a care home or at home more stressful than choosing their child's nursery or school.⁵⁶

This stress is shown in Louise's experience of finding a nursing home for her mother, Mary, who had vascular dementia:

"You're just on your own at a time of great stress and anxiety. I had my brother and sister. We yomped round homes together, ended up having a bit of a giggle about it all because that's how we cope. But many people are doing it on their own – it's a heart-breaking experience. Where's the support for people? And there's going to be more and more and more people like us, whose loved ones need care, because we're keeping our old folks alive far longer."

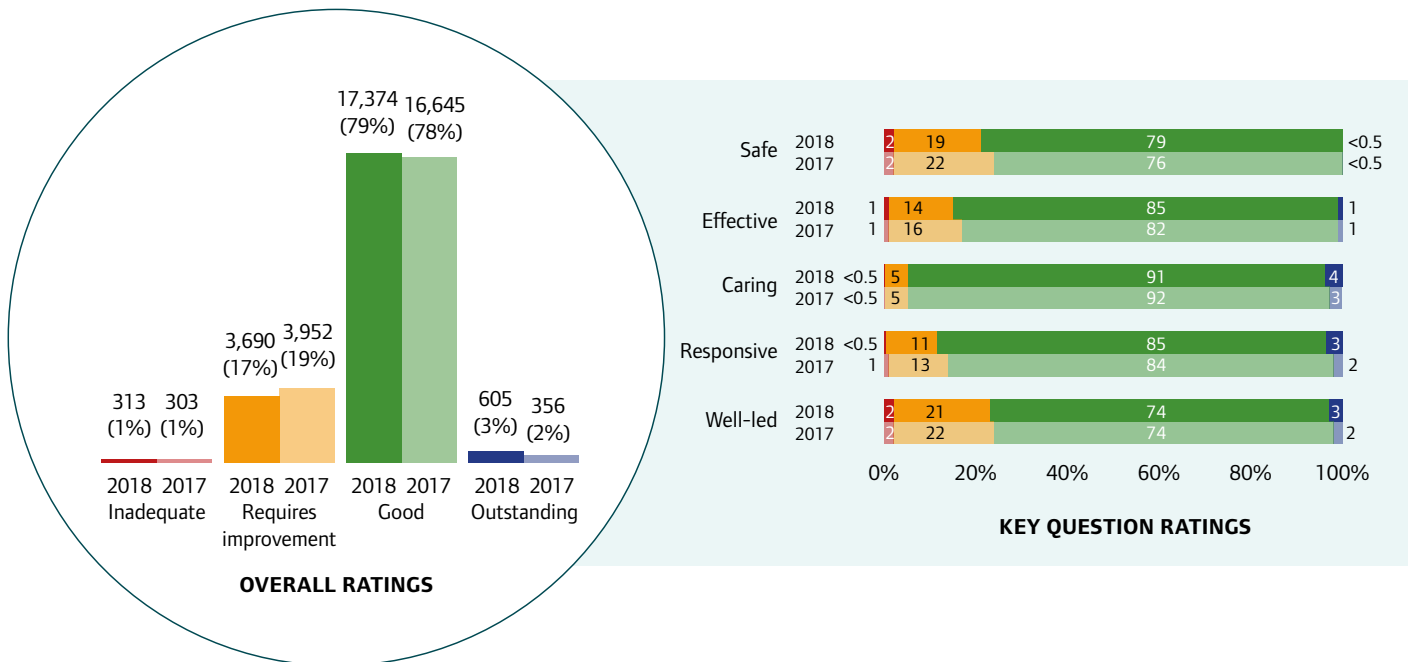
Using CQC data, Which? has predicted that almost nine out of 10 council areas in England could see a shortfall in care home places by 2022 unless urgent action is taken.⁵⁴

Services struggle to recruit and retain staff:

- The vacancy rate in 2017/18 for jobs across social care was 8.0%, up from 6.6% the previous year.
- The vacancy rate for domiciliary care was 9.9%, compared with 6.8% for care homes.
- The highest vacancy rate by job role was for registered nurses at 12%, up from 9% in 2016/17.
- The turnover rate of care staff in England has been increasing since 2012/13, and in 2017/18 reached 31% for all care staff. This rate was particularly high for care workers (38%) and registered nurses (32%).⁵⁵

The adult social care market is constantly changing, as businesses respond to these pressures and other factors. Over the last five years, the number of residential homes has been steadily reducing, while the number of domiciliary care agencies has been increasing (part 1, figure 1.11). In the 12 months to April 2018, the number of residential homes dropped by 2.4%, and the number of nursing homes dropped by 1.4%. In the same period, the number of domiciliary care agencies rose by 4.3%.

Figure 2.1 Adult social care, overall and key question ratings, 2017 and 2018



● Inadequate ● Requires improvement ● Good ● Outstanding

Source: CQC ratings data, 31 July 2017 and 2018.

What is the quality of care like for people using services?

Overall and key question ratings

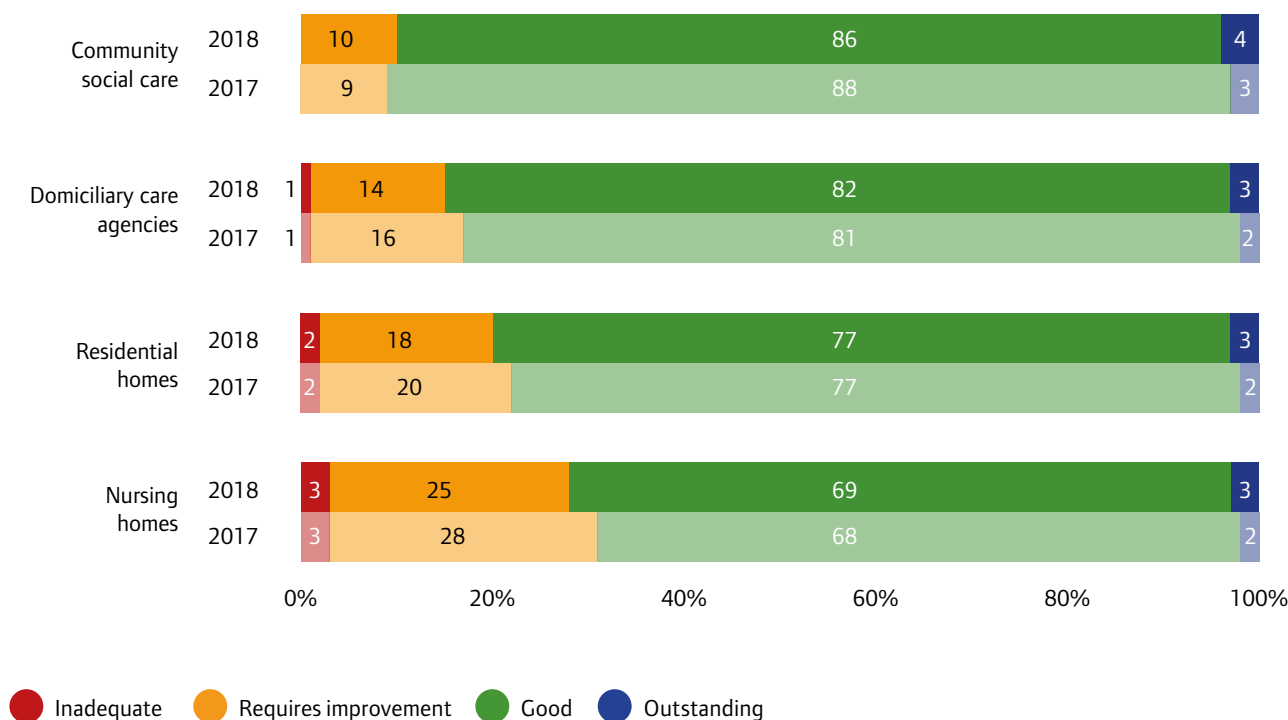
At the end of July 2018, more than four-fifths of adult social care services were rated as good (79%) or outstanding (3%) overall (figure 2.1). Seventeen per cent of services were rated as requires improvement and 1% as inadequate. These percentages show a slight improvement compared with those reported last year.

The proportion of services rated as outstanding increased from 2% to 3% this year. This means that people in 605 adult social care services are receiving the very best care – nearly 250 more than when we reported last year. However, there is a slight increase

Impact of poor leadership

Inspection staff spoke of a care home resident who was in a chair from 8am until 6pm, shouting out for help, without receiving any care from staff. When the community nurses visited, the person had a grade three pressure sore and a urine infection and was admitted to hospital. This happened because staff had not been instructed on what to do. There was no registered manager in place and a lack of leadership from the provider. The home has subsequently closed.

Figure 2.2 Adult social care, overall rating by type of service, 2017 and 2018



Source: CQC ratings data, 31 July 2017 and 2018.

in the number of services rated as inadequate and, as seen in this report, this level of care can have a highly negative effect on staff and people receiving services.

Staff continue to care well for people, with 91% of services rated as good and 4% rated as outstanding for the caring key question. This demonstrates the tremendous dedication and commitment of thousands of adult social care staff who can be proud of the difference they make. By contrast, 2% of services were rated as inadequate and 21% as requires improvement for well-led. Considering the strong link between good leadership and high-quality care, this is an area that providers need to focus on.

Types of service

There continued to be variation in quality between different types of adult social care service, with 4% of community social care services, such as Shared Lives and supported living, rated as outstanding and 86% rated as good. None are now rated as

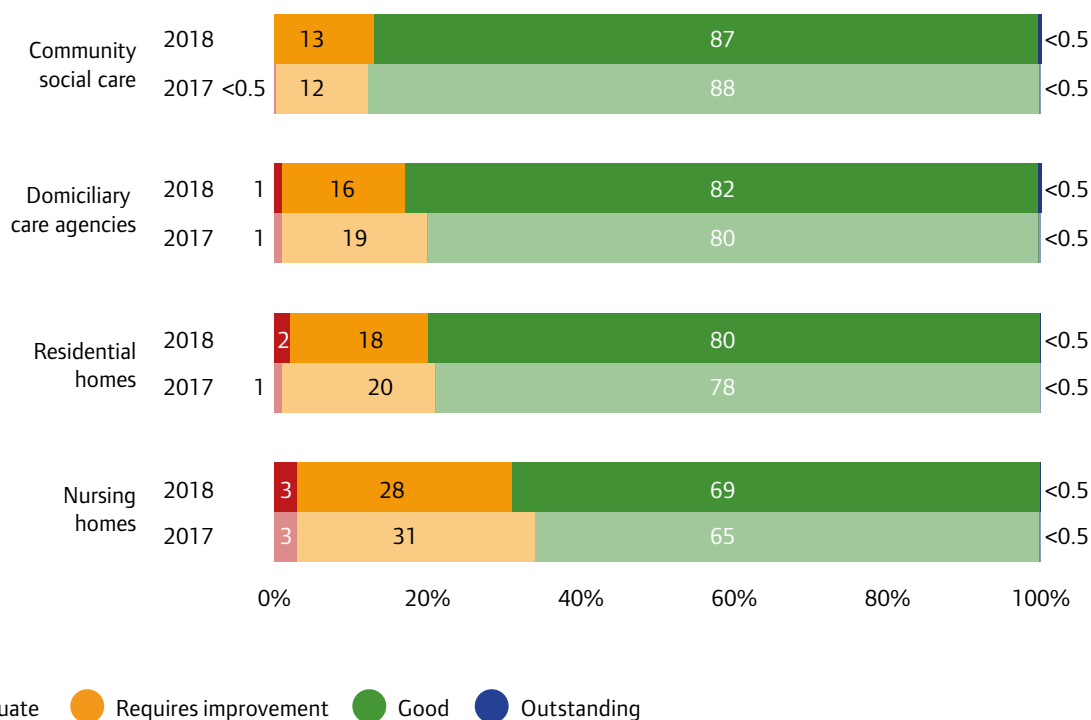
inadequate (figure 2.2). This compares with 3% of nursing homes rated as outstanding, 69% as good and 3% as inadequate. This variation has persisted, although there has been some improvement in nursing home ratings since last year.

Nursing homes are particularly affected by workforce issues. We have found that the national shortage of qualified nurses is a particular problem in adult social care. Low pay and disparities in employment terms and conditions between NHS and independent services may be a factor here.

Safety in adult social care

The question about whether services are safe remains an area for concern but, as mentioned in part 1 of this report, there have been improvements in this area. In adult social care services, 79% of services were rated as good for the safe key question compared with 76% at the same point last year.

Figure 2.3 Adult social care, rating for safe key question by type of service, 2017 and 2018



Source: CQC ratings data, 31 July 2017 and 2018.

This improvement in the safe key question is reflected across the different types of adult social care provider in figure 2.3. Although the proportion of nursing homes that were rated as inadequate or requires improvement is still notably higher than other types of service, there is improvement: 69% of nursing homes were rated as good for safe, compared with 65% at the same point last year.

Our *Learning from safety incidents* resources,⁵⁷ introduced this year, share critical issues that we have seen through our enforcement work –

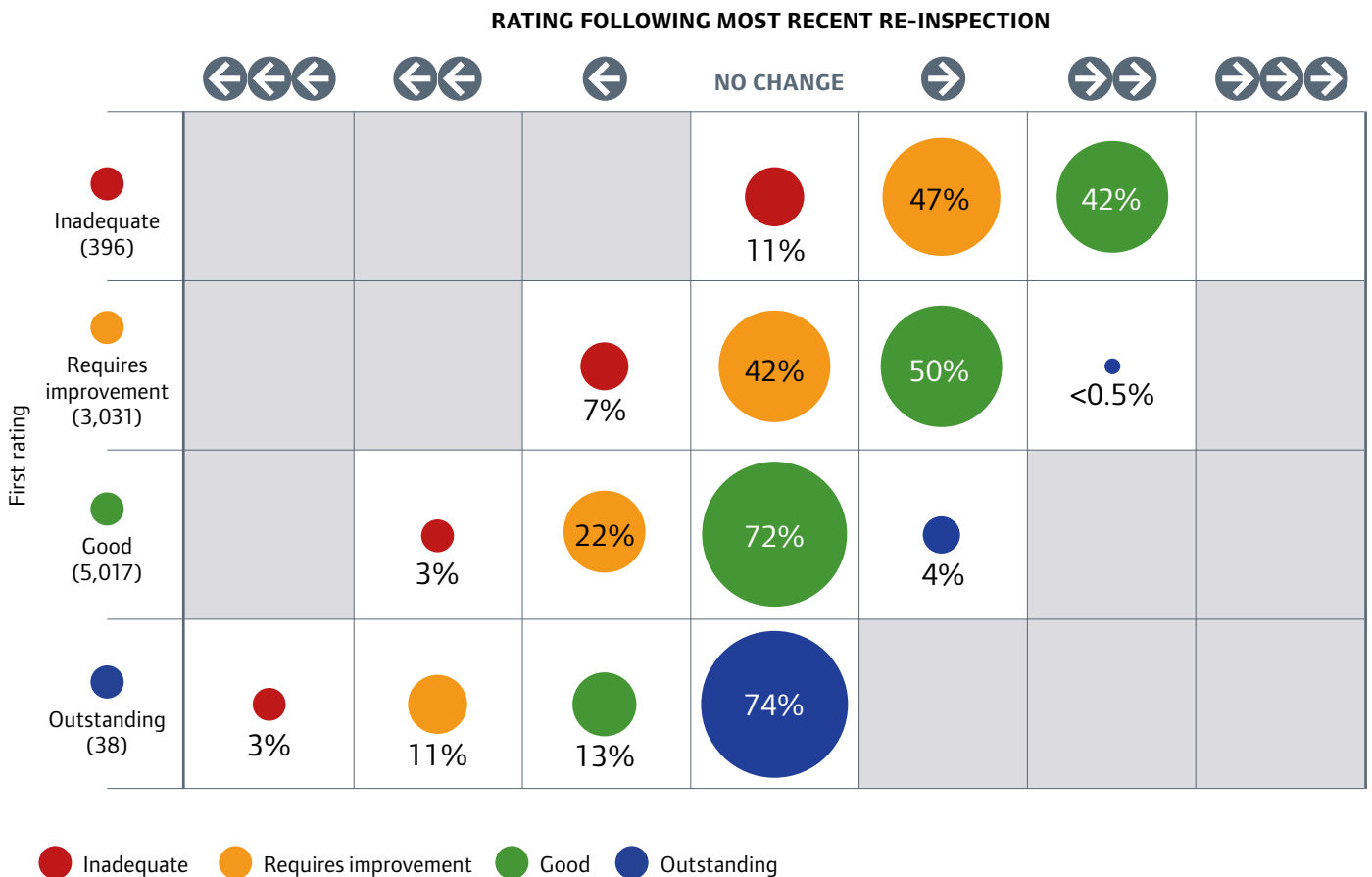
principally prosecutions of providers. By focusing on issues such as burns from hot surfaces and the improper use of bedrails, we show the devastating impact that safety incidents can have on people who use services. As well as tracking the result of the enforcement actions, these resources show what CQC and the provider have done to make care safer for people, and the steps other services can take to avoid a safety incident happening to them. We will build on these resources to share learning in the sector.

Where has the quality of care improved for people using services?



By looking at the 8,482 adult social care services that have been re-inspected since we last reported a year ago, we can see whether these services

are improving. Figure 2.4 shows that, of the 396 services that were originally rated as inadequate and have been re-inspected since 1 August 2017, 47%

Figure 2.4 Adult social care, change in rating on re-inspection, year to 31 July 2018



Source: CQC ratings data, re-inspections published in the year to 31 July 2018. Change in rating is from first to most recent inspection.

-  One level of rating change up (for example, from requires improvement to good)
-  One level of rating change down (for example, from good to requires improvement)

improved to a rating of requires improvement and 42% improved to a rating of good. This leaves 11% of services that were rated as inadequate and, on re-inspection, have not been able to demonstrate sufficient improvement to change their rating. This is an improvement on re-inspections published up to 31 July 2017 (as reported in *State of Care* last year), where 18% of services originally rated as inadequate failed to improve on re-inspection. We give special attention to services rated at this level to make sure that they do not continue to give an inadequate service to people.

There were 869 services operating in July 2017 of varying types and quality that by 31 March 2018 were no longer active. Closure of services can happen for many reasons. One of these comes from our enforcement powers, which protect people from poor care. Our inspection staff are using the full breadth of our enforcement powers to take more criminal actions than before. In 2017/18, of the 141 locations where we enforced the closure, 73% were adult social care services.⁵⁸

Closures can be deeply unsettling for people using services and their families. They can also have an

effect on other services in the area. However, one of our inspectors recounts how a closure brought about positive changes for people:

“I remember one woman saying to me, ‘I thought you were the devil incarnate because you’ve closed the home I’ve lived in for years. But this new home is so much nicer. I didn’t know care could be like this. Before, I couldn’t see the TV, but I was told that that was my seat and I had to sit there. Now I can choose where I sit.’”

Our June 2018 report, *Driving improvement: Case studies from nine adult social care services*, tells the stories of services that have been able to transform the quality of their care. While acknowledging that improvement involves a lot of hard work, the report gives practical guidance to others running services, to make things better for the people they support and care for. The report highlights several key factors that had a positive influence on the nine services that had improved their rating from inadequate to good.

Accepting that problems exist and developing an action plan

Although most providers were shocked by an initial poor rating, they used it as a wake-up call. Managers treated their inspection report as a “roadmap to improvement”, using the issues identified to create an action plan and work out priorities. Having a ‘we will get this right’ attitude was a key first step for improvement to happen. For some committed staff the report came as a relief, since they had previously felt unfairly overburdened. Other staff had felt “disgusted” at the standards before, but felt unable to talk about it until the poor practice was out in the open.

Recognising the importance of good leaders

In most of the services we looked at, a new manager had come in to deliver the improvements needed. They engaged with staff, people who use services and their families – being open to suggestions but taking tough decisions where necessary. Staff and

family members commented about a manager’s door ‘always being open’.

Services rated as inadequate tended to have a culture where staff were afraid to speak out. It’s the job of good leaders to change this. One senior care worker at a care home said, “Being encouraged to talk about things was a big change. Now, if we make a mistake we are more than happy to speak up, knowing we won’t be blamed or persecuted for it. We focus on what we have to do to stop it happening again. Before, we would have been hung out to dry.”

Successful managers were able to develop good teams who could take responsibility for providing good care and for contributing to improvements. One told us, “I would say I’m 80% leader and 20% manager. I’ve always wanted to give care staff so much confidence that they believe they are a leader.” Managers also emphasised the scale of improving inadequate services. In providing top tips for others, one manager said, “Be prepared to work very, very hard. It will normalise, but you need to put in the hours to start with.”

What person-centred care means

Louise defines what person-centred care means for her mother, who had vascular dementia:

“Person-centred care means it’s not about me – I’m just a random family member. It isn’t about the home. It isn’t about what the carer thinks is a jolly good idea. It’s about what is good and right for the person; what’s right for them. And as we all know, what’s right for Jack is not right for Jill.”

Prioritising person-centred care

Typically, one of the first things a new manager wanted to do was look through people's care plans. In most cases these were lacking in detail and did not show that the care being provided was based around the person. One care home provider explained, "We completely re-wrote all the support plans. Part of that re-write was a life story sketch. We found out what people liked doing before they came to the home." This focus on person-centred care works across all adult social care services. As a domiciliary care agency manager put it, "It's the people who use services that come first. They should get the care plans they want for their care, not what we think."

Valuing staff

Before they improved, some providers were operating without enough staff to deliver safe and effective services. To address this, one provider reduced the number of people using the service, handed some contracts back and did not take on

any more people paying for their own care. This took pressure off staff, one of whom confirmed, "I never rush my customers. I had felt before that we were not able to do the job."

Another manager told us that "there were not enough staff commissioned to meet the needs of the people using the service... I had all the residents reassessed and actually got extra funding from the local authority".

Other features of poorly performing providers were a lack of training and staff appraisals: improving these areas paid dividends. In one service, the husband of someone using services saw improved training "coming through" in the care his wife received.

Working with system partners

Despite the importance of good leaders, it was clear that they cannot make improvement happen on their own. Successful managers talked about:

- the support they had from their own organisation, local commissioners and NHS partners
- how they involved their staff

Person-centred care in the community

The parents of a man in his twenties with a learning disability said that they never thought he'd be able to leave home. But his domiciliary care service supported him to find his own flat, where he lived with his friend, who also used the service. The man was now able to think of new things that he wanted out of life, and he really wanted a dog. But his flatmate didn't like animals. The service therefore helped him produce fliers, which he delivered round his local neighbourhood offering to walk dogs for older people who received care at home. This was a win-win situation: the older people were helped to keep their pet as their companion, and the man was able to meet people in the community, exercise in the outdoors, and enjoy walking the dogs.

Valuing staff

Karen has been the main carer for her 35-year-old son, Sam, who has Down's syndrome. He recently decided to move into a residential care home. Karen feels that, currently, care staff are not paid enough or supported through appropriate training:

"Teach people how to care properly, give them a qualification and a decent wage and that's all it needs really, isn't it? And then you get the right people in the homes. It's like anything: train them well, monitor well, appraise well, reprimand when it's not good enough. There's ways of doing it without losing staff, you know; we all have to re-train."

- the support and encouragement they received from their CQC inspector
- how external agencies helped them to improve.

To support its journey from being rated as inadequate to being rated as good, one local commissioner visited a care home once a week

to champion its improvement. According to the registered manager, “She was amazing, she wanted it to succeed and supported me a lot. We also had the local safeguarding team, who used to come in once a week to help us; the support from them was really good.”

Where are people still not receiving the quality of care they can expect?

As well as showing where improvement for people using services has improved, figure 2.4 also shows that too many services rated as requires improvement have not done enough to raise the quality of their care. Of the 3,031 services we re-inspected from August 2017 to July 2018 that were originally rated as requires improvement, 42% failed to improve and have retained this rating. This is a higher percentage than when we reported last year, when this figure was 36%. Alongside this, a higher proportion of these services actually deteriorated from requires improvement to inadequate from their first inspection to their most recent (7%, compared with 5% reported in last year’s *State of Care*).

Figure 2.4 also shows that high-quality care is not easily maintained. Of the 5,017 services that we re-inspected from August 2017 to July 2018 that were originally rated as good, 22% changed their rating to requires improvement and 3% to inadequate.

Re-inspections of services rated as good and outstanding can be prompted by concerns from staff, people using services and their families, or from notifications from the provider itself. We are doing more of these types of inspection. Up to July 2017, the proportion of all re-inspections that were of services originally rated as good was 37%, compared with 54% that were of services originally rated as requires improvement. In the following year, to 31 July 2018, this pattern reversed, so that 59% of re-inspections were of services originally rated as good, compared with 36% of services originally rated as requires improvement.

Even services rated as outstanding have seen changes in quality. From August 2017 to July 2018, more than a quarter of the 38 re-inspected services

that were originally rated as outstanding have seen their ratings fall – some even deteriorated to requires improvement or inadequate.

Our qualitative analysis has identified a number of common factors that drive variation in the quality of care, and can lead to this decline in quality. As the previous sections highlight, an effective, stable manager who engages with people using the service and staff can mitigate pressures on the system and provide good and outstanding care. However, as the themes and examples below show, problems with management and leadership support can exacerbate these pressures and have a real impact on the quality of care people receive.

Lack of leadership and governance

Leadership and governance are key factors that underpin quality. Effective governance systems make it easier for senior leaders to monitor quality and risk, and may help to insulate services from external pressures or unexpected changes, such as a key member of staff moving on. A lack of monitoring and oversight can quickly lead to problems with care delivery.

For example, in one domiciliary care agency, the main concern at inspection was that the service was no longer being proactively managed, which contributed to a change in rating from good to requires improvement. There was no systematic quality monitoring of the service and internal audits were not picking up issues. Medicines Administration Records were not accurate or up to date, which meant that people were at risk of not receiving their medication as prescribed.

Also, because the registered manager was also the provider, there was no one else to monitor the quality of the service and the way it was being managed. Since the service was not one of the local authority's preferred providers, and many of the people using services were private, the authority did not monitor the quality of care being provided. This may also have had implications for the registered manager's involvement and attendance at local authority learning events and forums.

Issues with management continuity and staffing concerns

Problems with staff recruitment and retention are having an effect on local services' capacity to provide stable leadership and meet the needs of people (although we have not been able to demonstrate that this correlates to aggregated quality ratings at a local authority level). We highlight in our report, *Beyond barriers*, that the challenges faced by care services are affecting their ability to provide consistent care for older people. For example, we heard about one person receiving domiciliary care who had been seen by 42 different care workers in one week.

Each local area has their own, distinct pressures to find the right staff in adequate numbers. Poor management of staffing levels, an over-reliance on agency staff, and issues with management continuity were at the heart of concerns at a care home in Surrey. However, these internal challenges were also influenced by broader issues relating to the recruitment and retention of staff, which were shared by other care homes across the county. Low wages meant that other employment opportunities, such as working in a supermarket, were thought to be more attractive than working in a care home. Also, most of the care home staff could not afford to live locally and many were not able to travel to the countryside location without a car. Some other services in the county had managed this problem by arranging for a minibus to pick up staff from train stations.

Poor relationships between the provider and manager

Although a registered manager is likely to have the greatest influence over the day-to-day running of a care service, it is important that they are supported by the provider or owner where possible. Poor relationships between provider and manager can have negative knock-on effects for people working at and using services.

For example, a small care home declined from a rating of good overall in 2016 to one of inadequate a year later.

The first inspection noted that the registered manager had a significant presence at the location and was proactive in developing the quality of the service. However, during the summer of 2017, the relationship between the registered manager and the provider deteriorated. The manager told CQC that she felt she was being bullied by the provider to admit more people to the service and reduce staff numbers. The registered manager was later dismissed.

The provider immediately appointed an interim manager from an agency. The new manager received no induction, no action plan, no prioritisation of work, no assessment of resources, and no structured contact or support arrangements from the provider. Instead of trying to fill those gaps with good leadership, the manager mainly involved themselves in caring duties on the floor.

As a result, the final inspection found that most care plans did not contain up-to-date, relevant information about people's needs and people had not had any input into them. The home was closed in December 2017 following safety concerns.



Hospitals, community health services and ambulance services

Key points

- During 2017/18, the majority of NHS acute hospitals have continued to provide a good quality of care, with 60% of core services rated as good and 6% rated as outstanding at 31 July 2018, compared with 55% and 6% respectively last year. However, the quality of care people experience is still variable, with 31% of core services rated as requires improvement and 3% rated as inadequate.
- Growing demand, coupled with limited capacity, is putting increasing pressure on the health and social care system, compromising the quality of care provided and potentially putting patients at risk.
- Urgent and emergency care services remain an area of concern, with many still struggling to make improvements. As at July 2018, 7% of urgent and emergency care services were rated as inadequate and 41% were rated as requires improvement overall.
- The safety of maternity care is a key focus for us, with nearly half all maternity and gynaecology services, and over a third of maternity services inspected under our new methodology, needing to improve.
- The majority of independent acute hospitals are providing high-quality care for their patients, with 63% rated as good and 8% rated as outstanding. But we found that independent acute services for children and young people need the most improvement, with 37% of services rated as requires improvement and 3% rated as inadequate.
- The majority of NHS community health trusts and independent community health services are providing good care, with 75% rated as good at July 2018. However, we continue to monitor the safety and leadership of these organisations, as 26% were rated as requires improvement for the safe key question and 18% were rated as requires improvement for being well-led.
- The quality of leadership in an organisation is a key factor in its ability to deliver high-quality care. Leaders are integral to setting the culture of an organisation: capable, high-quality leaders create a workplace culture that is conducive to high-quality care.



Mr James's story

Mr James, 72, was admitted to a frailty unit after he fell while getting out of a taxi.

He had a mental capacity assessment after two days in the frailty unit. Although Mr James was medically fit for discharge, the unit made a Deprivation of Liberty Safeguards application.

A decision was not received until four days later. During this time, Mr James was also assessed by an occupational therapist, who concluded that he needed a walking frame to be able to move around at home.

Mr James also needed a home visit from the occupational therapist in the community team to make sure he was coping. But there were no therapists available to assess him at home in the following days.

Because of these delays, Mr James ended up staying on the frailty unit for 15 days. The average length of stay for all patients was 72 hours.

On day 15, when Mr James was finally ready and able to go home, he fell again and fractured his hip. Mr James was then admitted to a ward and eventually went home a month later.

Introduction

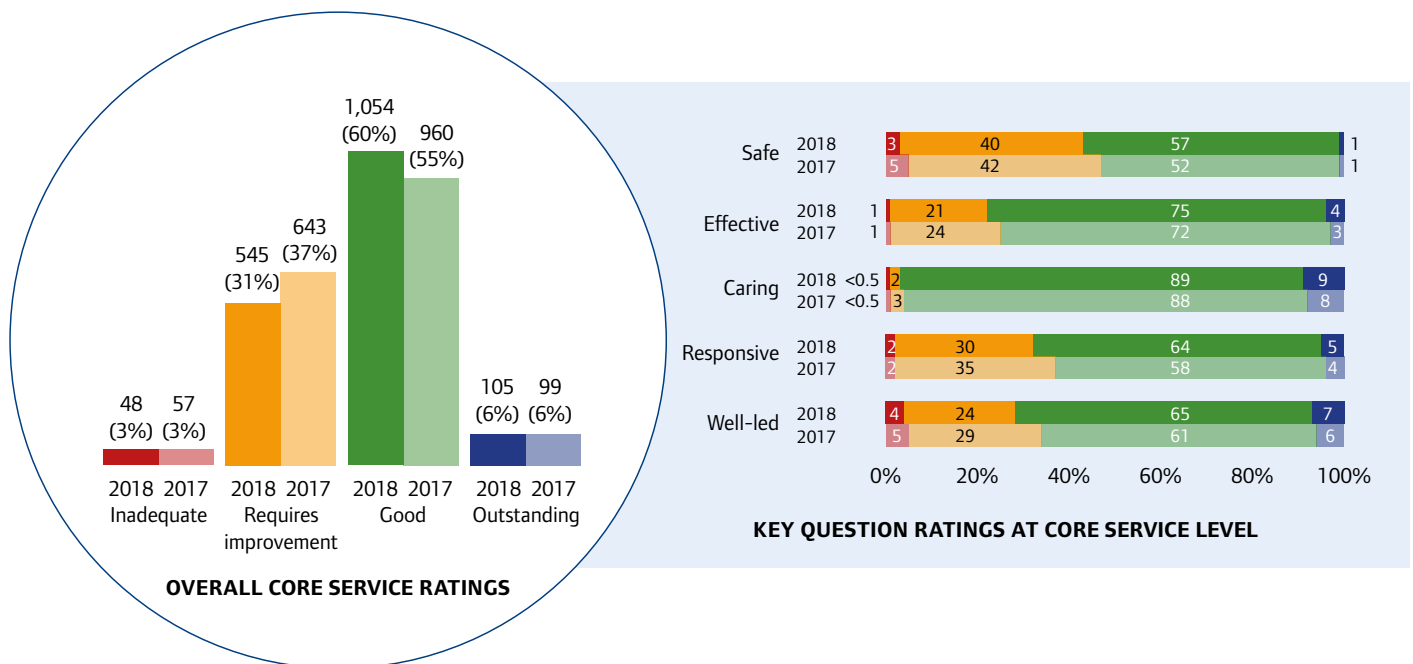
England's healthcare services face a formidable challenge. Every year, more and more people are looking to these services for care and support, and are presenting with increasingly complex health conditions such as diabetes, cancer, heart disease and dementia. In 2015/16, one in three emergency patients admitted for an overnight stay had five or more health conditions, up from one in 10 in 2005/06.⁵⁹ Coupled with this, we are also living longer into older age. Women born today can expect to live 11 years longer than those born when the NHS started.⁶⁰ This means that people need more support from the healthcare system at a time when resources are even more stretched.

Hospital emergency departments are often the first point of contact for people in need of care. The

number of people seeking help there is continuing to increase year-on-year, made worse by spikes in seasonally-related conditions. Winter 2017/18 saw an unprecedented number of people needing help from emergency services for this time of year. This follows an ongoing pattern of rising demand, with the number of emergency admissions growing by 42% over the last 12 years.⁶¹ Rising demand and a lack of capacity within the system is affecting organisations' ability to meet the needs of the people they are caring for.

In addition to rising demand, trusts are operating in an increasingly tight financial climate, which is adding pressure to their ability to maintain the quality of care. Cuts in social care funding are also adversely affecting trusts. There are not always

Figure 2.5 NHS acute hospitals, overall core service and key question ratings, 2017 and 2018



● Inadequate ● Requires improvement ● Good ● Outstanding

Source: CQC ratings data, 31 July 2017 and 2018.

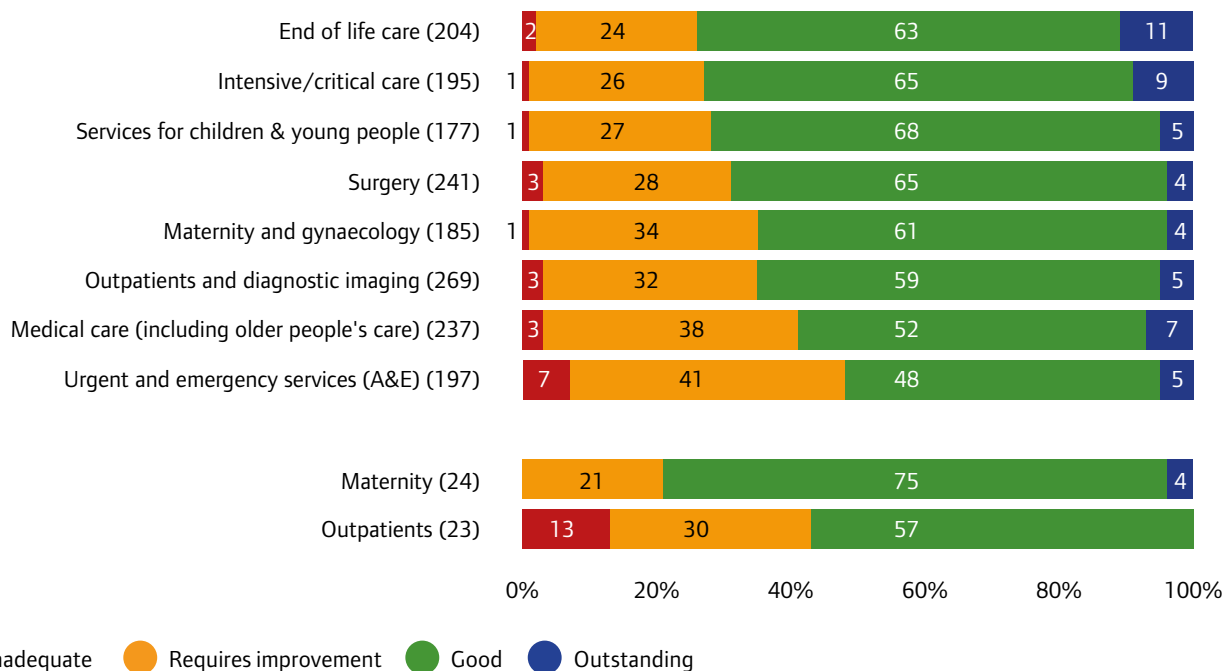
enough social care services available to meet demand, and they sometimes struggle to provide adequate numbers of staff to give people the care they need in the community to avoid the need for admission to hospital. This, together with gaps in the provision of community and primary care, is preventing timely and effective discharge from hospital. It is encouraging to note that the number of delayed transfers out of hospitals has decreased in 2017/18, following a drive from the Department of Health and Social Care. However, evidence from our report *Beyond barriers* suggests that, in some areas, this focus may have overwhelmed other health and social care priorities.

Through our local systems reviews, and as highlighted in the case study of Mr James, we have seen how delays in discharge can lead to a deterioration in people’s condition and can lead to them not going home following an admission

to hospital. People we spoke to who work in the health and social care sector also told us that, while preparing for winter pressures was vital, systems need to be resilient enough to respond to surges in demand throughout the whole year.⁶²

While the increasing demand for services can make it harder to maintain the quality of care, the trusts featured in our report *Driving improvement: case studies from eight NHS trusts* have illustrated that it is possible to improve while managing system pressures. Our inspections also tell us that high-quality care is associated with a culture of improvement that uses quality improvement methods, and that empowers and encourages staff to raise and report concerns, leading to improvement activities.

Figure 2.6 NHS acute hospitals, core service ratings, 2018



Source: CQC ratings data, 31 July 2018. Since June 2017, the core services of maternity and outpatients do not include gynaecology and diagnostic imaging respectively, which are now inspected as additional services. We show ratings for both the previous and the new core services separately as they are not comparable.

What is the quality of care like for people using services?

NHS acute hospitals

During 2017/18, there was improvement in the quality of care in NHS acute hospitals, with 60% of core services rated as good at 31 July 2018 compared with 55% the previous year.^b The quality of care people experience is still variable, with 31% of core services rated as requires improvement and 3% rated as inadequate (figure 2.5).

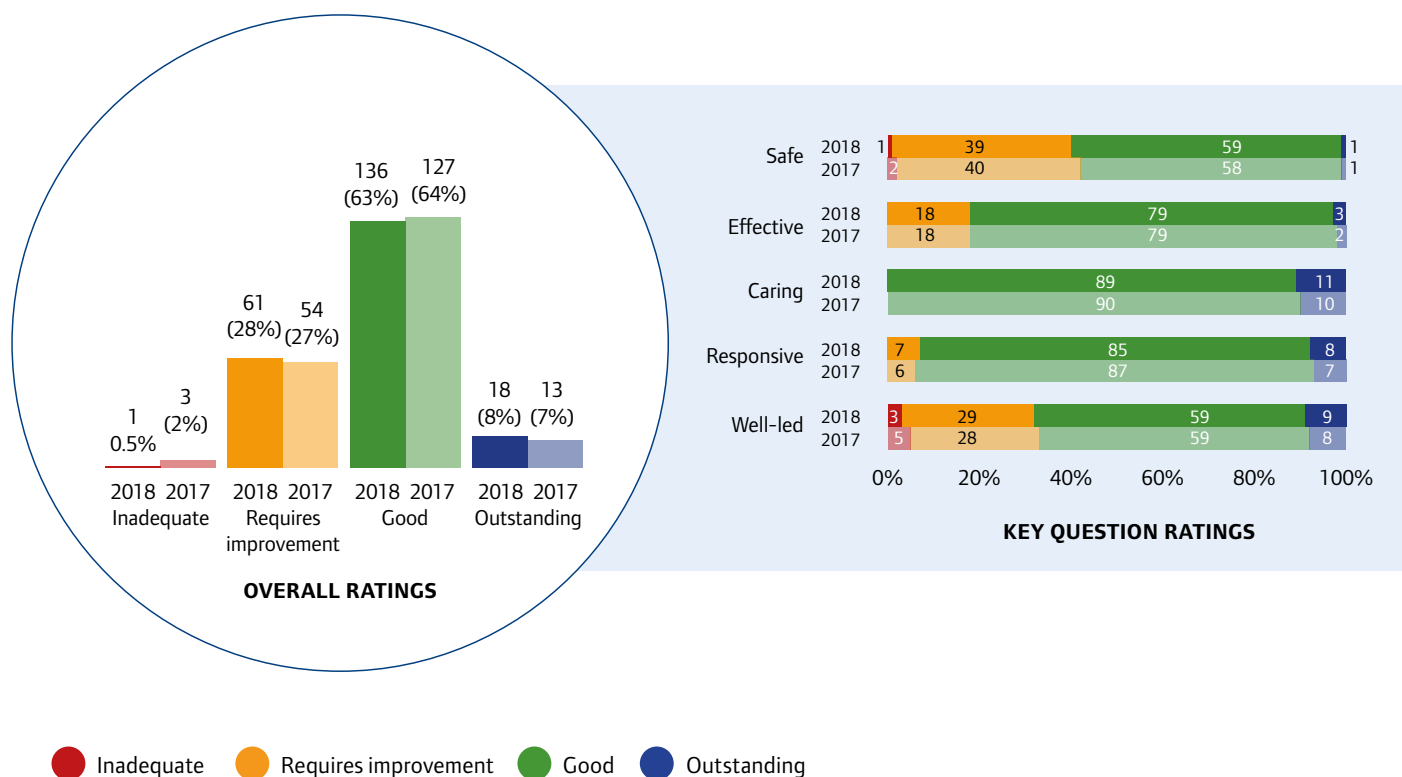
Urgent and emergency care services remain an area of concern, with many still struggling to make improvements. As at 31 July 2018, 7% of urgent and emergency care services were rated as inadequate and 41% were rated as requires improvement (figure 2.6). The safety of these services is a particular concern, with 7% rated as inadequate for safety.

The safety of maternity care is another key focus for us, with nearly half all maternity and gynaecology services, and more than a third of maternity services inspected under our new methodology, needing to improve.

While the safety of core services overall is of concern, with 40% of core services rated as requires improvement and 3% rated as inadequate, there has been a slight improvement in this area. As noted in last year's *State of Care*, the quality of leadership, management and governance is an important influence in driving the quality of care. This year, there has been a slight improvement in the leadership of core services, with 24% rated as requires improvement and 4%

^b Core services are the ones that most organisations provide. They are typically services that people use the most, or in some cases, the ones that may carry the greatest risk.

Figure 2.7 Independent acute hospitals, overall and key question ratings, 2017 and 2018



Source: CQC ratings data, 31 July 2017 and 2018.

rated as inadequate for the well-led key question; this compares with 29% rated as requires improvement and 5% rated as inadequate for this question last year (figure 2.5).

Looking in more detail, there is a strong link between the safety of services and the quality of leadership: in 68% of NHS hospitals, the ratings are the same for both the well-led and the safe key questions.

Independent acute hospitals

We have now completed our programme of comprehensive inspections for all independent acute hospitals in England. In April 2018, we published an overview of the findings from these inspections, which showed that the majority of these hospitals are providing high-quality care for their patients.⁶³ As at July 2018, 63% were rated as good and 8% were rated

as outstanding. However, 28% were rated as requires improvement and one (0.5%) was rated as inadequate (figure 2.7).

The overall profile of ratings for core services in independent acute locations is broadly similar to that for small NHS acute sites that do not provide emergency care. However, it is not really valid to compare independent and NHS services in this way. The independent acute sector generally focuses on patients with single conditions and routine, elective surgery. The NHS cares also for very different types of patient – those with more complex or multiple conditions, including dementia. NHS acute hospitals also mostly provide urgent and emergency care and admit patients through an emergency department, which the independent sector does not. Independent hospitals therefore have the advantage of not facing

the pressure from emergencies that most NHS acute hospitals do, but this also means they have less expertise and infrastructure to manage very unwell and deteriorating patients.⁶⁴

The two main core services provided by independent acute hospitals are surgery, and outpatients and diagnostic imaging. They also provide, to a lesser degree, medical care services, services for children and young people, and critical care. In 2017/18, independent acute providers admitted around half a million elective patients funded by the NHS, which was around 9% of all such admissions.

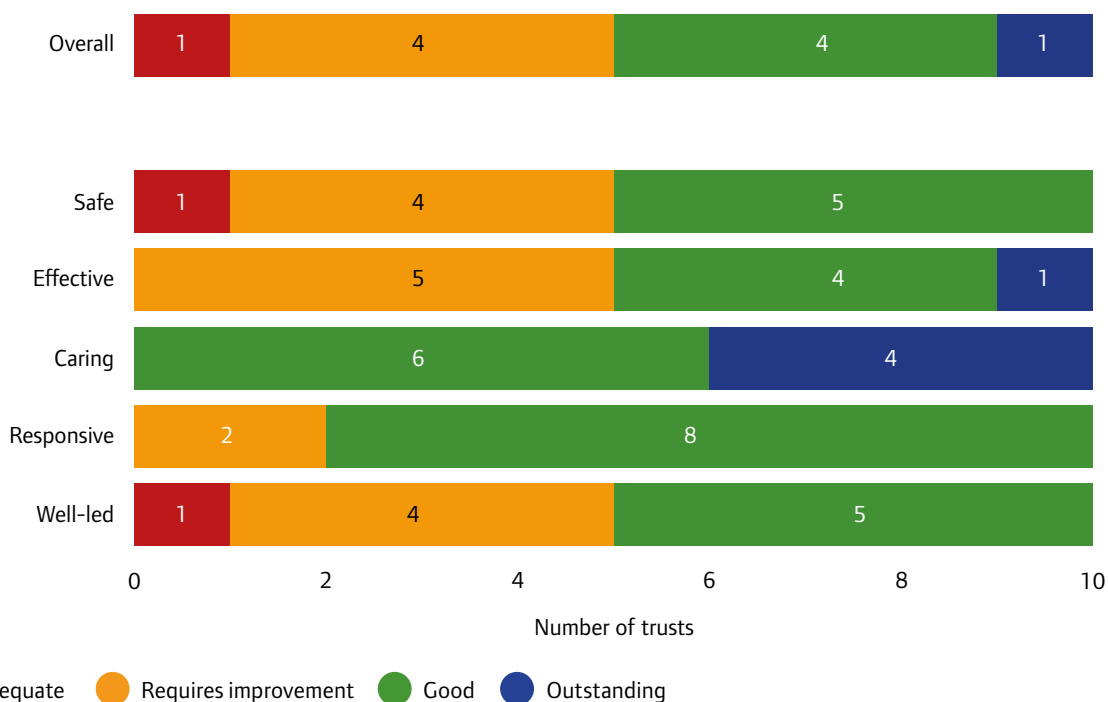
Overall, in independent acute health care, outpatients and diagnostic imaging services received the highest ratings, with 79% of services rated as good and 6% rated as outstanding. This was followed by surgical services, with 69% rated as good and 7% as outstanding.

Acute services for children and young people needed the most improvement. While 50% of these services were rated as good and 11% as outstanding, 37% of

services were rated as requires improvement and 3% were rated as inadequate. These services only tend to treat a very low number of children. We found that sometimes staff were not sufficiently trained, or they were not adjusting the environment to recognise and meet children’s needs. Children could often be treated as ‘small adults’, with no specialist environment, equipment or staffing, and cared for in rooms and facilities used by adults. Another concern was low compliance with safeguarding training requirements.

Because of the low numbers of children and young people that access independent services, there could be a lack of specialist paediatric staff on site. As staff did not have the experience of a high number of children, this had implications for their ability to recognise issues such as safeguarding concerns. Staff might also be unable to retain their knowledge, skills and experience when their hospital treated very low numbers of children. We also had concerns at some services about having the correct experienced clinical support for a deteriorating child.⁶⁵

Figure 2.8 NHS ambulance trusts, overall and key question ratings, 2018



Source: CQC ratings data, 31 July 2018. Numbers on bars are the number of trusts not percentages.

We found a range of outstanding and good practice within independent acute health care across all our five key questions. In particular, no providers have been rated as requires improvement or inadequate for the key question ‘are services caring?’. The responsiveness of the sector is also notable, with 85% of hospitals rated as good and 8% rated as outstanding as at July 2018.

However, the safety of care was one of the main areas that needs to improve. Overall, 59% of independent acute hospitals were rated as good for safety, but 39% were rated as requires improvement and 1% were rated as inadequate as at July 2018.

Ambulance services

Ambulance services are often the first point of contact when someone is in crisis and they provide a vital link between the public and urgent and emergency care. They can also play a key role in preventing inappropriate admission to hospitals.⁶⁶ However, like urgent and emergency services, resourcing of ambulance services is not always enough to be able to meet the needs of the increasing numbers of people who need them.

As highlighted in our report *Under pressure: safely managing increased demand in emergency departments*, problems in the wider system, for example overcrowding in emergency departments, mean that ambulances can face long delays in patient handovers from ambulance into hospital. Not only does this put the patients at risk, but also puts other people who are waiting for ambulances at risk as they have to wait longer for an ambulance to become available.⁶⁷

This sets the context for our inspections of England’s 10 ambulance trusts (note that additionally, the Isle of Wight NHS trust provides ambulance services). Across these trusts, we found that the quality of care has not changed since last year and remains variable. Four of the trusts were rated as requires improvement and one trust was rated as inadequate at 31 July 2018 (figure 2.8). As with NHS acute trusts, the leadership and safety of these organisations is closely linked.

Despite these difficulties it is possible to improve, with the London Ambulance Service NHS Trust moving from an initial rating of inadequate to a rating of good in the last inspection. The organisation’s leadership was a key driving force in this success.

A culture of improvement

London Ambulance Service NHS Trust covers an area of approximately 620 square miles, with demand for services increasing year-on-year. In 2016/17, the trust responded to more than 1.8 million 999 calls, and attended 1.1 million incidents, including a number of major events.

In November 2015, the trust was rated as inadequate and placed into special measures for quality following an inspection that found issues with its safety, effectiveness, responsiveness and leadership.

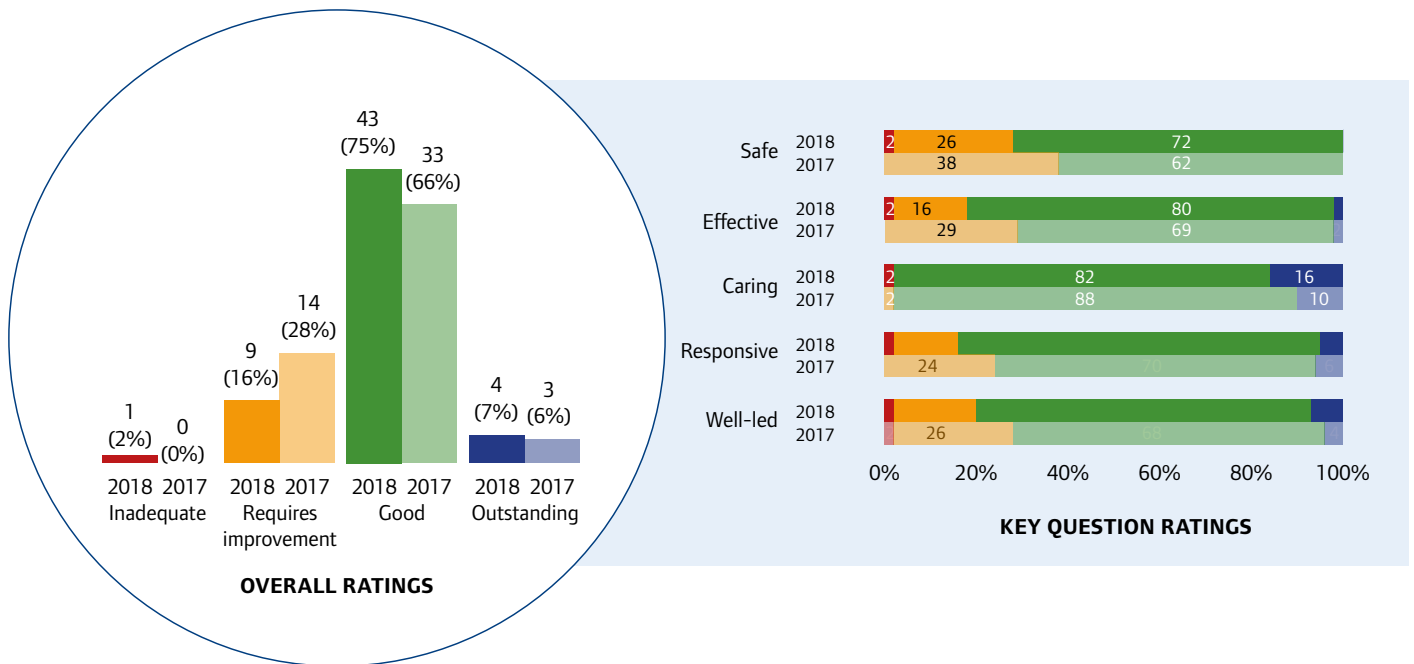
Since this inspection, the trust has been on an ongoing journey of improvement. It has strengthened its senior leadership team to form an executive team with an appropriate range of skills, knowledge and experience.

The executive team has been aware of the priorities and challenges and has acted to address them. The culture of the trust has improved, with staff feeling more able to raise concerns.

The trust also developed a number of innovative changes to the way it operates, such as the ‘hear and treat’ service, which provides clinical assessments over the phone to callers with less serious illnesses and injuries. Overall, staff are better supported to carry out their crucial work.

As a result of these changes, after the last inspection in March 2018, it was rated as good, with a recommendation that it should come out of special measures for quality.

Figure 2.9 NHS and independent community health organisations, overall and key question ratings, 2017 and 2018



● Inadequate ● Requires improvement ● Good ● Outstanding

Source: CQC ratings data, 31 July 2017 and 2018.

We also remain concerned about the quality of care being provided by the independent ambulance sector. Following the first 70 comprehensive inspections of independent ambulance organisations in 2017, we wrote to providers to raise concerns identified on inspection, including issues with:

- recruitment and training of staff
- infection control standards and vehicle and equipment maintenance
- staff training, supervision and performance management
- managing complaints, with patients often finding it difficult to complain
- variable standards of quality around governance and risk management processes.

We do not believe these concerns have substantially changed, as we have taken a significant amount of

enforcement action in the sector over the last year. The most common regulations breached include those relating to governance, safe care, and treatment and safeguarding.

Community health care

Community health services are used by people who need long-term care or regular support and are provided in locations such as clinics that are closer to home, or in a person's own home. Examples of community health services include physiotherapy, health visiting and care for people with long-term conditions such as diabetes. These can play an important role in helping to avoid unnecessary admissions to hospital.

Community health services span a range of different types of organisations and settings. There are 16 specific NHS community health trusts but care is also

provided by more than 30 NHS acute trusts and more than 20 NHS trusts that also provide mental health services. There are also more than 100 independent community health services, often social enterprises, charities and community interest companies.

Most of the community health trusts and the independent community health services are providing good care, with 75% rated as good at July 2018 (figure 2.9). However, we continue to monitor the safety and leadership of these organisations. Twenty-six per cent of trusts were rated as requires improvement for the safe key question and 2% were rated as inadequate, with 18% rated as requires improvement

for being well-led. This is an improvement on last year, which saw 66% of services rated as good overall, with 38% and 26% rated as requires improvement for the safe and well-led key questions respectively.

Hospices have also continued to provide high-quality care at the end of people's lives, and quality has improved slightly since last year. More than a quarter (27%) of hospices were rated as outstanding at 31 July 2018, with only 2% rated as requires improvement and none rated as inadequate. Furthermore, more than a third (35%) of hospices were rated as outstanding for the caring key question.

Where has the quality of care improved for people using services?

Many NHS trusts are taking steps to improve their services in the face of operational and system-wide pressures. Since the end of our comprehensive inspection programme in December 2016, we have seen improvements in all NHS acute core services, but particularly medical care services, surgery and end of life care.

While maternity and gynaecology services have not seen such notable improvements in ratings, the 2017 maternity service survey, which looked at the experiences of women receiving maternity services in February 2017, showed small improvements across most questions. This is a consistent upward trend that we have seen since the results of the 2013 survey. Notable changes include improvements in women's perceptions of being offered choices, and having the information to make choices, during their antenatal care.⁶⁸

Organisational culture is a key factor in driving the quality of care. Our inspections highlight the importance of having a focus on patients, openness, transparency and a culture where staff are encouraged to raise and report concerns, and feel empowered to make improvements. Our inspections have shown that good care is often inextricably linked with care that is person-centred and inspectors have highlighted the value and positive impact that this can have on patients. For example, we heard of one urgent care centre where staff went the extra mile in caring for

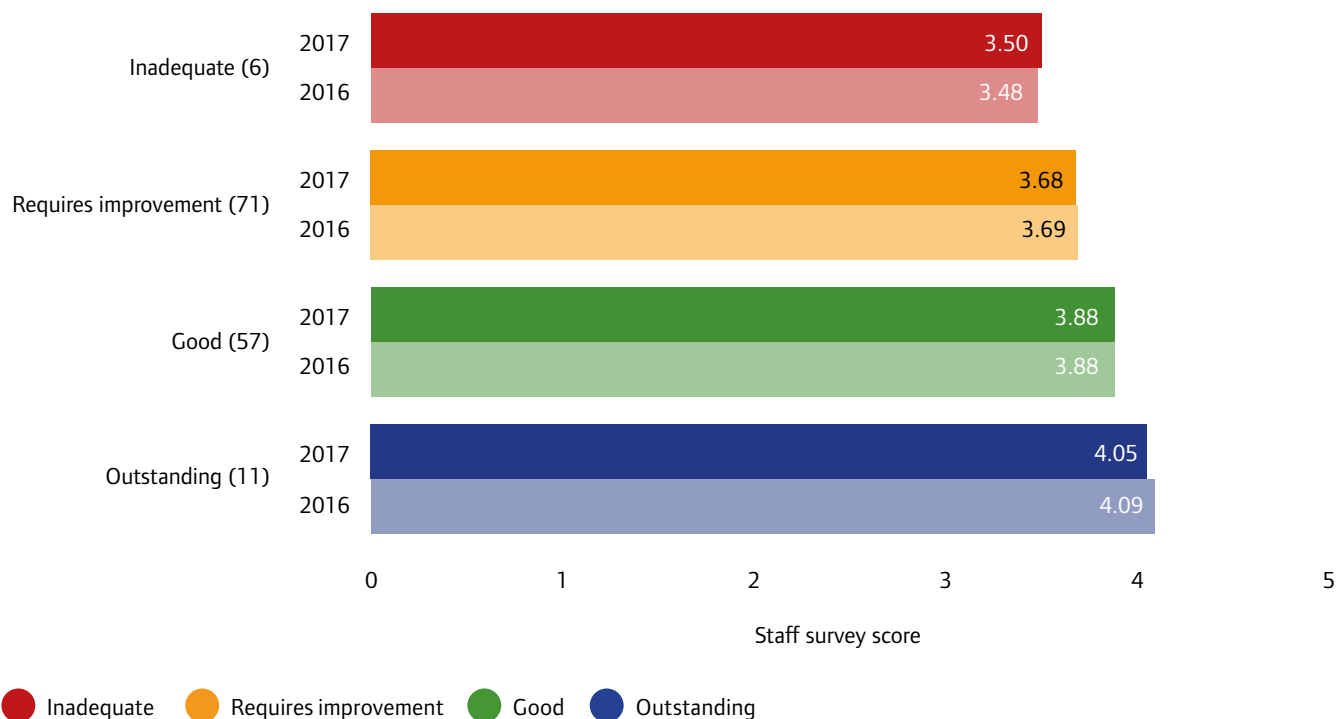
vulnerable patients and those with additional needs. In one case, they created a specific plan for a young person to enable them to be seen at the centre quickly and in a safe place, away from people and objects that would usually cause distress and anxiety.

Leaders are integral to setting the culture of an organisation; capable, high-quality leaders create workplace cultures that are conducive to providing high-quality care. This is borne out in the NHS annual staff survey data, which shows that more staff in outstanding trusts would recommend their trust as a place to work or receive treatment (figure 2.10). Through our inspections we have also found that, in general, good and outstanding trusts have a positive approach to equality and diversity.

This was reflected in our report *Driving improvement: case studies from eight NHS trusts*, which highlighted the importance of leadership in action.⁶⁹ Our case studies demonstrated the importance of having visible and approachable leaders who ensured that staff were engaged and felt empowered to make changes.

Looking more widely, our inspections have shown how important it is for leaders to work with partners across the health and social care system to tailor provision of care to the needs of the local population. Where organisations work collaboratively with community groups and other health sector organisations to understand and meet the needs of the local population,

Figure 2.10 Staff recommendation of their trust as a place to work or receive treatment, by overall trust rating



Source: NHS staff survey 2016 and 2017; CQC ratings data, 31 July 2018.

they are able to deliver more timely and responsive care. There is value in trusts working with system partners to take a strategic approach to the planning

and delivery of care, particularly in relation to winter planning and workforce planning, and in trusts working with each other to share good practice.

Where are people still not receiving the quality of care they can expect?

Increasing demand for services coupled with a lack of capacity within the system is putting more pressure on services, compromising the quality of care, and potentially putting patients at risk.

The safety of hospitals remains an area of concern with 3% of NHS acute core services rated as inadequate for safety. With this increasing demand, trusts need to make sure that capacity issues do not compromise safe care. Patient safety is a key focus of our current thematic review of serious, preventable incidents in NHS trusts. The review, commissioned by the Secretary

of State for Health and Social Care, is exploring the reasons why these ‘never events’ happen even where there is preventable measures guidance in place. It is looking at what can be done to improve compliance with safety guidance, and how we can apply the learning from these events to wider safety issues.

Having the right number and mix of skilled, permanent staff is a key factor in an organisation’s ability to provide high-quality care. National staffing shortages combined with local factors, for example the desirability of an area or a trust’s reputation, can add to the

staffing challenges that trusts face. However, with proactive planning and management, acute hospitals can work to mitigate staffing issues. It is important that national workforce shortages do not become an excuse for poor care. On our inspections, we have found some trusts that are struggling with staffing, blaming national shortages and failing to recognise their own role and responsibility to ensure a safe level of staffing for patients. This can include a lack of a focus on succession planning and internal governance of workforce issues. Trusts with good governance systems approach these problems proactively and are able to find innovative ways of working and upskilling existing staff to ensure all needs are met, regardless of these national pressures.

The impact of workforce shortages is also being felt in community healthcare services. From 2009 to 2017, there has been a 40% decrease in the number of community matrons and a 44% drop in the number of district nurses. Shortages in community nursing were found to have an adverse impact on delivering responsive seven-day care.

Funding issues equally contribute to the quality of services in an acute trust, both in their ability to maintain the quality of care and to make improvements where they find underperformance. In trusts that had made improvements, we found strong leadership with a focus on finances but also on quality. In our *Driving improvement* report, one trust credited a focus on quality and efficiency, and investing in the right areas so that people get the treatment they need, as the reasons for its improved financial situation.⁷⁰

However, we have also found that commissioning affects the variation in the quality of care. Gaps in commissioning of acute services, where trusts have not been allowed to provide a service because they have not been commissioned to provide it, have a clear knock-on effect on the trust's capacity to meet local needs.

Investment in community health and care services and the provision of high-quality community support can help to keep people at home, reducing the need to access acute services, and in some cases, avoid admission to hospital. However, gaps in the

Impact of leadership on the quality of a trust

In January 2016, we rated a large NHS trust as requires improvement. By the next inspection in July 2017, this had fallen to an overall rating of inadequate. As with other trusts, a number of internal and external factors influenced this deterioration in its rating.

The hospital has struggled with issues around leadership and governance. The inspection in July 2017 revealed significant issues with the trust's governance structure, and a number of urgent areas of concern where risks to patient safety were not being properly managed. Poor communication between middle management and executives was also an issue.

In addition, one of the biggest contributing factors was a lack of continuity in executive leadership, with a series of interim leaders. These leaders were appointed to make improvements in

certain areas, but did not have time to establish and embed systems and processes before they left. This change in leadership had an impact on staff morale at the front line, as there was continuing uncertainty about who would be staying in the longer term.

The geographical location of the hospital was a contributing factor to the high turnover in senior leadership, and perhaps one explanation for the lack of continuity in the executive team, as one inspector described:

"It is quite isolated... and that's quite a consideration in terms of recruitment... there is an issue around trying to get fresh blood into the place because people don't want to move there; people go there towards the end of their career."

commissioning of services and reductions in income in real terms are affecting services' capacity to provide person-centred, holistic care, particularly in community and adult social care services. This can have a significant impact on people receiving the right care in the right setting at the right time as we highlighted in our report *Beyond barriers*.⁷¹

The case study at the beginning of the chapter showed that not being able to access the right care at the right time can adversely affect a person's health and wellbeing. We have also seen through our inspections how a lack of system working, and not providing joined-up care, can result in people deteriorating and not going home following an admission to hospital, but instead needing residential care.

The quality of an organisation's leadership and its ability to mitigate these external influences, including partnership with other organisations, are important factors in whether trusts are able to maintain quality. Through our inspections, we have found that executive teams were a key influence in both the deterioration and improvement of a trust. Other issues, including a high rate of turnover in leadership positions and a failure to implement and adhere to governance frameworks and board-level oversight, could also affect the quality of care. In some trusts where leadership may be less effective, we have found that when leaders are focused on responding to issues flagged in inspection reports they have then 'taken their eye off the ball' in other areas, which has led to the quality of care deteriorating.



Mental health care

Key points

- The majority of NHS mental health trusts are continuing to provide good care in their core services, with 70% rated as good and 8% rated as outstanding. Independent providers are also doing well, with 72% rated as good and 6% rated as outstanding.
- We continue to be concerned about the safety of NHS core services. Ratings from 31 July 2018 show that 37% of core services were rated as requires improvement and 2% were rated as inadequate for the key question 'are services safe?'. The figures are similar in the independent mental health sector, with 30% and 3% rated as requires improvement and inadequate respectively.
- Our greatest concern is about the quality and safety of care provided on mental health wards, and in particular on acute wards for adults of working age. Investment is needed to replace or refurbish wards located in unsuitable buildings. Also providers must make sure that patients have access to the full range of care interventions, such as specialist psychological therapies.
- We continue to find variation in the quality of mental health care and issues with access to services, with people having little or no choice about which service will provide their care.
- Mental health trusts are working in an increasingly tight financial climate. Despite this, we have seen that improvement is possible. Overall, there is a general trend of improvement, with 58% of the 55 NHS mental health trusts and independent hospitals that we re-inspected improving from requires improvement on their first inspection to good following re-inspection. However, this improvement doesn't translate to good care for everyone.

David's story

David has a history of using mental health services and primary medical services. He is currently attending counselling and regularly visits his GP, but also has experience of receiving care as an inpatient on a mental health ward.

David's experiences of using mental health services have been mixed. When he has had a positive experience, he felt that staff genuinely cared about him and involved him in decisions about his care. From his perspective, it goes beyond compassion and is based on a sense of openness, honesty, and trust:

"...just being open, treating me like a human being. You know, I wasn't just – how can I put it? – another patient suffering with mental illness ... I felt I could just open up and be honest about whatever I was feeling, whatever was going on and I know that I could trust them with having my best interests at heart."

Being able to work with his GP to make decisions about the medication that best suited him, rather than being told what was best for him, gave David a sense of control, which helped him with his recovery:

"I was in control of my life; it helped me to recover, you know; it helped me along the road to recovery."

David found that the quality of his experiences as an inpatient was also directly related to the relationships he established with members of staff. In particular, he felt that managers who spent time listening and creating a supportive environment provided the best care:

"I think you'll find that... the best wards [are] where staff are ... not exercising their authority so much; but more building a relationship, more like a friendship, a supporting role to that person, you know, where that person feels very comfortable in communicating with them and dealing with them..."

Where David had a negative experience, he felt his choices and preferences weren't listened to or that staff were detached or disinterested:

"Some people I didn't mind; some people, I didn't feel like their heart was in the job and I just didn't want them around me because I didn't feel that they were there for my care..."

David also felt that the use of restraint and restrictive practices on inpatient mental health wards was unnecessary and could be detrimental to recovery. But, positively, he felt that he had witnessed improvement in this area.

Introduction

The stigma around mental health is gradually being eroded and there is greater recognition that people in need of mental health care have a right to the same level of care and support as those with physical health care needs.

Since the publication of *The Five Year Forward View for Mental Health* in February 2016, the government has continued to emphasise the importance of improving mental health care in the UK.^{72, 73} In 2017, it asked CQC to review the mental health care of children and young people, published a Green Paper on the same subject and commissioned the independent review of mental health legislation and practice, led by Sir Simon Wessely.

The landscape of mental health care provision is complex and can be difficult to navigate. The majority of people with mental health problems who seek help receive it from their family doctor, with nine out of 10 adults with mental health problems being supported in primary care. There has also been an expansion in access to talking therapies, following the introduction of the national IAPT programme (Improving Access to Psychological Therapies).⁷⁴ People who need specialist help for more severe mental health problems are likely to be under the care of an NHS trust. These are large organisations that provide both inpatient and community care – usually from a large number of locations. The independent sector is a major provider of specialised inpatient care, much of which is funded by the NHS.

In last year's *State of Care* report, we set out the challenges faced by specialist mental healthcare providers. We expressed particular concern about the state of some inpatient services where a combination of rising demand, rising acuity, poor physical environment and staffing shortages has led to wards that are unsafe and where staff resort to over-restrictive practices in an attempt to cope. We include an update on these concerns on page 87.

We are also committed to improving the mental health care for people detained under the Mental Health Act (MHA). As the independent monitoring body for the MHA, we are working with the Wessely Review's advisory panel and working group. We are also carrying out a collaborative evaluation of the way the MHA

Code of Practice (2015) has been implemented with patients, providers and experts. This will help identify practical solutions to help improve areas of practice and we will be sharing our findings with the sector, the Wessely Review and the government. In our evaluation, we are focusing on what service and professional factors can have an immediate impact on the experience and outcomes for people affected by the MHA.

In addition, we have a particularly important role in supporting national policy relating to people with a learning disability and/or autism who display behaviour that challenges. This includes the Transforming Care Programme and the accompanying service model of care. These aim to ensure that people with a learning disability and/or autism who display behaviour that challenges are effectively supported to live in their communities, close to home, and are only admitted to a hospital when that is the intervention most suited to their needs at that time. We published *Registering the right support* to clearly set out our approach to registering providers of services for people with a learning disability and/or autism.⁷⁵ The Transforming Care Programme has continued to focus on ensuring that people are discharged from hospital into community services. CQC applies its policy to support appropriate community services and, earlier this year, the First-tier Tribunal^c upheld our decision to refuse an application to increase the maximum number of people with a learning disability in a campus and congregate setting.^d Approval would have been contrary to the principles of our *Registering the right support* policy, which is underpinned by *Building the right support* and the Transforming Care Programme.

Looking to the future, we have provided NHS England with information on areas of concern, as well as opportunities to address key issues faced by mental health services, to inform their work on mental health in the 'Long Term Plan for the NHS'. Our feedback focuses on ensuring we improve the care of people with

c Appeals against our decisions on registering providers are determined by the First-tier Tribunal (Care Standards), one of seven chambers of the First-tier Tribunal.

d See *Registering the right support*, page 12 footnote c and page 13 footnote d, for definitions of 'campuses' and 'congregate settings'.

Figure 2.11 NHS mental health trusts, overall core service and key question ratings, 2017 and 2018

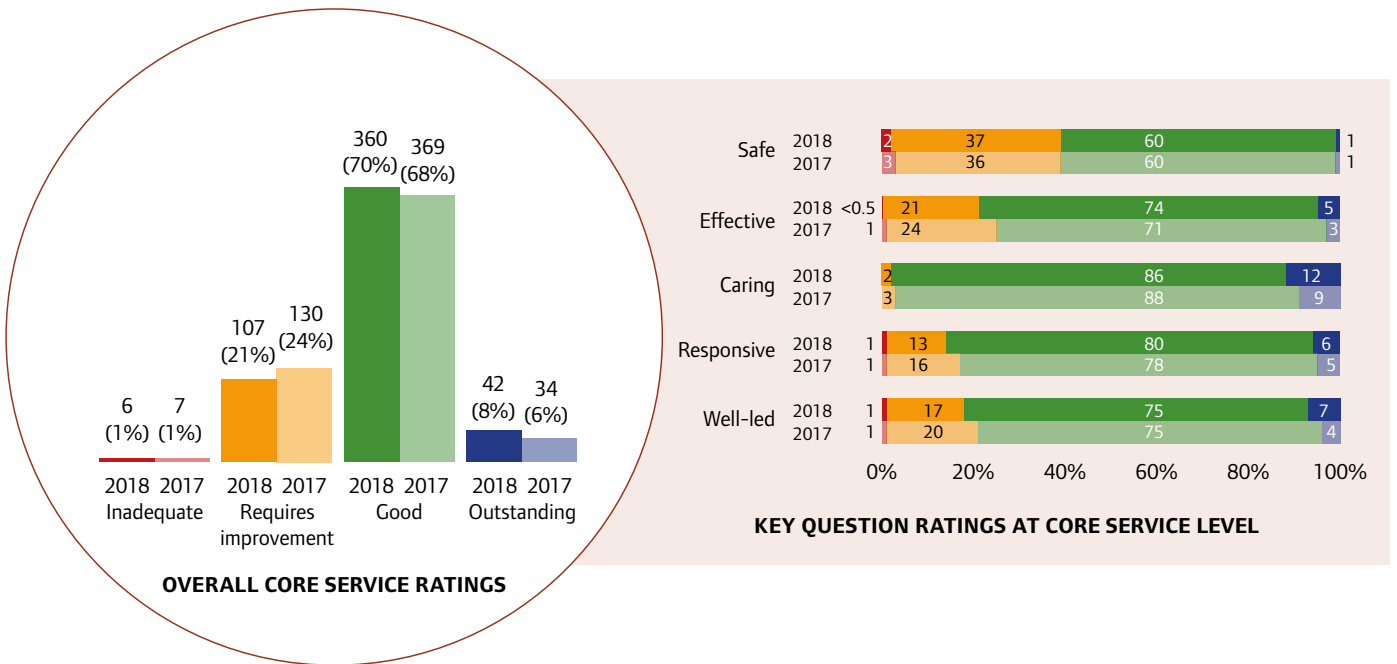
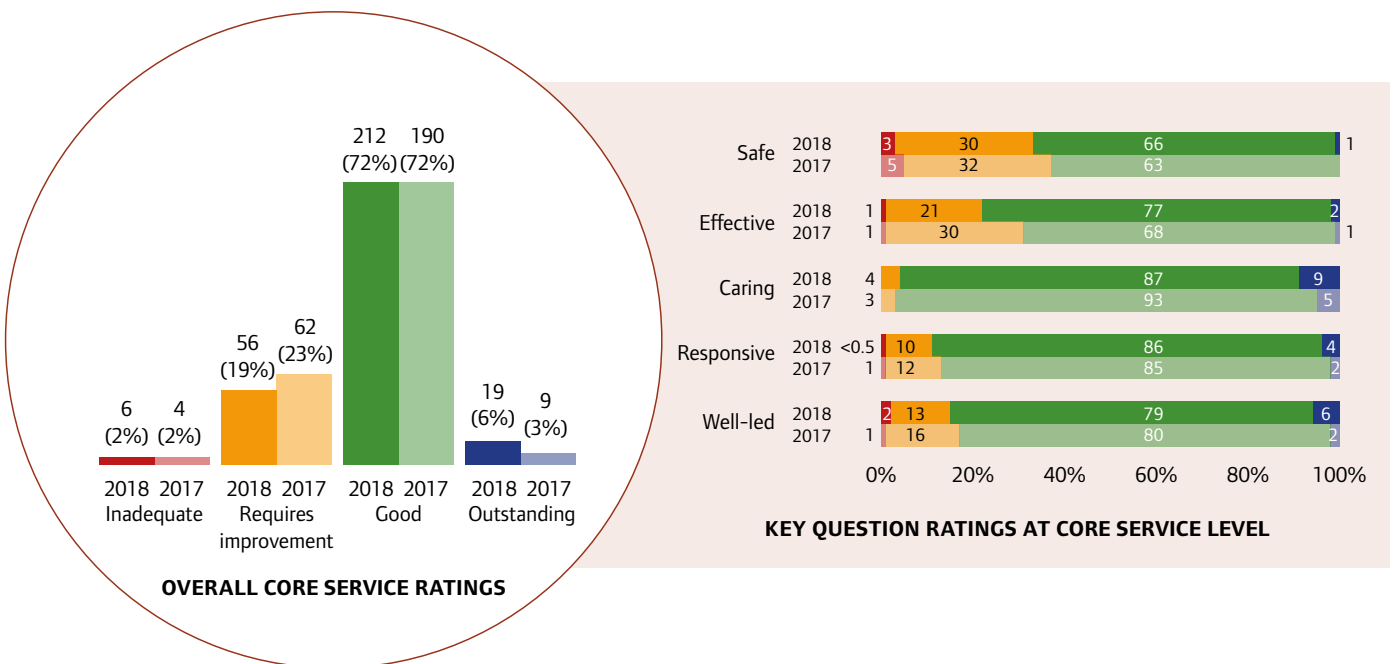


Figure 2.12 Independent mental health providers, overall core service and key question ratings, 2017 and 2018



● Inadequate ● Requires improvement ● Good ● Outstanding

Source: CQC ratings data, 31 July 2017 and 2018.

the most severe and enduring forms of mental illness, including through safe ward environments, adequate staffing, access, care near the home, and access to community mental health services.

Despite all the challenges that mental health services currently face, the trusts featured in our *Driving improvement: case studies from seven mental health NHS trusts* publication have shown that, with the right leadership and culture, positive change is possible.⁷⁶

What is the quality of care like for people using services?

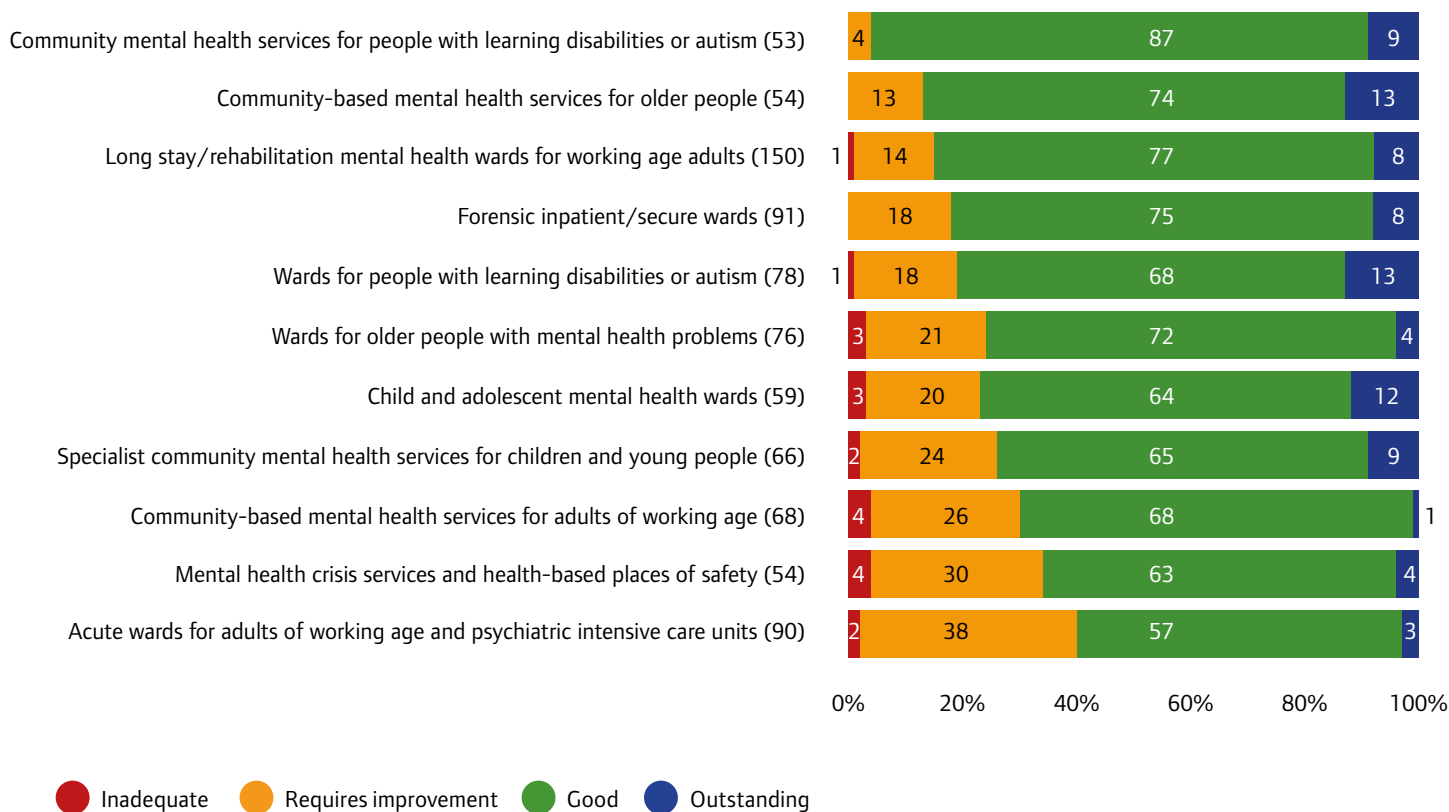
Overall, the majority of mental health NHS trusts are continuing to provide good care in their core services^e, with 70% rated as good and 8% rated as outstanding (figure 2.11). Independent providers are also doing well, with 72% rated as good and 6% rated as outstanding (figure 2.12).

Looking in more depth at the core services, our ratings suggest that the quality of care remains strongest in

community services for people with a learning disability or autism, with 87% rated as good and 9% rated as outstanding. Community based-mental health services for older people are also performing well, with 74% rated as good and 13% rated as outstanding. However, more than a quarter of specialist children

^e Core services are the ones that most organisations provide. They are typically services that people use the most, or in some cases, the ones that may carry the greatest risk.

Figure 2.13 NHS mental health trusts and independent providers, core service ratings, 2018



Source: CQC ratings data, 31 July 2018.

and adolescent mental health community services, community services and acute wards for working age adults, and crisis services were rated as either requires improvement or inadequate (figure 2.13).

The safety of core services is an area that we continue to be concerned about. Ratings from 31 July 2018 show that 37% of NHS core services were rated as requires improvement and 2% were rated as inadequate for the key question 'are services safe?'. The figures are similar in the independent mental health sector, with 30% and 3% rated as requires improvement and inadequate respectively. To support trusts to improve the safety of their services, we have been asked by the Secretary of State to work on a joint Mental Health Safety Improvement Programme (MHSIP), led by NHS Improvement. The overall aim of the programme is for every NHS trust providing mental health core services in England to have understood their safety priorities and have made a measurable improvement in at least one key area of mental health safety by 31 March 2020.

Mental health and learning disability services should be proud of their staff; the great majority

go above and beyond to provide people with the care they need with limited time and resources. This is reflected in the high proportion of core services rated as good or outstanding for the key question 'are services caring?'.⁷⁷

However, caring is about more than staff treating people with kindness and compassion. It is also about services supporting people to express their views and be actively involved in making decisions about their care and treatment. As a result, it is concerning that our 2016/17 *Monitoring of the Mental Health Act* report continued to show issues in the involvement of patients in care planning.⁷⁷ Likewise, the 2017 Community Mental Health Survey found that people feel less involved in their care. The proportion of respondents who said they felt listened to by their health or social workers fell by five percentage points from 2014 to 2017 (from 68% to 63%) and there was a similar reduction in the proportion of people reporting that they had enough time to discuss their needs and treatment.⁷⁸

Where has the quality of care improved for people using services?

The Mental Health Five Year Forward View Dashboard shows that the total NHS spend on mental health has increased year-on-year since 2015/16.⁷⁹ However, the Royal College of Psychiatrists has reported that mental health trusts received £105 million less to spend on patient care in 2016/17 in real terms compared with 2012.⁸⁰ Despite the tight financial climate that mental health trusts are working in, we have seen that improvement is possible. Comparing the ratings of core services from the position at 31 July 2017 (last year's *State of Care*) to 31 July 2018, there has been some improvement in services including both wards and community services for people with autism or a learning disability, and long-stay rehabilitation wards for adults of working age.

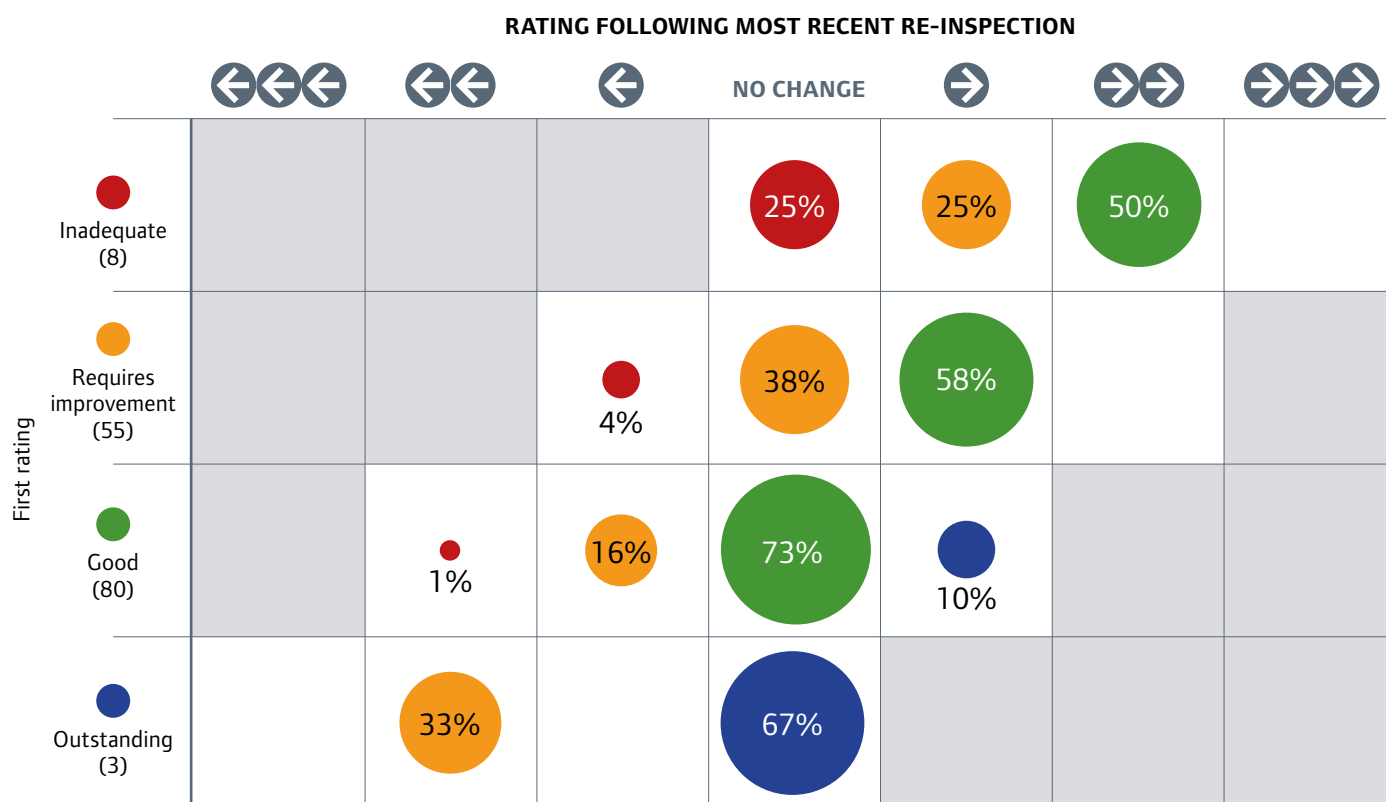
Looking more widely at the overall performance of services there is a general trend of improvement,

with 58% of the 55 NHS mental health trusts and independent hospitals that we re-inspected improving from a rating of requires improvement on their first inspection to good following re-inspections published in the year to 31 July 2018 (figure 2.14).

Looking specifically at NHS trusts, we have seen examples of how providers have managed to improve. Figure 2.15 shows the great contrast between first and last ratings in the 10 most improved trusts to date, four of which were featured in our *Driving improvement* report.


As in other sectors, good leadership and governance are needed if organisations providing mental health care are to improve. Having strong leadership that fosters a positive and inclusive culture, where staff feel able to speak up and speak out can be a key feature in improving trusts.


Figure 2.14 NHS mental health trusts and independent providers, change in rating on re-inspection, year to 31 July 2018



● Inadequate
 ● Requires improvement
 ● Good
 ● Outstanding

Source: CQC ratings data, re-inspections published in the year to 31 July 2018. Change in rating is from first to most recent inspection.

 One level of rating change up (for example, from requires improvement to good)

 One level of rating change down (for example, from good to requires improvement)

While leaders in the trusts in our *Driving improvement* report were clear that improvements had to be owned and driven by staff, there was also strong direction from senior teams that included clinicians. At the same time as devolving authority for decision-making, leaders of these trusts created strong governance systems and clear accountability. They were not afraid to draw red lines when needed and some told us of tough decisions they had made to ensure that they had the right people in place to lead improvement.

In addition, on inspection we have found that good and improving trusts are often outward looking. These trusts recognise the importance of working with partner organisations, including commissioners and other services, to deliver local solutions that can lead to more responsive and timely experiences of care. Involving people who use services and their carers fully in design can also support the development and improvement of services and of care.

Figure 2.15 NHS mental health trusts, overall and key question change in rating on re-inspection – 10 most improved trusts

Trust name	First rating	First rating					Overall	Most recent rating	Most recent rating					Overall	
		Safe	Effective	Caring	Responsive	Well-led			Safe	Effective	Caring	Responsive	Well-led		
Sussex Partnership NHS Foundation Trust	28/05/2015	●	●	●	●	●	●	23/01/2018	●	●	●	●	●	●	●
Humber Teaching NHS Foundation Trust	10/08/2016	●	●	●	●	●	●	01/02/2018	●	●	●	●	●	●	●
Northamptonshire Healthcare NHS Foundation Trust	26/08/2015	●	●	●	●	●	●	28/03/2017	●	●	●	●	●	●	●
Kent and Medway NHS and Social Care Partnership Trust	30/07/2015	●	●	●	●	●	●	12/04/2017	●	●	●	●	●	●	●
Camden and Islington NHS Foundation Trust	21/06/2016	●	●	●	●	●	●	06/03/2018	●	●	●	●	●	●	●
North East London NHS Foundation Trust	27/09/2016	●	●	●	●	●	●	18/01/2018	●	●	●	●	●	●	●
Dorset Healthcare University NHS Foundation Trust	16/10/2015	●	●	●	●	●	●	13/04/2018	●	●	●	●	●	●	●
Somerset Partnership NHS Foundation Trust	17/12/2015	●	●	●	●	●	●	01/06/2017	●	●	●	●	●	●	●
North Staffordshire Combined Healthcare NHS Trust	22/03/2016	●	●	●	●	●	●	15/02/2018	●	●	●	●	●	●	●
Lincolnshire Partnership NHS Foundation Trust	21/04/2016	●	●	●	●	●	●	09/06/2017	●	●	●	●	●	●	●

Source: CQC ratings data, 31 July 2018

● Inadequate ● Requires improvement ● Good ● Outstanding

Where are people still not receiving the quality of care they can expect?

Our inspections continue to find a substantial variation in the quality of care between mental health providers, and issues with access to services. This has partly been attributed to the complexity of mental illness and the fragmented nature of mental health care. In general, people with mental health problems or a learning disability have little choice of which service will provide their care, and people who are treated compulsorily under the Mental Health Act have no choice about where they are treated.

The decisions that commissioners make have a direct impact on ensuring that the right care and support

is available, especially for those with limited or no choice in where they are treated. Feedback from inspection staff suggests that a lack of investment can have an effect on both the availability and quality of mental health services and the capacity of the system to care for people with mental health problems. This includes services' ability to maintain the right staffing levels and their ability to put people at the centre of their care.

The quality and safety of care provided on mental health wards, and in particular on acute wards for adults of working age, is a key area of concern.

In core services rated as requires improvement for safety we have regularly found issues with ligature points, poor ward layouts that hinder observation and breaches of guidance on the elimination of mixed sex accommodation. Investment is needed to replace or refurbish wards located in unsuitable buildings. Also, providers must make sure that patients have access to the full range of care interventions, such as specialist psychological therapies, and to support ward staff teams to create a ward environment that is both safe and that minimises restrictions.

The quality of care people receive is also being affected by problems with staffing. Mental health services are expected to care for more and more people with complex mental health needs. This increased complexity of need requires more specialist staff to cope with demand, but services are often failing to recruit staff with the right skill-set. In the independent hospitals sector, the size and location of the hospitals and the nature of the sector compared with NHS trusts can be a specific factor in workforce issues. For example, independent hospital managers often work in a more isolated fashion, with a smaller pool of staff to draw on and less capacity to effectively manage staffing levels and mixes.

Staffing is a particular problem for child and adolescent mental health services (CAMHS), where there are fewer people with the right experience and staff retention can be a challenge. The experiences of our inspection teams suggested that the problem has been made worse in recent years by the loss of a specific CAMHS qualification, which means that fewer staff have the specialist skills needed. In addition to this, the removal of training bursaries for nurses means that there are fewer nurses entering the workforce.

Our thematic review of children and young people's mental health services *Are we listening?* highlighted the problems that can be caused by a complex and fragmented system. Our review concluded that young people, their families and their teachers often do not know where to turn to find help when a young person develops a mental health problem. Services managed by different providers may put up barriers in the form of referral exclusion criteria to manage demand.

Our inspection teams have highlighted that funding pressures, together with a failure to commission the right number and type of services, have had an effect on the provision and quality of mental health care. This, in turn, is leading to long referral times and young people receiving treatment far from home. For example, in our report *Are we listening?* we identified gaps in mental health support for children with autism or attention deficit hyperactivity disorder (ADHD).⁸¹ In July 2018, research by the All Party Parliamentary Group on Autism highlighted the long wait times for people suspected of being autistic.⁸² Linked to this, disinvestment in lower level support by local authorities, for example for schools mental health or voluntary sector services, are contributing to pressures in other parts of the system, including a rise in demand on specialist child and adolescent mental health services.

Our thematic review highlighted the well-known problem faced by young people making the transition from CAMHS to adult mental health services. However, we are also concerned about the interface between services at the other end of the age-range, including the question of whether 'ageless' services have the specialist skills to meet the specific needs of older people with mental health problems. We plan to explore this issue further over the coming year.

Updates on key issues

As noted in the introduction, in last year's report we set out the key challenges facing specialist mental health services. This section revisits our areas of concern and looks at the developments and continuing challenges for providers.

Locked rehabilitation wards

We have expressed concern about the high numbers of people being cared for in locked mental health rehabilitation wards. We are concerned that some of these rehabilitation hospitals are in fact long stay wards that institutionalise patients, rather than a step on the road back to a more independent life in the person's home community.

In October 2017, we sent an information request to all 54 NHS and 87 independent healthcare providers

identified as managing mental health rehabilitation inpatient services. This asked about:

- the number of locations and wards providing mental health rehabilitation services and the average daily cost of a bed on those wards
- the type, size and 'locked' status of the ward
- each patient's length of stay, funding authority and the mental healthcare provider that would be responsible for aftercare.

Results showed that nearly two-thirds (63%) of placements in residential-based mental health rehabilitation services are 'out of area', which means they are in different regions to the clinical commissioning groups (CCGs) that arranged them. In addition, there is very wide variation between

Impact of staffing issues in child and adolescent mental health services

Following concerns raised through both intelligence and previous inspections, we looked at all the child and adolescent mental health service (CAMHS) provision across one independent provider.

We found a range of concerns including a lack of access to psychological interventions, failures in reporting of safeguarding concerns at some sites, issues with the quality of physical health monitoring and treatment at some sites, frequent use of physical restraint and a shortage of registered mental health nurses with relevant experience. We rated two of these services as inadequate and placed them in special measures. The provider voluntarily closed one of these services. We also rated another service as requires improvement and issued a Notice of Proposal. The provider also voluntarily closed this service.

To understand if these were isolated problems or part of a wider failure in leadership and governance, we carried out a well-led review of the provider. We found that workforce

issues and shortages of nurses with expertise in child and adolescent mental health was a systemic issue affecting all of the services provided. We also identified other problems with the governance of the hospitals. For example, there was no identified member of the senior leadership team accountable for the CAMHS service delivery across the provider. This hindered their ability to standardise good practice across the specialism. This was reflected in our findings across the services of inconsistent implementation of policies, sharing of good practice and embedding of lessons learned across teams. As a result, we have told the providers that they must:

- ensure that CAMHS services are staffed by a sufficient number of permanent, trained and qualified registered nurses with experience in CAMHS.
- provide staff with specialist CAMHS training relevant to their roles and maintain oversight of its delivery.

CCG areas in the use of rehabilitation beds, and in the use of beds that are out of area. This is a costly element of provision. We estimate that the annual expenditure on mental health rehabilitation beds is about £535 million. Out of area placements account for about two-thirds of this expenditure.⁸³

NHS England and NHS Improvement have accepted these recommendations and the latter have established a workstream of the Getting it Right First Time (GiRFT) programme to support local systems to implement them.

Physical restraint

We have highlighted ongoing concerns about the use of physical restraint, and in particular the wide variation in the number of incidents of use of physical restraint reported by providers. At that time, we advised NHS England that proper regulation of this important aspect of practice can only happen if there are better definitions of types and levels of restraint, more complete and consistent reporting, and better and more consistent training for provider staff in how to manage challenging behaviour.

In response, NHS England has set up a programme to address these issues. From April 2019, NHS Digital will introduce new definitions that commissioners will require providers to submit, and the United Kingdom Accreditation Service will introduce an accreditation scheme for training provider staff.

To support improvement, we have published a good practice guide that shares the experiences of five NHS mental health trusts where we've seen effective ways of reducing the use of restrictive practices. The resource shares examples of good practice in:

- improved leadership and governance (North West Boroughs Healthcare NHS Foundation Trust)
- a programme to reduce restrictive interventions (Mersey Care NHS Foundation Trust)
- supporting positive behaviour (Tees, Esk and Wear NHS Foundation Trust)
- providing person-centred care (Cambridgeshire and Peterborough NHS Foundation Trust)
- embedding a positive and therapeutic culture (East London NHS Foundation Trust).⁸⁴

Sexual safety on mental health wards

In 2017, following concerns raised on an inspection of a mental health trust, we carried out a review of reports on patient safety incidents that staff had submitted through the NHS National Reporting and Learning System. We started by analysing reports of incidents that took place on wards in the three-month period from April to June 2017. Our analysis of nearly 60,000 reports found 1,120 sexual incidents involving patients, staff, visitors and others described in 919 reports – some of which included multiple incidents. More than a third of the incidents (457) could be categorised as sexual assault or sexual harassment of patients or staff.

As part of our review, we also consulted widely with people who have used services, clinicians and managers, the professional bodies and with other arms-length bodies who told us that:

- People who use mental health inpatient services do not always feel that staff keep them safe from unwanted sexual behaviour.
- Clinical leaders of mental health services do not always know what is good practice in promoting the sexual safety of people using the service and of their staff.
- Many staff do not have the skills to promote sexual safety or to respond appropriately to incidents.
- The ward environment does not always promote the sexual safety of people using the service.
- Staff may under-report incidents and reports may not reflect the true impact on the person who is affected.
- Joint-working with other agencies such as the police does not always work well in practice.

We are working with system partners, including providers, commissioners and improvement organisations to take action to improve the sexual safety of people who use services.⁸⁵ Read more about these actions at www.cqc.org.uk/sexualsafetymh.

Shared sleeping arrangements on mental health wards

Last year we reported that our inspectors had identified a number of mental health wards that had bedrooms that contained two or more beds. We said that, “In the 21st century, patients, many of whom have not agreed to admission, should not be expected to share sleeping accommodation with strangers – some of whom might be agitated. This arrangement does not support people’s privacy or dignity.” This position is consistent with the Department of Health and Social Care’s *Health Building note for Adult acute mental health units*. This states that “since 2000, all new-build units have been required to incorporate single bedrooms, ideally with their own bathrooms”.⁸⁶

From our inspections, we estimate that more than 1,000 beds on mental health wards are located in a bedroom with two or more beds. People who have experience of sleeping on wards with such arrangements, and their carers, have told us that key concerns with these wards include disturbed sleep, personal safety, risk of theft, proximity of other people and lack of privacy.

We expect providers that have wards with shared sleeping arrangements to take every possible action to ensure that the safety, dignity and privacy of patients are maintained.

Staffing of the high-secure hospitals

Last year, we expressed concern that staff shortages at Rampton and Broadmoor Hospitals were restricting patients’ access to therapies and leisure activities during the day and, in the case of Broadmoor Hospital, could have been putting patients at risk.

We shared our concerns with the Secretary of State for Health and discussed our findings with NHS England Specialised Commissioning and the National Oversight Group for high-secure services. Following recent inspections, we found improvements at both Broadmoor Hospital and Rampton Hospital. Following our last inspection in June 2018, we rated Broadmoor Hospital as good overall.

Residential substance misuse services

In November 2017, we published a summary of our findings from inspections of 68 independent sector residential substance misuse services. We found a number of concerns including:

- Providers that did not assess risk to individual clients adequately.
- Doctors and nurses that did not follow best practice guidance when assisting clients to withdraw from alcohol and/or drugs.
- Poor management of medicines, including controlled drugs.
- Providers that did not provide staff with the training required to work with this client group.
- Failure to safeguard clients by carrying out employment checks on staff.

In response, we have strengthened our working relationship with Public Health England, the body that supports local authorities to commission and deliver alcohol and drug treatment services. Since July 2018, we have also had the power to rate independent substance misuse services. This will improve our ability to report on the quality of these services, and to monitor and report on whether they are improving over time.⁸⁷

Primary medical services

Key points

- In general practice, 91% of GP surgeries were rated as good and 5% as outstanding, with 1% rated as inadequate and 4% as requires improvement – this is despite continuing pressures from a growing demand and high workload for staff.
- The quality of the majority of urgent primary care services is good. These include walk-in and urgent care centres, NHS 111, and GP out-of-hours services. At 31 March 2018, out of 147 ratings from inspections, 118 urgent care services were rated as good and 10 as outstanding. However, the public needs a better awareness of the different services available, so that they turn to the most appropriate service when they become ill.
- Most regulated independent GP services delivered online have improved on re-inspection. Some arrangements for prescribing medicines are still an area of concern, particularly for opioid analgesics, asthma and antimicrobial medicines.
- 90% of dental practices inspected in the year to 31 March 2018 were meeting regulations and providing safe, effective care. This isn't always extended to effective prevention, with a wide geographical variation across England of the number of children having teeth extracted (often in hospital under general anaesthetic) because of tooth decay.
- Our early findings indicate that military personnel generally receive good quality primary health care. Issues mirror the challenges for NHS services, for example shortages of staff and the need for strong and clear governance arrangements. Some problems related to poor infrastructure as a number of dental and medical centres are not purpose-built to deliver primary care.
- In criminal justice settings, regulations were breached in almost half of the 41 prisons inspected, mainly because of a lack of appropriate policies and processes to run services safely and effectively. Many prisoners receive substandard care for reasons beyond the control of registered providers, such as poor physical environments.
- For children in the care of a local authority, the complex arrangements of health services make it difficult to share information, and agencies fail to agree ways to deal with it to improve children's health outcomes. Some local agencies failed to spot the signs of neglect in older children, and did not always share information on adults with limited parenting capacity with partner agencies. Mental health and substance misuse services did not always consider the whole family and the impact of adults' behaviour on children.
- For primary health care in all settings, collaborative working as part of a local system can enable people to have a better experience of care. This needs commissioners to look at the needs of people in an area and resource them appropriately.



Carl's story and Melissa's story

Carl is the main carer of his parents who have early stage dementia. He also cares for his brother, who is undergoing treatment for cancer. Carl's story of supporting his family to access health and social care services is mainly positive.

He feels that the local GP practice offers a specifically personal service, with continuity of care – they know his parents and they understand their needs. When it's urgent, the practice is also responsive, as the GP visits his parents at home. This personal approach to care means that his parents have confidence in their doctor. It also enables Carl to feel assured that his parents are receiving good care.

"The doctor there has been absolutely brilliant with both my parents... he's really welcoming... he'll even stand up and shake my Dad's hand and give my Mum a hug when they leave... it's really good, personal care... They've got the confidence in him. And I have personally, as their main carer."

Melissa has been a carer for most of her life. Over the years, she has cared for her mother, who suffered a stroke and moved into a nursing home, her son, who had Down's

Syndrome, and, most recently, her sister and brother-in-law, who have been diagnosed with dementia and continue to live at home. Melissa's personal story of supporting her family is marked by periods of struggle. She feels that improving communication between health and social care professionals, carers and family members is key to providing high-quality care. In her experience, there is often a general lack of support for carers as they navigate the health and social care system.

However, Melissa has received good care and support from her local GP, which has had a positive impact on her family and supported her own wellbeing. These experiences make Melissa feel supported in caring for her family. They contrast with times when she felt she had to fight to ensure her family received good quality care.

"It makes me feel brilliant because I think somebody does care; somebody is out there to help us... they listen to you and you feel listened to. And you're not having to fight for everything, that's the main thing."

Introduction

An effective healthcare system that ensures positive outcomes for its local population starts with health care at a primary level. Primary medical care, particularly from GPs, is crucial in keeping people well in their own homes and preventing them from needing secondary

care in hospital. Therefore, primary care that is tailored to a population plays a fundamental and vital role in reducing pressure and using resources effectively in other parts of a local health and social care system.

Ratings for individual primary care services have improved over time – many locations have been able to improve specific aspects of service on their own where inspection has pointed out areas of concern, such as the need for policies and processes to minimise risk.

But, as discussed in part 1 of this report, our reviews of care in a local system show that, too often, services focus on their own goals rather than working with others to provide person-centred care. The fragmented nature of different services can also make it difficult for people to navigate. To provide more accessible and seamless care, individual services need to work collaboratively across health and social care as part of a local system to focus on the patient. An example of this in primary care is where patients can receive diagnostic tests locally at a health centre or GP practice, rather than having to travel to a hospital.

The Next steps on the NHS Five Year Forward View states that one of the key ways to transform care in the longer term is to encourage practices to work together in ‘hubs’ or networks.⁸⁸ A growing number of GP services are now working in multidisciplinary, multi-agency ways. For example, primary care networks are supporting groups of GP practices to come together locally, in partnership with community services, social care and other providers of health and care services. Networks can still provide the personal care valued by both patients and GPs, but are large enough to have economies of scale. In a similar way, the ‘primary care home’ model aims to bring together a range of health and social care staff to provide enhanced personalised and preventative care closer to patients’ homes, usually to a local registered GP population of between 30,000 and 50,000.⁸⁹

Even if not in an organised network of practices, with the support of a clinical network, we have found that small GP practices, particularly in a rural area, can also deliver good, consistent care to patients in a local community and they can be rightly proud of their service.

As well as helping patients, collaborative working can also benefit general practice nurses as it provides the opportunity to work in teams and offer specialised care for patients, for example those with diabetes or

respiratory conditions. This enables greater possibilities for nursing staff to progress through a career framework, while staying in primary care.

Collaborative working is one positive step in improving access, quality and patient outcomes, although we are yet to see this taking place across all of England.

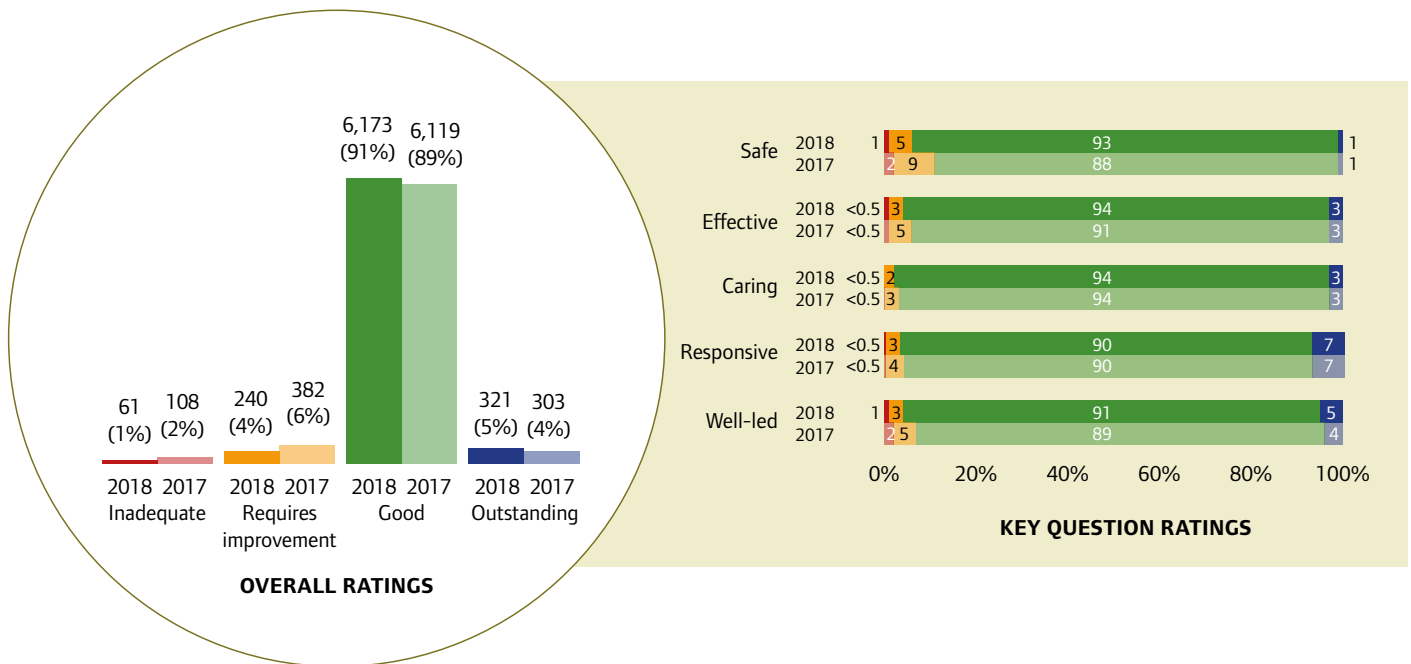
Primary health care is changing in response to well-documented continuing challenges: a rising demand for services from a growing and ageing population with more complex health needs. This results in a higher workload and less sustainable work-life balance for GPs and other health and care staff, which then affects the sector’s ability to recruit staff.

Shortages in the workforce mean that some services cannot effectively meet the growing demand from patients. For example, we found that almost all urgent primary care providers experience some difficulties in filling rotas, which has a negative effect on the quality of care. Commissioning arrangements need to take into account the benefits of effective primary care services on the wider local health and social care system – not just the cost of the service.

Changes are also a response to opportunities from innovation. Many services were early adopters of technology to provide easier access and relieve pressure on more traditional parts of the service, for example, by making effective use of telephone and video triage and consultations. CQC encourages the use of new technology and change through innovation to improve both the quality and sustainability of care.

The *GP Forward View* identified a £45 million programme to encourage the uptake of online consultation systems for every GP practice, and NHS England estimates that around a third of practices will offer online consultations in 2018/19. Nearly 14 million patients across England are now securely using online services with their GP practice to book appointments, order repeat prescriptions and view their records, saving time for themselves and busy GP practices.⁹⁰ However, in the 2018 GP patient survey only 41% of respondents knew that they could book an appointment online.⁹¹ A shift in public awareness would improve this.

Figure 2.16 GP practices, overall and key question ratings, 2017 and 2018



● Inadequate ● Requires improvement ● Good ● Outstanding

Source: CQC ratings data, 31 July 2017 and 2018.

General practice

In England, the vast majority of people who are registered with a GP practice receive good quality services, as 91% of practices were rated as good and 5% were rated as outstanding overall at 31 July 2018 (figure 2.16).

Both the caring and effective key questions showed that 94% of practices were rated as good. We continue to find that some practices providing care to the most vulnerable people in society and those in more deprived areas of the country are rated as good and outstanding overall. For the responsive key question, 7% of practices were rated as outstanding. The most recent NHS GP patient survey shows that almost 84% of patients described their overall experience of their GP practice as very or fairly good. However, the survey also shows that some patients are still not able to book timely routine appointments, as only 45% of patients reported being offered a choice of time or day.

Although ratings for the safe key question showed the poorest performance, this has improved, with 93% of practices rated as good for safety at 31 July 2018 compared with 88% rated as good at 31 July 2017.

What drives positive change?

GP practices have continued to demonstrate high rates of improvement to ratings of good or outstanding when we re-inspect them. For example, 80% of re-inspected practices that were originally rated as requires improvement and 60% of re-inspected practices that were originally rated as inadequate improved to good (figure 2.17).

This is despite many common challenges around the pressures of meeting the growing demand from patients with the current limited workforce and resources. Practices share a number of similar experiences when tackling these challenges along

Accessing care from one place

David uses mental health and primary medical services. He visits his GP regularly as he has been diagnosed with diabetes. He had a positive experience when his GP arranged therapy sessions quickly from community-based mental health services at a place that was easily accessible:

“So I asked for some therapy sessions, which got arranged pretty quick and they were at my local GP practice as well, so I didn’t have to travel to different destinations or anything; it was really within my comfort zone.”

their journey to improvement. We highlighted these experiences in our *Driving improvement* report.⁹²

In both *Driving improvement* and in our inspections, we found that a key element of a good or outstanding GP practice is its leadership and culture. With strong leadership, effective governance and a positive culture, a practice can work as a team – including its clinical, administrative and managerial staff – with a shared vision, values and commitment to improvement. We found that the practice manager in particular is a key player in ensuring the effective running of the practice and enabling GPs to focus on patient care. Good leadership was also linked with positive change to a more inclusive, multidisciplinary and non-hierarchical culture that includes and values all staff.

We are seeing a growing number of services establishing multidisciplinary, multi-agency teams, and we recognise the value of nursing teams, physician associates, pharmacists and others such as paramedics and secondary care staff in providing good quality care. As well as

taking some of the clinical workload off GPs, these staff have the advantage of having expertise in a specific area, such as that of specialist nurses. Partnership working can improve people’s access to primary resources and give better, more local access to secondary care consultants at the practice. However, we recognise that this way of working requires a shift in approach and depends on other services being willing to engage.

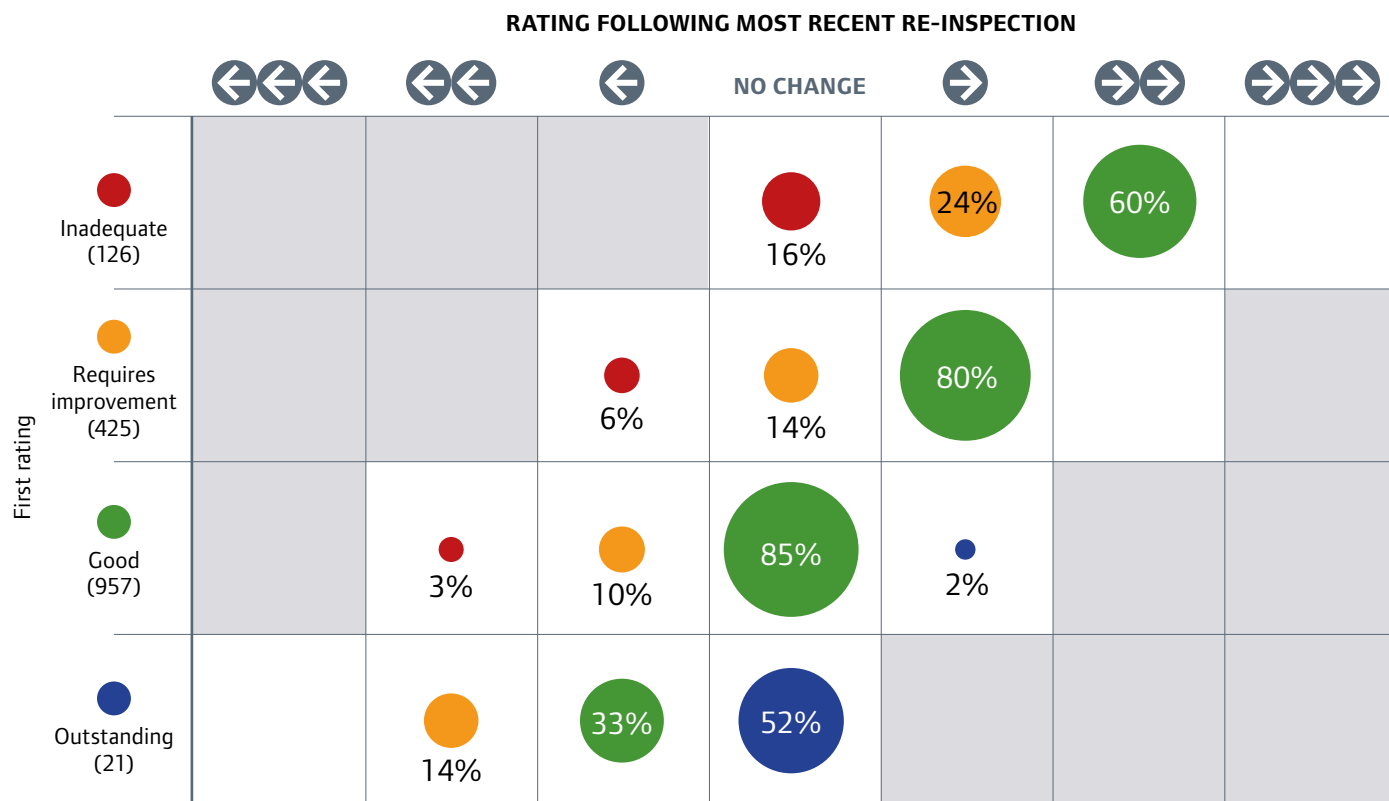
One of our key findings in *Driving improvement* was that it can be harder for smaller practices to deliver and then sustain improvement. A number of the featured practices believed that in order to move forward they needed to work in partnership or merge with larger practices to help to sustain their improvement. Practices that improved the

Improvement through multidisciplinary team working

The Lakes Medical Practice in Penrith has improved from a rating of good to outstanding. The practice employed an in-house Well-being Practitioner who provided psychotherapy to help improve outcomes for patients with long-term conditions. It offered holistic, joined-up services that catered to people’s needs, which included a six week in-house chronic pain group, where patients could learn about how to respond to stress through meditation and relaxation. Following a proactive programme, the practice had reduced the number of patients prescribed benzodiazepines and opiates from 180 to 20.

The practice also identified a lack of services in the area to support women around termination of a pregnancy. They developed a nurse role and set up a sexual health and women’s health service to offer these patients a review, including advice and support about contraception and, if necessary, referrals, including to their in-house Well-being Practitioner.

Figure 2.17 GP practices, change in rating on re-inspection, year to 31 July 2018



● Inadequate ● Requires improvement ● Good ● Outstanding

Source: CQC ratings data, re-inspections published in the year to 31 July 2018. Change in rating is from first to most recent inspection.

- ➔ One level of rating change up (for example, from requires improvement to good)
- ➔➔ Two levels of rating change up (for example, from requires improvement to good)
- ➔➔➔ Three levels of rating change up (for example, from requires improvement to outstanding)
- ➔➔➔➔ Four levels of rating change up (for example, from requires improvement to outstanding)
- ➔➔➔➔➔ Five levels of rating change up (for example, from requires improvement to outstanding)
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- ➔➔➔ Forty nine levels of rating change up (for example, from requires improvement to outstanding)
- ➔➔ Fifty levels of rating change up (for example, from requires improvement to outstanding)

quality of their care became less isolated by working with others locally and accepting the support and guidance of other professionals, and through national initiatives such as support from the Royal College of General Practitioners, local medical committees and CCGs. A practice’s relationship with its local commissioners is an added factor in securing investment and support, and therefore improvement.

What are the barriers to positive change?

Of the 126 GP locations rated as inadequate at their first inspection, and that have been re-inspected, 60% have improved up to a rating of good, and

24% are now rated as requires improvement (figure 2.17). However, 16% were still rated as inadequate at their most recently published inspection. Only 14% of locations initially rated as requires improvement have remained at this rating, and, although 6% have deteriorated to be rated as inadequate, 80% of locations have improved.

We re-inspect practices rated as requires improvement or inadequate earlier than those rated as good or outstanding to follow up concerns. Re-inspections show that some practices find it difficult to improve, and a small minority that do improve are unable to sustain the improvement.

We have looked in detail at the circumstances of a number of locations that have failed to maintain the quality of care. Deterioration, as shown by changes in ratings, can often be linked to workforce issues: poor management of staffing levels, staff deployment, training and turnover. Problems with staff recruitment and retention mean that practices can struggle to cope with the growing demand and workload. With unfilled vacancies, practice staff are under pressure to maintain adequate services to their local population with too few permanent members of the team to deliver them.

For example, we saw a practice that understandably had to focus on the short-term to ensure sufficient clinical cover for patient appointments, rather than looking at the bigger picture. To do this, they had to use a high number of locum staff for a prolonged period. Although this approach enables practices to provide a responsive service for patients, the long-term result can bring financial implications and inconsistent care.

The demographic profile of the general practice workforce is changing. Large numbers of experienced staff are reaching retirement age: more than one in five GPs are aged 55 and over. Data shows that an increasing number of GPs are working part-time, as the number of full-time equivalent GPs has fallen while the headcount has remained fairly stable.⁹³ Similarly, general practice nurses provide a highly skilled and valuable contribution to primary care, but many practices report difficulties in recruiting. In a 2016 survey, 33% signalled their intention to retire by 2020, which will lead

to the loss of knowledge and experience.⁹⁴ NHS England's 10 point action plan for general practice nursing brings together key actions to meet these challenges.⁹⁵

Some GP practices continue to remain rated as requires improvement. There are often a number of contributory factors, but this can result from the quality of management and leadership at the location. We have seen examples of practices where, although staff resolve the areas that contributed to that rating in the first place, the practice then 'take their eye off the ball' in another area so, on re-inspection, they may breach regulations in a different area and are rated as requires improvement again. This shows that sustained poor practice overall isn't limited to the same issues.

Our inspections tell us that the quality of management, the culture in the practice and the relationships between leaders (at provider and location level) and staff are central to quality. Professional isolation, where a GP does not have access to peer support, or does not ask for it, can also lead to an insular working environment that is not open to change. For example, the deterioration in a single-handed GP practice that we inspected was underpinned by its managerial and leadership structure, which was not conducive to an open and transparent working environment and was not receptive to learning and adapting in line with new requirements. In this case, being a single-handed GP practice also meant there was limited management time available. This makes the role of a competent practice manager even more important.

Primary urgent care services

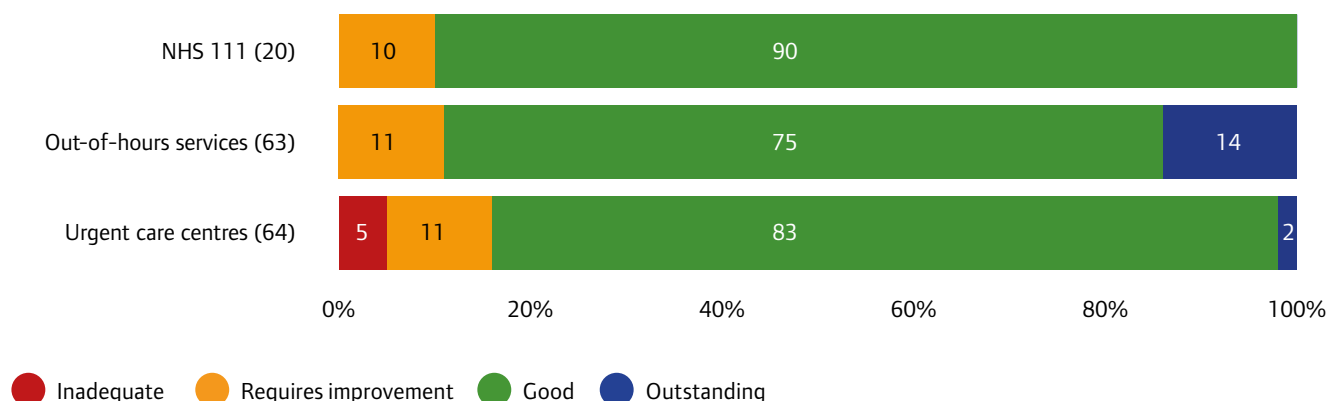
The quality of care in the majority of urgent primary care services in England is good. These include walk-in and urgent care centres, NHS 111, and GP out-of-hours services. At 31 March 2018, out of 147 ratings from inspections, 118 urgent care services were rated as good and 10 were outstanding (figure 2.18).

A prompt, safe and effective response from these services provides a good outcome for patients and takes pressure off other parts of the urgent care

system – particularly emergency departments during the winter and other periods of high demand. Recent data shows that 20,000 people every day are getting urgent medical health advice over the phone from a doctor, nurse, paramedic or other clinical professional.⁹⁶

Despite the different types of service and arrangements to deliver them, we found some common characteristics in good and outstanding providers. In NHS 111 services, the best providers

Figure 2.18 Primary urgent care services, overall ratings, 2018



Source: CQC ratings data 31 March 2018.

had good communication between call-handlers and clinicians, ensuring that staff could access clinical guidance quickly and consistently. Urgent care centres rated as good and outstanding ensured that patients received a timely initial assessment, typically either using a healthcare assistant working with clinical supervision from a nurse or GP, or by training reception staff to use an assessment system such as NHS Pathways. The urgent and emergency care sector as a whole is becoming more integrated, bringing together the 111 and face-to-face components of care, for example with contracts split between organisations. We found that good and outstanding urgent care providers worked proactively and effectively with other providers at an operational level, even where there was no formal integration from contracts.

However, at 31 March 2018, 16 services (around one in 10) still required improvement, three were rated as inadequate and no NHS 111 providers were rated as outstanding overall. Our report *The state of care in primary urgent care services* reported that variation in the quality of care across England is partly a result of the complex way these services are commissioned and delivered.⁹⁷ We found that where providers were commissioned by a series of different geographically remote clinical commissioning groups (CCGs), there was an adverse impact on the quality of service at some locations. For example, if an

incumbent provider loses a contract to another, it results in loss of continuity and organisational learning. Commissioning also needs to take local needs into account and reflect the true costs of delivering services in an area. There have been a number of service failures in areas where contracts have been awarded at an unrealistic price, and some providers have reported having to go back to CCGs part way through a contract to ask for additional funding to continue to run it.

Other challenges, for example recruitment, staffing and workforce planning also affect quality. We found that almost all urgent care providers experience some difficulties in filling rotas. A shortage of staff affects a provider's ability to meet growing demand for services. The volume of calls to NHS 111 has increased year-on-year, and the highest ever volume of calls received was in December 2017.⁹⁸ The percentage of calls answered within the 60-second target drops in the winter months, showing the peak demand for this period.

Although more people are using urgent care services, our report voiced concerns from voluntary sector groups about the lack of awareness among the public about which services to contact and when, and that people need more guidance to overcome an historic reliance on emergency departments as the default.

Internal and external factors affecting quality at re-inspection

We inspected an urgent care centre providing GP out-of-hours services and rated it as good overall. We then re-inspected later in the year to check whether the service had complied with a requirement notice for an issue in the safe key question. But after this focused inspection, the rating deteriorated to requires improvement. A combination of interrelated internal factors underpinned the failure to maintain quality:

- complex governance arrangements
- lack of a visible managerial presence
- failures in managerial oversight at service and provider level.

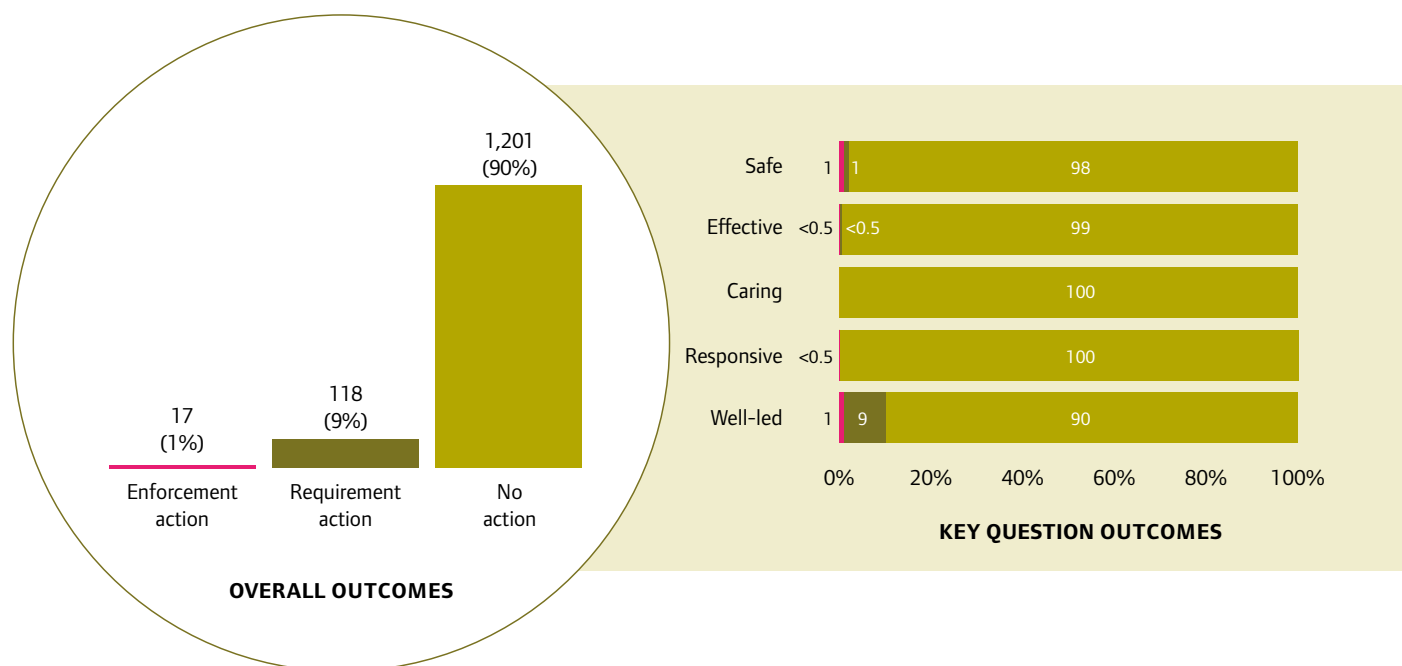
As this provider was spread over a wide geographical area, senior management were often unavailable. The local clinical director was responsible for a number of locations, so was unable to be physically present regularly and could not provide adequate support because of the pressure on time. This meant that the

oversight for core governance areas, such as staff training, appraisals and safety checks on equipment was more challenging.

External factors such as the rural location and patient demand may also have contributed to the failure to maintain quality. Patients and clinicians had to travel some distance to receive or deliver care. We noted that urgent care centres located in rural areas are required to run several locations to serve the local population. This means they often need to employ more staff, drivers and cars compared with urban urgent care centres, which increases costs that may not be reflected in the value of the commissioned contract.

This provider lost the contract for providing the service, which was taken over by a different provider that also runs services at other locations.

Figure 2.19 Dental practices, inspection outcome overall and by key question, year to 31 March 2018



● Enforcement action ● Requirement action ● No action

Source: CQC inspection outcome data. Comprises active dental practices with inspection reports published in the year to 31 March 2018 (total 1,336 locations).

Primary care dental services

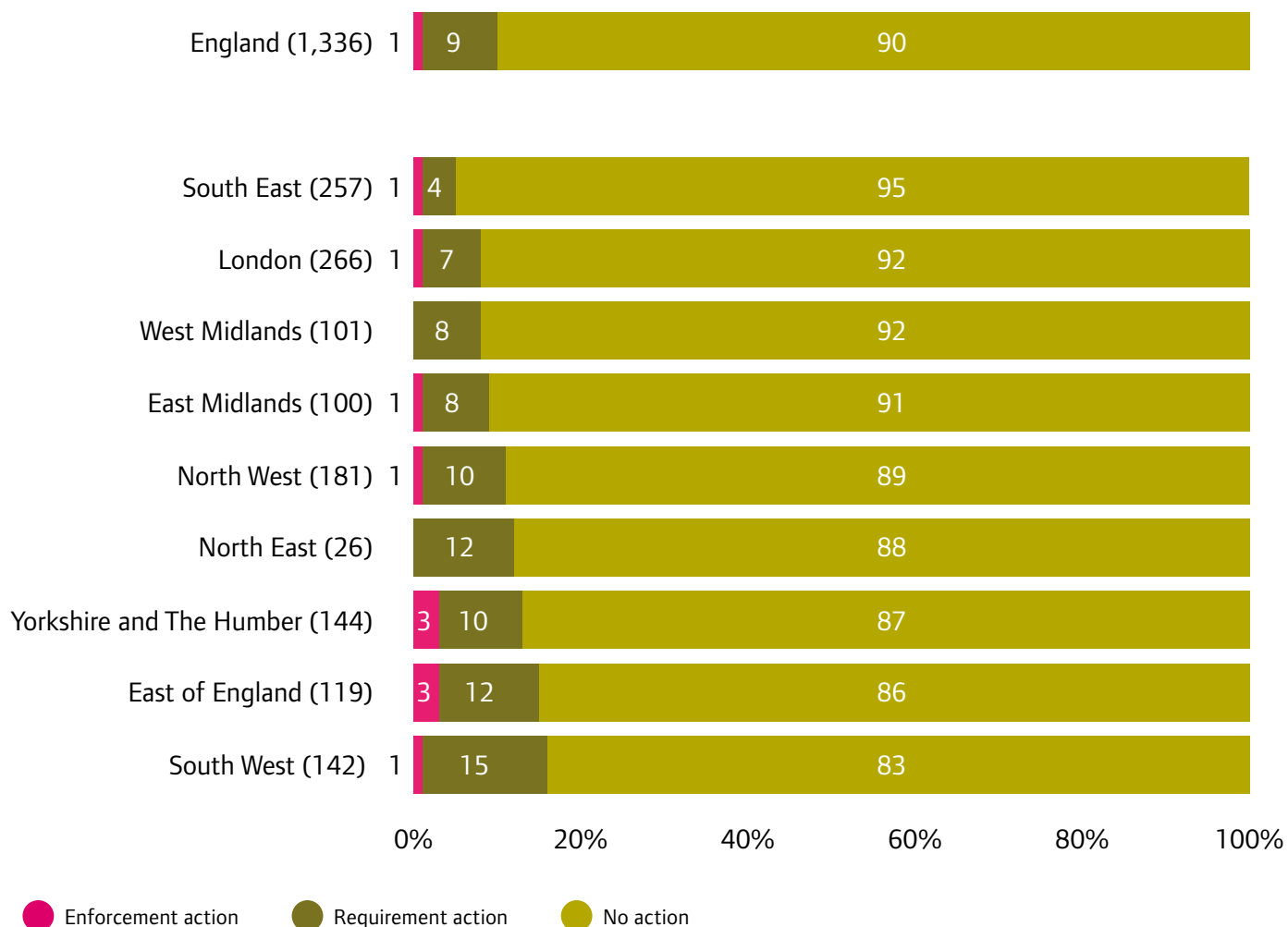
Each year, we inspect 10% of all registered primary care dental services in England but we do not give a rating to these providers. Following the pattern from previous years, most services that we inspected (90%) were meeting regulations, which means that they are providing safe, effective, caring and responsive care and treatment, and that they are managed well (figure 2.19). Inspection shows that the majority of practices are following the advice of Public Health England in *Delivering better oral health*.⁹⁹ This means that people are receiving evidence-based advice on improving their oral health.

Looking at the responsive key question, an important consideration for dental inspections relates to how services address physical accessibility issues for patients. A number of dental practices are on upper

floors in older buildings that cannot be modified for people using wheelchairs, or who cannot climb stairs. To respond to this, some practices have found ways to make their service accessible even if the quality of their premises is not entirely suitable. For example, we have found arrangements between practices where those in a more modern, accessible unit will allow a patient from a colleague practice to be treated in their surgery.

As figure 2.20 shows, there is some regional variation in the proportion of inspections that resulted in no regulatory action, ranging from 95% in the South East to 83% in the South West. Quality is more variable when looking at the safe and well-led key questions. As with all services, we find that leadership plays a key part in the

Figure 2.20 Dental practices, inspection outcome by region, year to 31 March 2018



Source: CQC inspection outcome data. Comprises active dental practices with inspection reports published in the year to 31 March 2018 (total 1,336 locations).

quality of care; some inspection staff perceived that having an empowered practice manager who is not necessarily a clinician can be an advantage to a well-run practice, as they have more experience of management, rather than concentrating purely on clinical practice.

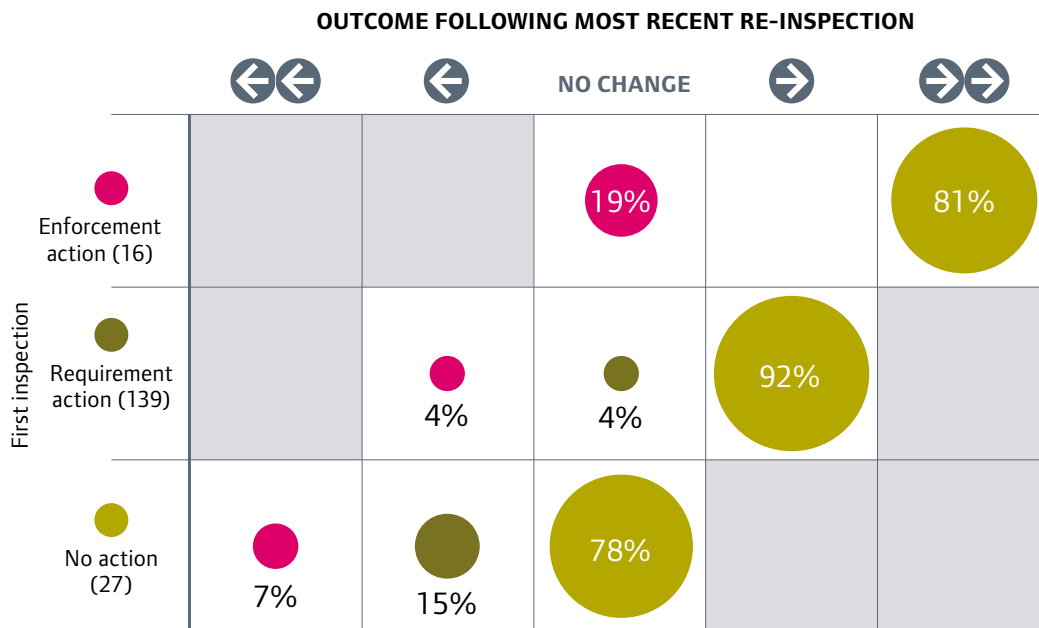
Of the 1,336 practices inspected, we required 118 to take some action to improve and we took enforcement action against a further 17 practices. The main triggers of enforcement action were usually poor leadership cultures in practices, an unwillingness or inability to take prompt and decisive action to address issues, and a failure to act when things have gone wrong. A specific issue

that we responded to swiftly was unsafe practice of conscious sedation of patients.

We published reports in 2017/18 of the re-inspections of 182 dental practices (figure 2.21). For 89% of these services they were meeting regulations and no action was required.

Of the 16 practices where we had taken enforcement action on their first inspection, more than 80% (13 practices) had improved on re-inspection and we took no action. Of the 139 re-inspected practices where we initially applied requirement actions, 92% had addressed them and had no further actions.

Figure 2.21 Dental practices, change in outcome on re-inspection, published in year to 31 March 2018



● Enforcement action ● Requirement action ● No action

Source: CQC inspection outcome data, re-inspections published in the year to 31 March 2018. Change in outcome is from first to most recent inspection.

➔ One level of outcome change up (for example, requirement action to no action)

➔ One level of outcome change down (for example, requirement action to enforcement action)

However, on re-inspection we applied requirement actions for 4% (six) of these practices, and a further 4% (five) resulted in enforcement actions.

We published the results of 27 re-inspections of practices whose first inspection resulted in no action. These re-inspections will mostly have been triggered by concerns that inspectors received. The majority (21 practices) remained without actions on re-inspection, but four practices had requirement actions applied on re-inspection, and two had enforcement applied.

Where practices have not improved on follow-up inspection, there is often a lack of insight and understanding of the regulations and the need to embed improvement, rather than simply introduce

policies and processes. Examples of this are in recruitment, staff development, learning from incidents and acting on the results of audit.

In the changing landscape of primary care, NHS dental practices are not fully involved in the developing models of integrated care. Within the dental sector itself there is consolidation as the size and number of corporate providers grows. Because dental practices are also able to choose how they balance NHS and private provision of treatment, this may affect people’s access to NHS services in a local area.

Access to NHS dental care was included in the 2018 GP patient survey.¹⁰⁰ This found that of the respondents who had tried to get an NHS dental

appointment in the last two years, 97% were successful if they had visited the practice before, but those who had not previously visited the practice were less successful (77%). Younger adults and people in minority ethnic groups also reported a lower success rate, and a lower proportion of these respondents had been to the practice before, compared with other respondents.

An effective practice will provide preventative care. There has been steady overall improvement in the oral health of children over many years. In 2007/08, the average number of decayed, missing or filled teeth in five-year-olds was 1.11 and by 2016/17 it reduced to 0.8.^{101, 102} However, there is wide variation at regional and local authority level, in both the severity and prevalence of dental decay. Public Health England's oral health survey found that this appears to be linked with levels of deprivation, as prevalence among the most deprived children is 33.7% and for the least deprived is 13.6%.¹⁰³ The lowest average number of decayed, missing or filled teeth in five-year-olds is 0.1 in Waverley, Surrey, compared with 2.3 in Pendle in Lancashire. The survey also found that other factors such as ethnicity, exposure to water fluoridation and geographic location are also independently associated with levels of dental decay in children.

National initiatives to address this inequality include NHS England's Starting well project, which launched in target areas where inequalities in children's dental health are the greatest.¹⁰⁴ The Dental Check by One initiative also encourages dental practices to engage with parents of very young children and encourage them to visit the dentist with their child to receive preventive help and advice.¹⁰⁵

Through inspection, we have found examples of responsive notable practice in dentistry where practice teams have used innovative ways to target children and prevent dental disease.

Dentists have raised concerns with CQC that there may be issues about the oral health of people in residential care homes. We intend to carry out a review of this and expect to be able to report on this next year.

Prevention through fun education days

Chipping Manor Dental Practice in Wotton-under-Edge holds children's days in school holidays, focused on preventing dental decay and disease. Parents make this a diary date as a fun day out for their children, as the practice provides storytelling and games in the children's waiting room. To make check-ups less threatening and more interesting, the dentist and dental nurses dress up and hold themed surgeries, for example a pirate or dinosaur surgery. Children also dress up and can choose which themed surgery to go to for their check-up. The foundation (trainee) dentist and a nurse with an oral health qualification run walk-in brushing advice and play 'good food, bad food' games in a surgery. Dentists carry out check-ups and apply fluoride varnish if needed.

Parents receive information sheets and everyone is re-booked before they leave according to the dentists' recommendation for recall. The practice has noticed an increase in the number of children now attending, along with their parents, with positive feedback from the parents and carers and the children themselves.

Independent primary medical care provided online

Following re-inspection, we have seen improvement in independent providers that offer online-only consultations with a clinician. These providers enable people to access medical advice and treatment through GP consultations and prescriptions using websites and apps. Some provide a questionnaire-based interaction with clinicians, usually for a fixed range of conditions and medicines, and some provide real-time interactive health care by video. As we will not start to rate these services until April 2019, we currently judge whether they meet the necessary regulations associated with each key question.

Using online technology in primary health care has the potential to improve accessibility and convenience for patients, and may provide cost benefits to the wider health system. Although there are differences between services delivered remotely and those delivered in person, the fundamentals of good clinical practice apply – regardless of how the care is provided.

In March 2018, we reported on our first programme of inspections.¹⁰⁶ We are seeing some good practice in GP services provided online, and services are using digital technology effectively to enhance people's health care.

In the first programme of inspections, performance was poorest for the safe key question. Our concerns ranged in seriousness from where we identified examples of unsafe practice, to where we saw a lack of processes that increased the risk of poor quality care. Specifically, we found concerns in the following areas:

- Unsafe prescribing, including antimicrobial medicines, medicines for asthma, diabetes and

other long-term conditions, and medicines with potential for misuse, including opioid analgesics. Prescribing long-term opioid analgesics – particularly in isolation from the wider healthcare system – was a significant concern. Although not widespread, the issue was compounded by the volume prescribed and a lack of communication with patients' GPs (NHS or independent sector) either before or after prescribing.

- Ineffective safeguarding and verifying patients' identity to provide safe care and treatment. The lack of face-to-face contact can also limit a service's ability to appropriately assess people's mental capacity and obtain their consent.

Even though most concerns related to regulations around the safe key question, this was the area in which we saw the greatest improvement after re-inspection. Providers did this by introducing changes such as:

- limiting the list of medicines that GPs are able to prescribe, and setting the maximum allowed doses against the patient's condition
- changing the range of clinical conditions that they were prepared to manage in an online environment, for example no longer treating long-term conditions online, including asthma
- implementing safeguarding emergency alerts to send to the clinical lead to investigate further
- strengthening processes to verify patients' identity, including children under 18 and family members of registered patients.

Medicines optimisation

Although the overall volume of controlled drugs prescribed in primary care in England decreased by 2% in 2017 compared with 2016, some patients with complex health needs are being prescribed a higher quantity, including opiate-containing

painkillers.¹⁰⁷ This presents risks when obtaining them from more than one provider in both the independent and NHS sector, including GP out-of-hours, secondary care services and those offering online-only consultations as mentioned above. This

can enable patients to stockpile controlled drugs and increases the potential for diversion and misuse, risk of accidental death, and of suicide from overdose. This is particularly pertinent for patients with long-term pain, as they may be at high risk of suicide.¹⁰⁸

Prescribers need to ask patients about their existing prescriptions and current medicines. Sharing

Joint inspection activity

Health and justice inspections

We inspect and regulate health and social care in criminal justice and immigration removal services jointly with other inspectorates. We carried out 61 inspections in 2017/18. We do not give a rating to these services, but our findings feed into joint inspection reports and overall thematic reviews of areas that need to improve. Although many issues that we find are outside CQC's remit, joint inspections enable us to tackle them in partnership, and contribute to how other inspectorates assess the wider systems.

We found that health and social care providers had breached regulations in almost half of the 41 prisons we inspected. As in the previous year, these failings commonly related to lack of person-centred care, how they managed medicines safely and the governance of services. However, in all 26 focused follow-up inspections we found that services had made all the required improvements.

Commissioning and providing health care in a prison environment is complex. We frequently find that people are receiving substandard care for reasons beyond the control of registered providers, such as poor physical environments, or partnerships that do not enable providers to deliver services that meet people's needs. For example, a shortage of prison staff limits prisoners' access to the care and treatment they need.

In a joint review with HMI Probation, we looked at the problem of adults who develop a dependency on illegal psychoactive substances while in prison and the support from probation services in the community.¹⁰⁹ When information is not shared, many prisoners are released without probation providers

information appropriately between those involved in a patient's care is an important part of good practice. This is also particularly important when managing long-term conditions or prescribing medicines that require ongoing monitoring, to minimise the risk of overprescribing that could lead to harm.

knowing of their dependency. In the cases inspected, a lack of support in the community resulted in problems with housing, mental health, relationships and finances. Many of those who lost their accommodation ended up on the streets, sleeping rough in an environment where psychoactive substances were easy to obtain. The report also found that probation providers did not routinely consider the risks associated with psychoactive substances to other people, including children, staff or the wider community.

Health care and safeguarding for children who are looked after

The joint targeted area inspection programme of services for vulnerable children and young people continued in 2017/18 with our partners: Ofsted, Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services, and HMI Probation.

The second programme inspected six local authorities and examined the multi-agency response and effectiveness of children's social care, health professionals, the police and probation officers in safeguarding children who live with domestic abuse. The joint report found that, in some areas, the complexity of health services and incompatible electronic systems made it difficult to share information and allow access to practitioners to all the information about a child and their family circumstances. It also found that agencies failed to agree appropriate ways to handle this. Where there are good systems and processes to share information, practitioners worked together effectively and made good decisions that protected children.¹¹⁰

Following this, the joint inspectorate group focused on older children living with neglect, looking at cases of children aged seven to 15 across six local authority areas. In young children, neglect is usually easier to identify as the signs are more obvious, but inspectors found that too often, local agencies are failing to spot the signs of neglect in older children suffering the same abuse, and that they are slipping through the cracks.¹¹¹ They found that older neglected children are not always receiving the support and protection they need because adult services, such as those for mental health and substance misuse, do not always think about the family as a whole and the impact of adults' behaviour on children. Also, information about adults with limited parenting capacity because of

mental health conditions or substance misuse is not always shared with partner agencies.

Ofsted and CQC inspect how well local areas fulfil their duties under the special educational needs and disability code of practice. A summary report of the first year of inspection reported delays in accessing services, weak strategic leadership and slow progress in jointly commissioning services.¹¹² In the second year, we are seeing slow progress in commissioning services to support children to transition to adult services and to help families to access short breaks and respite.

Primary health care for military personnel

Armed forces personnel and their families should have the same access to high-quality care as civilians. All military personnel, some of their dependants and civilian staff, are entitled to the services of a military GP practice. But unlike most NHS patients, military staff do not have the right to register with a GP practice of their choice, and must register at the location where they are assigned.

The Surgeon General has therefore invited CQC to inspect healthcare and medical operational capabilities. In 2017/18, we carried out comprehensive inspections of 35 medical facilities, 24 dental services, two regional rehabilitation units and two Departments of Defence Community Mental Health. This allowed us to form an initial view of the quality of care provided by Defence Medical Services in the first year of this programme.¹¹³

Our early findings indicate that the dental centres and regional rehabilitation units are delivering good quality care, as are a number of medical facilities. But so far, we have identified some pockets of poor practice at some medical centres. In addition, although the care is effective in the two Departments of Defence Community Mental Health inspected, patients need more timely access to care. Many of the issues mirror the challenges that face NHS services, for example shortages of staff and the

need for strong and clear governance arrangements to support good standards of care when key staff are deployed at short notice. For some, the problems were related to poor infrastructure as a number of dental and medical centres are not purpose-built to deliver primary care, limiting best practice in infection control. Compared with NHS services, few patients in military settings need support to manage a long-term physical health condition. However, we identified a need for Defence Primary Healthcare to ensure safe and effective systems across all medical centres to provide good standards of care for patients.

Our recommendations have prompted regional and national improvement work. For example, medical centres are developing innovative ways to collect patient experience data to improve services, and working groups are sharing and learning from notable practice. We have only inspected two Departments of Defence Community Mental Health and although early indications show the care is effective and compassionate, services need to make sure patients have timely access.



Equality in health and social care

Key points

- There is evidence that some inequalities in experience are slowly reducing for some people. Improvements in person-centred care and values-led cultures in services play a big part in advancing equality and inclusion. Innovative new technology is also being used to help improve equality, for example through enabling disabled people to communicate their needs.
- But overall progress is very slow and there is potential for much more improvement. For change to happen, leaders need to proactively tackle equality issues and engage with staff and people using services.
- We still have concerns about the experience of people in some equality groups, particularly people with a learning disability, mental health condition or dementia who need to use acute hospital services, and people from Black and minority ethnic (BME) groups using acute mental health inpatient services. And still too few adult social care services carry out specific work to ensure equality for people using their service.
- Some longstanding issues need national action. More work is needed to implement the Accessible Information Standard to improve communication with disabled people using health and social care services.
- We know that equality and inclusion for staff goes hand-in-hand with good care. Yet there is slow progress in improving equality for NHS staff from BME groups and new gender pay gap reporting has highlighted inequality for female staff in the NHS.
- Some gaps in access to services and in health outcomes for people who use services are widening. This cannot be addressed by providers alone. One solution is for health and social care leaders in local areas to consider differences within population groups. For example, they need to consider the ethnicity, gender, disability, sexual orientation and socio-economic status of older people when planning and commissioning services.

Tanveer's story

Tanveer is 24. He has been a wheelchair user all his life. He uses a communication aid and has support from care workers through a home care agency. He says:

"I have had to fight for everything all my life – to get my carers, direct payments, to get funding to go to residential college. But having control over my care makes me feel like a man – I can go out and work. Some people are amazing, they cannot do enough for me, for example the local access to technology service which provides me with a voice. Now I can also use the internet and write reports.

Other people are not so good. The GP will ask my parents things instead of asking me directly. And when I was in hospital the doctor wanted to put a feeding tube in. They were asking my

parents instead of me, but I had to say no. I can now eat food but if they had put in the tube, I wouldn't be able to.

The care agency is really bad, they will let people down all the time and won't turn up.

The most important thing is for services to listen to people who use services. I think that each service needs a disabled spokesperson, as people who use services will not always talk to a 'regular' staff member – but they might talk to someone with a disability."

Inequalities in experience are slowly reducing for some people

In part 1 of this report, we discussed that the overall quality of care was improving slightly. The same picture emerges if we consider whether all people have an equally good experience of using health and social care services.

Hospital care

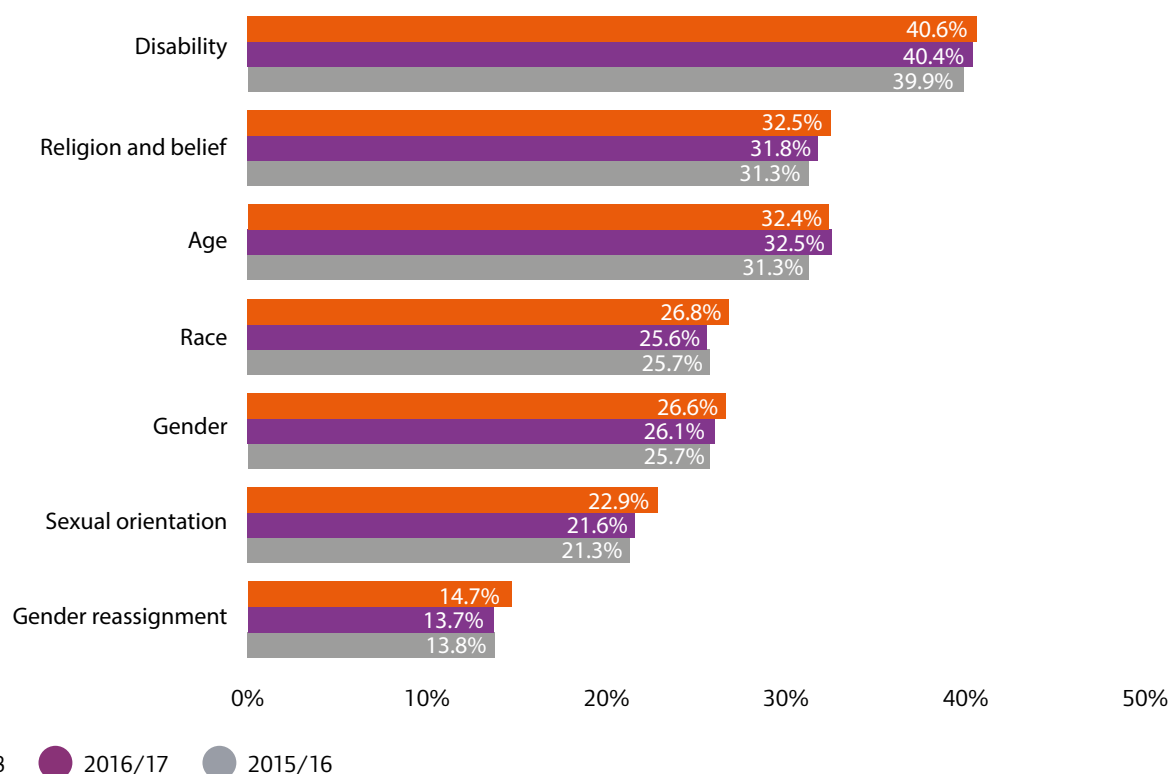
In the NHS acute inpatient survey, there were fewer differences between people in different equality groups, compared with the previous year, in questions about whether they received enough emotional support during their stay and whether they had adequate choice of food.¹¹⁴

Looking at age, ethnicity, sexual orientation, disability, and religion and belief, there were hardly any differences between groups, in the 2017 survey of women's experiences of maternity care.¹¹⁵

In the children and young people's inpatient and day case survey, there were no big differences relating to ethnicity, age and gender.¹¹⁶

In the latest community mental health survey, there were no differences based on gender or ethnicity in areas such as dignity, involvement, respect for values or communication.¹¹⁷

Figure 2.22 Equalities work by adult social care providers to meet the needs of people with particular equality characteristics



Source: CQC provider information returns data. Data for 2017/18 is for April to December 2017 only.

Primary care

In the 2017 GP patient survey, there were no differences between men and women in their overall experience of using GP practices. There were only small differences in overall experience for patients with a range of long-term conditions including people with Alzheimer’s Disease, people with a learning disability and people with a mental health condition.

Adult social care

The number of services working to improve the experience of people in different equality groups is slowly increasing (figure 2.22). The 2017/18 figures are based on our data for April to December 2017 only, as we changed the wording of our question to providers during the year.

There are still inequalities in experience

Despite some signs of improvement in some areas, there are still inequalities in experience for people who use services for some groups.

Hospital care

In the NHS acute inpatient survey, overall there was more variation in the experience of people in different

groups, compared with the previous year. However, this was mainly because some groups reported an above average experience, rather than more groups reporting a significantly below average experience. In particular, there was greater variation in how people from different groups reported their overall experience of care and whether they had confidence and trust

in staff treating them. As we have found in previous years, people with a mental health condition were less positive in their responses to the NHS acute inpatient survey. This repeats the trend in the results of the 2016 surveys of children and young people and patients using emergency departments (A&E). Younger people aged 16 to 35 and people with dementia were also less positive than others.

Asian and Asian British people were less likely to have a good experience overall of acute inpatient hospital care and emergency care.¹¹⁸ Black and Black British people also reported a poorer experience in some aspects of their care as acute inpatients and when using emergency care services. Heterosexual people were more likely than average to report that they were treated with dignity and respect in acute inpatient, emergency care and community mental health services.

In the children and young people's inpatient and day case survey, children with a mental health condition and their families reported poorer experience including communication, respect for their values and needs, and an understanding of their medical history. Children with a learning disability and their families reported poorer experience of communication and an understanding of their needs.

Primary care

In the GP patient survey, people from 'any Asian background' reported a poorer overall experience of using their GP practice compared with people in

other ethnic groups. People with autism and attention deficit hyperactivity disorder reported a poorer overall experience than other disabled people or people with long-term health conditions.

Adult social care

Despite the improvement mentioned above, still less than half (47%) of providers told us that they had done specific work to make sure that their service met the needs of people with protected characteristics in the previous 12 months. There is a projected increase in the ethnic diversity of older people.¹¹⁹ Older lesbian, gay and bisexual (LGB) people rightly expect that they will not be discriminated against. However, many are not confident that health and social care services can understand and meet their needs.¹²⁰ This means that there is an even greater need for adult social care providers to consider equality issues.

There are differences in local authority funding of care services per person, based on age and disability. This may contribute to people having different experiences of care. For example, a higher level of funding may allow more spending on activities, enabling people to have their individual needs met. On average, local authorities pay £543 a week towards residential care for an older person with a physical impairment. For people aged under 65 the average is £898. There are even wider differences when looking at disability. The average weekly funding is £1,436 for people with a learning disability aged under 65, compared with £550 for older people with dementia.¹²¹

Widening inequalities in access to care

There is evidence that being able to access services in the first place is becoming more difficult for some groups, or that longstanding differences in access are not improving.

GP services form a vital gateway into healthcare services. The gap in the previous two years has widened between patients in the least deprived areas and the most deprived areas, when they are asked how easy they find it to access GP services.¹²² In the latest GP patient survey, people from 'any Asian background' who responded were significantly less likely to say that

they found it easy to make an appointment with their GP, compared with people from other ethnic groups.

Hospital services can also play an important part in helping people to navigate the whole health and social care system. The NHS acute inpatient survey showed that people aged over 80 and people with mental health conditions or dementia were less likely to think that information and communication was good during their stay.

People with dementia and older people aged over 80 using community mental health services were less

likely to know who to contact in a mental health crisis compared with others.

We have been working as a member of the NHS Equality and Diversity Council to reduce inequalities in access to cancer care and mental health care.¹²³

Mental health

People from BME groups have much higher rates of detention under the Mental Health Act than White people nationally, and many people working in mental health believe that this trend is increasing.¹²⁴

Black and Black British people have higher rates of mental health hospital admission and readmission, and longer stays compared with other ethnic groups.¹²⁵ They are also more likely to enter mental health services through the criminal justice system, social services or police. However, Black adults are the least likely to report receiving preventative treatments (medication, counselling or therapy): 7% compared with 14% of White British adults.¹²⁶

People aged 65 and over with mental health issues are less likely to have access to talking therapies, despite evidence that these approaches can be highly effective for this age group.¹²⁷

Older LGB people have lived through direct discrimination in mental health services and there is not enough research exploring the effects of this on both the mental health of older LGB people and how they access services now.¹²⁸

Cancer care

Some people are not receiving cancer services early enough, and then when they approach emergency health services with symptoms, they are diagnosed with cancer.¹²⁹ This could be due to a range of reasons, including access barriers to health services or failure of health professionals to diagnose symptoms. The highest proportions of people who first approach emergency services with cancer symptoms are seen in the oldest age groups. People from BME groups are also more likely to first approach emergency services with cancer symptoms than White people.

Adult social care

Access to adult social care services is becoming more difficult. The number of older people with unmet needs is now estimated at 1.4 million, up nearly 20% in two years.¹³⁰ As explained in part 1, local

A focus on improving health outcomes

St Paul's Way Medical Centre is a GP practice in the London Borough of Tower Hamlets, rated as outstanding in February 2018. Many patients do not speak English as a first language. These patients are supported through interpreters and advocates and a patient champion in the reception area to help people access services, appointments and information.

The practice aims to address social factors that affect health. It uses 'social prescribing' to refer people to support with finances, benefits and employment. The practice has developed a patient Health Champion programme, providing a training course to 56 patients, so that they can act as volunteers to support other patients to improve individual understanding and control over their healthcare needs.

The practice has also developed services and health education events targeted at specific groups such as young mums, young adults and people from ethnic minority groups. It also acts as a hub for support groups, for example for patients experiencing depression.

The practice performs well on the GP Quality and Outcomes Framework and has developed initiatives to improve the outcomes that it does not meet. For example, to improve uptake of cancer screening, the practice used the Health Champions programme to raise awareness, and developed an access strategy and a system for prompting people to attend appointments, including text reminders.

authority expenditure on short-term adult social care to maximise independence has not risen as fast as spending on long-term support.^{131, 132} This may have an effect on particular equality groups – access to short-term care can be vital for older people and disabled people to stay at home and to maintain their choice and control over their lives.

Reducing variation in health and social care outcomes

Health outcomes are affected by many factors including poverty. Reducing the ‘health and wellbeing gap’ is a main aim in the *NHS Five Year Forward View*.¹³⁴ Differences in some outcomes are widening. Life expectancy is measured looking at two-year periods. The life expectancy at birth of men in 2014 to 2016 was 9.3 years greater in the most affluent areas compared with the most deprived areas. This has widened slightly since 2010 to 2012 when the difference was 9.1 years. The gap between life expectancy at birth for women in the least and most deprived areas over this period has increased from 6.8 years to 7.3 years.¹³⁵

Poverty is not the only factor that affects outcomes. The deaths reviewed by the Learning Disabilities

BME households are more likely to be on a low income.¹³³ Therefore, people from BME groups are more likely to be unable to pay for support themselves, if they have some needs that are below the threshold for funded care.

Mortality Review show that the median age of death for people with a learning disability is 23 years younger for men and 29 years younger for women compared with the general population, and that these deaths are often for entirely avoidable reasons.¹³⁶ Correctly diagnosing a person’s health conditions plays an important part in this. People with a learning disability have on average four times more symptoms that are unexplained compared with others.¹³⁷ A survey of 500 healthcare professionals by YouGov found that 66% would like more training focused on people with a learning disability, 64% thought that there was a lack of practical resources in their service, and 50% thought that a lack of knowledge might be contributing to avoidable deaths.¹³⁸

Promoting equality

Treloar is a residential further education college in Hampshire. It specialises in support for students with a physical disability, including those with complex needs. When we inspected the care at the college we found that it had published objectives for equality, diversity and inclusion, which were reported on each term to the senior management team and the board of governors. The student newsletter covered equality and diversity matters and student survey results were analysed according to the students’ sex and ethnicity. Events were organised to celebrate and commemorate Black History Month and Holocaust Memorial Day. The college has been re-accredited as a ‘Leader in Diversity’ by the National Centre for Diversity.

Equality through technology

Style Acre is a supported living service for people with a learning disability and autism in Oxfordshire. The service uses technology in innovative and creative ways to enable equality for the disabled people it supports. For example, Style Acre worked with IT specialists and the NHS to identify the most effective system for a person who was unable to communicate their needs. After significant research and trialling systems, the person was able for the first time to use a communication aid with pre-set phrases to tell staff what they needed, for example if they needed pain relief. This has had a large impact on the person’s ability to self-advocate and to advance their rights.

Work to tackle inequality in health and social care

In our good practice resource, *Equally outstanding*, we have found that many of the changes needed to ensure that people have an equally good experience are relatively low cost.¹³⁹ Inequalities in how people access care are more difficult to address. This is because they involve reaching out to people not using services or tackling barriers beyond the control of a single provider. There are challenges when trying to measure multiple disadvantages, for example looking at access to particular services for women from BME groups or outcomes for older people with a learning disability.

Equality at service level

Where we have found good practice in a service, we also often find that equality and inclusion is

embedded in the culture of the organisation. For a service to be rated as good or outstanding, it needs to pay attention to meeting the needs of everyone.

To achieve equality, some changes are also needed at a service level, as well as improving care at an individual level through placing the person at the centre of their care.

We have found that leadership is vital to help establish an inclusive service. The best services use the skills of both staff and the people using the service to help improve equality.

In general practice, good practice around equality is often based on tailoring services to meet the needs of the local population, as shown by St Paul's Way Medical

Lesbian, gay, bisexual and trans (LGBT) people having a good experience of adult social care services

- **Engagement and signposting:** The manager at Manor House in Birmingham put together a notice board with the help of some of the people living at the home. The notice board displayed information and visual representation of people's diverse sexual orientation and gender identity. This also signposted people to various resources, support groups and contacts around LGBT equality.
- **Staff learning:** Hill View Care Home in Lancashire arranged for its staff to complete LGBT awareness training, after this issue was highlighted during a CQC inspection at another service run by the same provider. This shows the value of a provider positively responding to inspection feedback from one service to improve equality in other services.
- **Inclusive policies and procedures:** The Royal Star and Garter Homes in Solihull welcomed and supported people from the LGBT community. The provider's policy called, 'veterans, spouses and partners' was inclusive to everyone regardless of their sexual orientation. The care planning process also included a sensitive discussion with people around how they choose to express their sexuality to make sure that the home could meet their needs.
- **Using external expertise:** Belong Crewe Care in Cheshire worked with Silver Rainbows, a local social network that works to help reduce isolation of older LGBT people. Silver Rainbows has helped deliver a number of LGBT events including a reminiscence event, and a poetry competition where poems were read out by those living at the service. People living at the service were able to engage in conversations that mattered to them and to share their life experiences. One person told us:
"I feel safe and quite empowered to talk about things that matter to me."

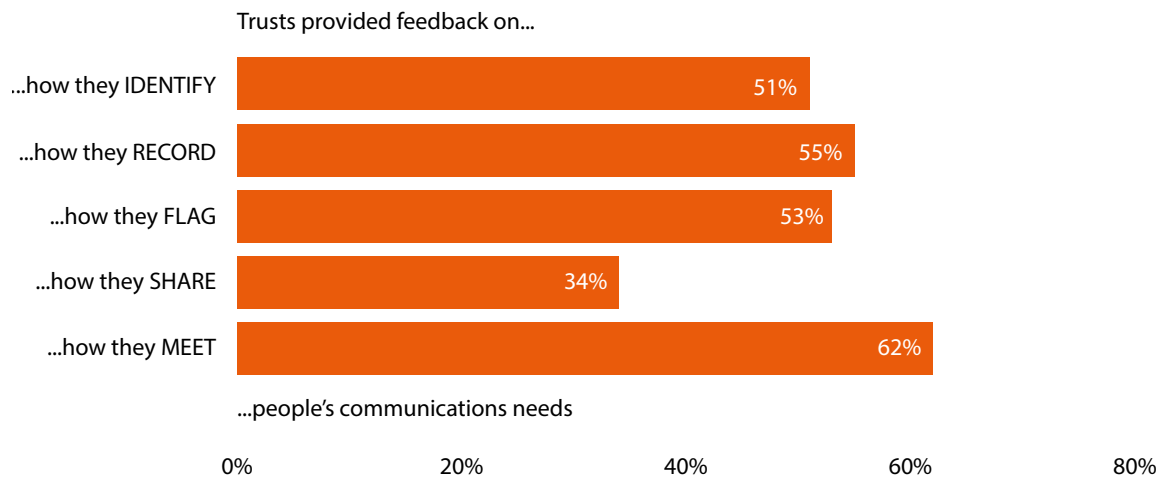
Improving equality in services through national initiatives

The Accessible Information Standard (AIS) is a national initiative to improve information and communication for disabled people using health or adult social care services, including disabled people who are carers and parents of people using a service. The AIS is a legal requirement.¹⁴⁰

We ask all NHS trusts to provide evidence on how they meet the five requirements of the

AIS – identifying, recording, flagging, sharing and meeting the information and communication support needs of these disabled people (figure 2.23). Looking at a sample of 53 trusts, 44 (83%) provided feedback on at least one of the five requirements. Eleven (21%) addressed all five of the requirements.

Figure 2.23 Feedback on the Accessible Information Standard from a sample of NHS trusts, 2017 to 2018



Source: CQC provider information returns data.

Of trusts in the sample who provided feedback on how they record people's needs, or how they flagged people's needs, the majority stated they either had or were in the process of procuring or upgrading electronic systems that allow them to record and flag specific communication needs.

This suggests that not all NHS trusts are meeting AIS requirements. There are also challenges in other services. We have found that the awareness of publicly-funded adult social care providers about AIS responsibilities is particularly low. There are not the same central mechanisms to communicate the AIS to this sector, compared with NHS providers such as GPs, dentists and hospitals.

Centre case study on page 110. There have been some national successes in primary care, for example high uptake of the national diabetes prevention programme by people from BME groups, some of whom are at high risk of developing type 2 diabetes.¹⁴¹

New technology also helps to remove barriers so that people experience equally good care (see Style Acre case study on page 111).

However, fewer than one in four adult social care services told us that they had carried out work on equality for LGB people during the previous year and fewer than one in six said they had done any work on equality for trans people. Our work suggests that there

Inclusive cultures and staff equality are important

The link between good quality care and equality and inclusion for staff working in health and social care services is now well-established. Staff work at their best when they feel valued and organisations maximise their potential when they make the most of their available talent – for example, by making sure that there are equal opportunities for career progression for people from BME groups and for women.

Workforce Race Equality Standard

The aim of the Workforce Race Equality Standard (WRES) is to reduce inequality between staff from BME groups and White staff working in the NHS and NHS-funded independent health care. It provides a measurable picture of equality and inclusion.

From the latest NHS staff survey, 87% of White NHS staff respondents agreed that their trust acts fairly about career progression and promotion, compared with only 72% of BME staff. Likewise, while 7% of White respondents reported that they had experienced discrimination from their managers and colleagues in the previous 12 months, this rose to 15% among BME staff. Seventy-nine per cent of the BME staff experiencing discrimination said that this was related to their ethnic background.¹⁴²

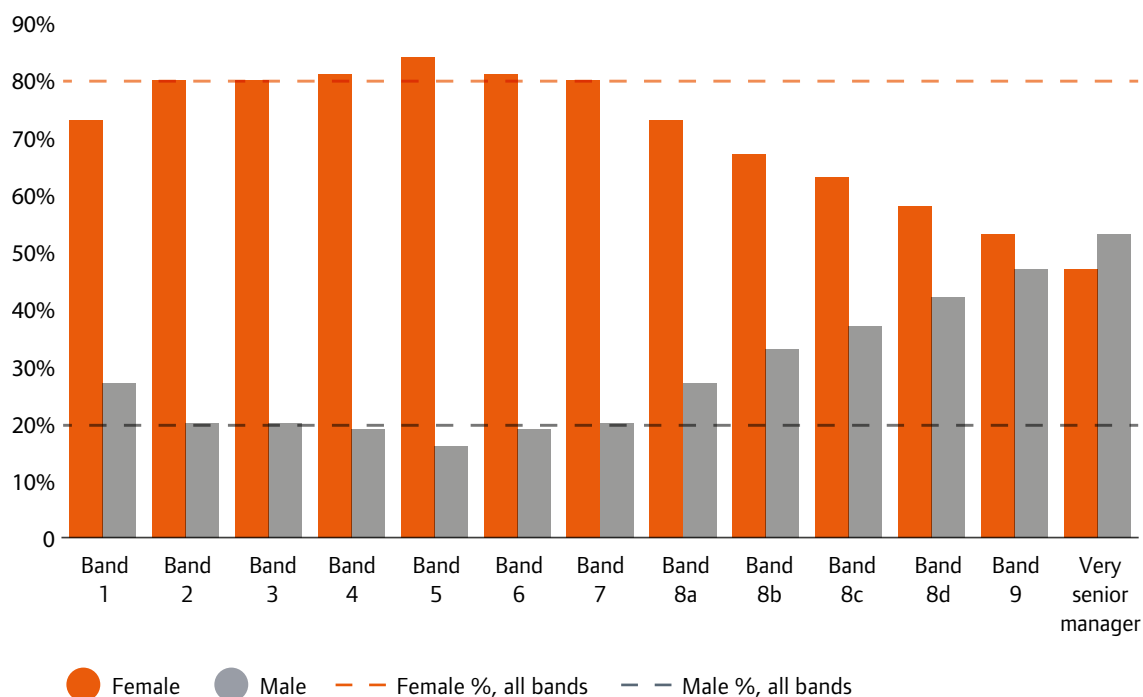
is the potential for many services to improve through taking an equality-focused approach to improvement.

A focus on human rights can also lead to greater equality and improved care for people using adult social care services. This can help service providers to think through challenging issues, such as when there are competing views and needs. Even though there are human rights topics in our regulations, people funding their own care do not have rights under the Human Rights Act 1998. This means that they have no way to challenge providers if they feel that their human rights have not been upheld. There is a lack of parity, where people may be at equal risk of poor care but not have the same legal rights available to resolve this.

Positive practice to improve workforce race equality

- A mental health trust developed a 'moving forward programme', which increased the number of leaders from BME groups. Thirty-seven graduates moved on to leadership posts or more challenging roles.
- Two mental health trusts adapted their interview processes to ensure that staff from BME groups were treated fairly, such as an external person being on the interview panel for senior positions.
- Two mental health trusts introduced mediators to reduce disciplinary allegations against staff from BME groups.
- One ambulance trust secured funding from Health Education England for outreach into schools to encourage young people to consider working for the trust, particularly aimed at young people from BME groups. They also secured funding for coaching staff from BME groups, and for supporting the BME staff network.

Figure 2.24 Percentage of NHS staff at each staff grade by gender, 30 November 2017



Source: NHS Digital, NHS hospital and community health service workforce statistics, 2017. Excludes medical staff. Bands are Agenda for Change paycales.

From our inspection reports, we found that 54 of the 69 trusts where we reported on WRES had a mixture of both positive practice and areas for improvement in implementing WRES. This is more of a mixed picture than the previous year. Overall, 59 of the trusts (85%) had showed some areas of positive practice, up from 78% the previous year. While we were more likely to find positive practice in trusts rated as outstanding and good for the well-led key question, we also found some positive practice in trusts rated as requires improvement and inadequate for being well-led.

Gender pay gap reporting

In March 2018, for the first time, organisations with more than 250 employees had to report the average pay that men and women receive by publishing their gender pay gap data on the government website.¹⁴³

We have analysed the published data from 232 NHS trusts and data from the NHS electronic staff records

(figure 2.24). This shows that there are 215 trusts where the pay gap favours men, 10 trusts where the pay gap favours women and seven where there is no pay gap. There are more, larger pay gaps in acute trusts than in other types of trusts, and community and mental health trusts predominate among those with no pay gap or one that favours women.

When we looked at the NHS electronic staff records, there are more male doctors (55%) than female doctors (45%), and considerably more men in the higher paid medical roles – male consultants (64%) and associate specialists (61%). There are more female doctors in foundation years 1 (55%) and 2 (57%). There are more women than men for all bands of non-medical staff, except for very senior managers, 53% of which are male. Non-medical staff includes nurses, associated healthcare professionals and management and support staff.

Local level action to reduce inequality

Some inequalities cannot be tackled by a single provider. This is particularly the case for inequalities in access and outcomes. Commissioners, providers and local system leaders need to work together on causes and solutions to address complex equalities issues.

As we outlined in part 1, services for some people such as people with a learning disability, a mental health condition or complex needs, are particularly difficult to navigate. In our report, *Are we listening?* we looked at children and young people's mental health services.¹⁴⁴ We found that in most areas, feedback was not being collected from children, young people, parents, families and carers from some sections of the local community. These included LGBT people and people from BME groups. We also found that services were not always responsive to the specific needs of children and young people from BME groups, even in areas that had a well-established ethnically diverse population. In several areas, commissioners and service planners had struggled to identify the scale and needs of young LGB people.

In our local system reviews looking at services for older people, we also found differences in the way areas engaged with people in particular equality groups to understand their needs.

Local voluntary and community sector organisations provide a vital 'bridge' between communities and health and social care services to improve access to care. These organisations can also work alongside statutory services to improve outcomes for individuals once they have accessed services. However, sometimes the potential of the voluntary and community sector is limited due to insecure funding and poor connections into local statutory systems of care.

▶ Reducing inequality through voluntary sector partnerships

During our review of a local health and care system in Northamptonshire, we found a voluntary organisation run by and for the Asian community that provided advocacy, advice, information and support services. Language barriers are an issue, particularly when trying to access a GP practice, have social care needs assessed or follow a care plan. Asian volunteers are available to help people with these areas. For

example, a person diagnosed with diabetes may not be able to understand their care plan and therefore how to manage their condition on a daily basis. However, there are challenges because some GPs and hospital staff do not know about the service and therefore do not refer people who would benefit. Funding has also been reduced so the service does not now cover the whole of Northamptonshire.



The Deprivation of Liberty Safeguards

Key points

- Good practice in applying the Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act (MCA) closely aligns with putting the person at the centre of care and focusing on human rights.
- Variation in how providers implement DoLS and the MCA continues to be an issue, as are delays in local authorities assessing and authorising DoLS applications. This increases the risk of people being unlawfully deprived of their liberty.
- Services that use overly restrictive practices often do so because they lack understanding of the MCA and DoLS legislation. Services can also find it challenging to balance safety and freedom with limited staff time and resources.
- Strong leadership and governance with a positive organisational culture are key factors underlying good DoLS and MCA practice. Together with partnership working, adequate staffing levels and embedded staff training, they foster positive risk-taking, and encourage greater autonomy for people.
- A dedicated MCA (including DoLS) lead and team in hospitals can be an important way to drive change and improvement in practice.
- It is important that system partners and providers continue to work together to improve and develop the delivery of the DoLS scheme in its current form, to protect people when they are deprived of their liberty, and to support their families and carers.

Elizabeth and Tessa's story

Elizabeth has experience of her mum, Tessa, having a DoLS in place. Tessa is in a care home and lives with severe dementia. Sometimes she can be violent and a risk to herself or others. Elizabeth can clearly see the positives of DoLS – that it helps keep her mum safe, while also protecting her liberty and human rights:

“The staff ask mum where she wants to go and take her to places like a dementia-friendly cinema. She is still making her own decisions in her own way – if she says that she doesn't want to do something then that is the decision and that is it.”

“The home gives mum options to sit in the lounge, the garden, her room... Sometimes she is not allowed to sit in the dining room if she becomes violent. It is in her best interests to be moved from there and is a case of what needs to be done at the time. DoLS does not restrict mum's freedom, it just gives us peace of mind to know that she can be kept safe.”

However, Elizabeth had a generally frustrating experience of the DoLS process and found it very confusing. She got very little information from the decision-making organisations and thought that it all took too long. She also felt that the various assessments and decisions took place without her fully understanding what was happening. For example, the local authority did a mental capacity assessment for Tessa but Elizabeth and her family were not notified in advance or properly involved. The care home also did not seem to understand much about the DoLS application process. She got most of her information from a charity organisation.

Introduction

Increasing numbers of people are living longer with multiple and complex health and care needs. One of the challenges is supporting people who may lack mental capacity to make a decision at the time it needs to be made, for example people living with dementia. The Alzheimer's Society has said that more than 850,000 people currently live with dementia in the UK and this is projected to increase to one million by 2025. Seventy per cent of people in care homes live with dementia or severe memory loss problems.¹⁴⁵

The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005 (MCA) and both work together to provide an empowering legal framework that balances safety and freedom through best interests decision-making, the right to representation, and advocacy arrangements.

DoLS make sure that people who lack capacity to make decisions and to consent to certain aspects of their care, have any significant restrictions on their liberty made in accordance with their human rights, and through a defined process including right of appeal.

The DoLS scheme has been the focus of strong criticism over recent years from the Law Commission, the House of Lords Select Committee¹⁴⁶ and organisations such as the Alzheimer’s Society¹⁴⁷ and the Local Government Association (LGA),¹⁴⁸ with concerns that it is not working for people. They and others, including CQC, welcome change and reform if correctly designed, funded and implemented to a high quality.

One of the main issues in recent years resulted from the Supreme Court ruling (see ‘DoLS and the MCA explained’ box) that generated an increase in the number of applications and the build up of applications not completed. Over four years, applications for DoLS authorisations have risen

from 13,715 in 2013/14 (before the ruling) to 227,400 in 2017/18. This has led to pressure on local authorities processing applications. The average length of time it took to complete an application in 2017/18 was 138 days, although this ranged from 68 days in London to 188 days in the South East. The number of incomplete applications that had been waiting for authorisation for more than a year was 48,555.¹⁴⁹ Providers must notify CQC of the outcome of a DoLS application to the local authority as soon as it is known, or if they have withdrawn it. Our data for 2017/18 suggest under-reporting of these notifications to us when compared with local authority authorisations.

The Deprivation of Liberty Safeguards and the Mental Capacity Act 2005 explained

People who are not able to make some or all of their own decisions at the time they need to be made due to a lack of mental capacity are protected and empowered by the Mental Capacity Act 2005 (MCA). The purpose of the Act is to promote and protect people’s decision-making within a legal framework. The Act’s principles are:

1. A person must be assumed to have capacity unless it is established that they lack capacity.
2. A person is not to be treated as unable to make a decision unless all practicable steps to help them to do so have been taken without success.
3. A person is not to be treated as unable to make a decision merely because they make an unwise decision.
4. An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in their best interests.
5. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person’s rights and freedom of action.¹⁵⁰

The Deprivation of Liberty Safeguards (DoLS) are one part of the MCA and protect the rights of people who are deprived of their liberty in their own best interests. DoLS are used in hospitals, hospices and care homes. If a person needs to be deprived of their liberty in other settings they should be referred to the Court of Protection. Providers apply for a DoLS authorisation through a supervisory body (the local authority).¹⁵¹

A Supreme Court ruling in March 2014 (‘Cheshire West’) clarified the definition of deprivation of liberty and expanded the criteria used to identify when someone is being deprived of their liberty.¹⁵² This ‘acid test’ can be described as applying:

- when a person is under continuous or complete supervision and control, and
- is not free to leave, and
- the person lacks capacity to consent to these arrangements.

In 2017, the Law Commission laid out reforms to DoLS following a review commissioned by the government.¹⁵³ The Mental Capacity (Amendment) Bill proposes a new scheme, the Liberty Protection Safeguards, to replace DoLS.¹⁵⁴ At the time of publishing, the Bill was under scrutiny in Parliament. The current DoLS scheme has put providers in a difficult position as they wait for an outcome of a DoLS application, leaving people without safeguards in place. The House of Commons and House of Lords Joint Human Rights Commission said in their report on DoLS in June 2018 that the current scheme has resulted in a situation where “those responsible for

care and treatment are having to work out how best to break the law”.¹⁵⁵

Despite the issues and uncertainty over the legislation, it is important that system partners continue to work together with providers to improve the delivery of the DoLS scheme in its current form to protect people when they are deprived of their liberty, and to support their families and carers. Providers must follow the legislation as it currently stands until full implementation of any new legislation takes place, which is likely to be several years ahead.

Varied practice and the reasons for this

In 2017/18, we continued to observe variation in how care home and hospital providers use DoLS and the MCA. This variation can lead to poor practice and have a negative effect on people using services, for example unnecessary restrictive practices that can result in a loss of freedom. In some cases, these practices can breach people’s human rights.¹⁵⁶ Our inspections found that although most care home providers comply with DoLS legislation, there remains variation in the quality of how the safeguards are applied in services.

Varied practice appears in different ways depending on the sector, but is commonly linked with a basic lack of understanding of DoLS and the wider MCA. This can then be reinforced by limited staffing levels and a lack of time to complete applications, as well as inadequate staff training. The general complexity of the DoLS legislation and a lack of local authority resources to deal with the number of DoLS applications also influence varied practice.

Understanding of legislation and practice

DoLS legislation is complex and providers can often misunderstand how to apply it – this can extend to a misunderstanding of the MCA. Providers can also be unclear as to when a restrictive practice amounts to a deprivation of liberty. This happens across different services but sometimes within services,

particularly in hospitals where DoLS and MCA practice can vary from ward to ward.

In relation to the MCA, we sometimes find that mental capacity assessments and best interests decisions are not properly completed or recorded. In some cases capacity assessments are too general and do not look at the individual elements of capacity, for example which decisions the person can and cannot make for themselves or whether they can make a decision with the right support. In other instances, a best interests decision has been made, but a capacity assessment has not happened first to trigger the process as required by the legislation.

In some hospitals, we found a lack of understanding as to what a DoLS authorisation means in practice. Some services were quite clear about what they needed to do, whereas others had very limited knowledge and understanding.

Implementing DoLS effectively needs providers to carefully balance safety and freedom, and strong leadership and a positive organisational culture tended to enable this. On the other hand, we found that a risk-averse approach to care and treatment can contribute to breaches despite a well-meaning desire to keep people safe. Concerns about safety and failing to fully understand the principles of the legislation can mean providers are not upholding people’s human rights.

For example, in some care homes, providers sometimes do not know when and in what circumstances to apply for DoLS authorisations, which can then result in a person being deprived of their liberty unlawfully. In other services, we see low staff awareness of when a restrictive practice may amount to a deprivation of liberty, with instances where safety gates, barriers, wheelchairs or tray tables have been used to restrict people without understanding how they might then impede a person's human rights. In relation to the MCA, we have concerns about the use of covert medication (medicines disguised in food and drink) without an understanding of whether it could be a restrictive practice, and sedatives to manage challenging behaviour. The DoLS Code of Practice sets out the distinction between a restriction or restraint, and if this is then a deprivation of liberty.¹⁵⁷

The challenge is for services to manage health, social and environmental risk, while ensuring that people are empowered to make choices and maintain their independence. The LGA has published a useful tool for promoting less restrictive practices.¹⁵⁸ Additionally, our ongoing work with NHS England and other national system partners to improve restrictive practice data and develop training standards will support providers, and help commissioners and regulators to identify concerning practice.¹⁵⁹

We found that tensions can arise between providers and families or carers where family members do not understand the DoLS scheme and how it relates to human rights. Similar to providers themselves, there can be a tendency for some families to be focused on the safety of their relative and to be less open to positive risk-taking. It can be difficult for providers to manage the involvement of families, friends and Independent Mental Capacity Advocates. Providers should take more of a role in helping families and friends understand best interests decision-making and the rights of the person being cared for.

Staff training

We found variation in the depth and frequency of the training provided. Online learning is very common, but perhaps less suitable for gaining a practical understanding of DoLS and the wider MCA. The way training is delivered, the quality of the content and the opportunities to embed, discuss and reflect on learning are fundamental to creating the conditions for good practice. Regular training is important as case law can frequently change the interpretation of the legislation.

Poor practice: Low staff levels leading to unnecessary restriction

In an adult social care service, one of the residents had a DoLS authorisation in place that lawfully deprived them of their liberty to freely leave the home. The system to manage this used keypad door codes known only to staff, including on doors that separated communal areas connected by corridors. This was partly a consequence of low staffing levels that impaired the service's ability to support the person's freedom of movement around the home. This had a negative effect on other residents who were not subject to DoLS. They were unable to move around the home without staff intervention and were therefore subject to blanket restrictions and unnecessary restraint. The MCA permits restrictions and restraint to be used, but only where they are in a person's best interests and where that person lacks capacity to make a decision themselves.

In response to CQC's inspection and regulatory action, the home has started to make some positive, person-centred improvements. The keypad doors are now unlocked during the day and the resident with the DoLS authorisation has one-to-one care to support her better. All residents can more easily access and enjoy the garden.

Staff numbers

Inadequate staffing levels can negatively affect DoLS and MCA practice. In acute hospitals, we found that when staff numbers are too low, person-centred care, which underpins good DoLS and MCA practice, is not always prioritised. Having a DoLS or MCA lead in a hospital helps to bridge this gap. We found examples of this working particularly well when the lead is part of a safeguarding team that supports frontline staff.

In adult social care services, we found that low staff levels can lead to the use of overly restrictive practices or ‘blanket’ restrictions (restrictions for one resident that then extend to others for practical but not necessarily lawful reasons). For example, residents are sometimes restricted to certain areas of their care home as staff do not have time to help them move around safely.

Good practice and improvement

We found good DoLS and MCA practice and providers that have improved despite the challenges. Common to these providers are:

- person-centred care that actively involves people who use the service and focuses on human rights
- proactive leadership with strong governance
- a supportive organisational culture
- good local joint working with system partners.

Person-centred care

A positive and supportive organisational culture is central to effective DoLS and MCA practice. Our evidence suggests that involving the person fully in their care and keeping them at the forefront of decision-making is closely related to good practice.

Services that are focused on the person are more likely to be working in line with the principles of DoLS and the MCA. We find that these services are more likely to make sure that people are supported in the least restrictive way and take account of people’s needs and capacity changing over time or on a

Applications not completed

There continue to be a large number of DoLS applications not completed, which varies by area. For example, across three regions of England approximately half of the applications that had not been completed at 1 April 2018 had already been waiting for more than a year (50% in the South East and 49% in both the South West and East of England). At the other end of the scale, only 8% of incomplete applications in London had been waiting that long.

These delays, including delays in sending out best interests assessors, can often undermine the importance and value that providers place on the legislation. There is often a mindset that DoLS are just an administrative burden. In acute hospitals, the context of high turnover of patients and short stays means staff can feel there is limited value, as a person can be discharged before their DoLS is authorised.

day-to-day basis. For example, in a care home rated as outstanding, the registered manager and staff had good knowledge of DoLS and the MCA, and of fluctuating capacity. The home had applied for several people to have their DoLS authorisations removed as their condition had improved and they had regained capacity to make relevant decisions. People had been very proud to be removed from a DoLS authorisation, and the home had even organised an afternoon tea for one resident to celebrate.

Our equality and human rights resource, *Equally outstanding*, highlighted that a focus on person-centred care will naturally lead to equality of access, experience and outcomes as the needs of the individual are met.¹⁶⁰ It also described how some human rights issues need to be addressed at a service level, rather than an individual level. This means having an overall purpose that supports human rights and that a provider’s leaders can get behind. Staff can then be supported to provide care in ways that maximise people’s rights.

Strong leadership and governance, and a positive organisational culture

We found that proactive leadership and strong governance are important for driving good practice in the use of DoLS and the MCA. They help to shape the general culture of a service, and reinforce a focus on person-centred care and human rights.

In adult social care services, both the provider and the manager play an important role in shaping DoLS practice. Similarly in hospitals, the leaders at organisational and ward levels can determine how staff view and implement DoLS and the wider MCA. Where leaders work collaboratively with staff so that people are at the heart of care and empowered to make decisions, it can lead to a cultural shift overall.

The role of governance is important, particularly the systems and processes that are set up to provide monitoring and oversight of DoLS practice. For example, in an acute trust rated as outstanding, there was a proactive safeguarding team that visited staff on the wards to talk about the MCA including DoLS. The team made sure that there was good consistency of processes and practices across all sites at the trust.

We found that leaders who respond proactively to CQC's inspection findings and other external feedback can improve DoLS and MCA practice. A CQC inspection report can act as a trigger to solve issues such as using overly restrictive practices.

At one specialist rehabilitation service, the leaders at the trust had been unaware of the extent of the poor DoLS practice until the inspection took place. DoLS applications and authorisations were not being monitored consistently; there were gaps in evidence for mental capacity assessments; and occasionally some people were being deprived of their liberty without a DoLS authorisation in place. After the inspection, senior leaders visited the service and supported a number of rapid improvements, including daily patient review meetings and a training programme for all staff in DoLS best practice.

Good practice: maximising rights through positive risk-taking

A residential care home for older people has a statement of purpose with dignity, privacy, respect for human rights and quality of life at its centre. The registered manager described creating:

“a homely, comfortable atmosphere – a place where people can do what they want, when they want and we work for them”.

During an audit, the manager had found some staff were risk-averse. Staff had decided that a person living in the care home was not safe to leave the home on their own. The manager then assessed the person's capacity and addressed this with staff. It was then agreed that the person was able to come and go freely.

To embed this approach across the home, the manager developed business cards with each person's name and the home's address. Residents who were assessed as having the capacity to come and go without the need for restrictions on their liberty could carry the cards so they could give them to someone in the community if they became lost. This meant the care home could support each person's right to maintain their autonomy.

Good local networks with system partners

Providers that demonstrate good DoLS and MCA practice can be more likely to be open to collaboration with others in the health and care system, and to seek out external expertise. For example, we have seen providers proactively link up with their local authority or clinical commissioning group for support.

In an example of the external support for providers, a local authority with a large backlog of DoLS

applications set up a team of best interests assessors (including an MCA lead) to address it. The team's role then extended to providing advice, support and training on MCA best practice to partners and providers.

Improved organisational culture leading to better practice

A home that provides care for older people living with dementia saw a turnaround in the quality of care, including its approach to DoLS and MCA practice. This helped the home's rating move from requires improvement to good.

In two previous inspections, we found that some applications had not been made for DoLS that should have been, and some best interests decisions had not been properly recorded.

We also found that two people's freedom of movement around the home had been inappropriately restricted without a proper assessment or best interests decision – specifically, a gate had been installed that restricted access to two bedrooms. The manager immediately removed the gate after inspection, but a wider cultural shift was needed.

With support from the local authority's quality assurance and improvement team, the manager worked together with staff to improve the organisational culture and develop an approach to care that focused on the person.

The manager was new to the home and her proactive leadership style was instrumental in encouraging a more open culture for people

living there, for their families and friends, and for the staff. She encouraged staff to tailor care to individual needs and preferences, and moved away from a task-based approach. She explained,

"We [the staff] put on dressing gowns and walk around with them at bed-time. It orientates them. We go into their world; we don't drag them into our world. They all get treated as the individuals they are. If they want to go to bed at 10, they go at 10. It's their individual choice."

Collaborating externally was also important for the improvement journey. The manager worked closely with the local authority to develop a service improvement plan. They supported her throughout and monitored progress.

Senior staff were also encouraged to develop their understanding of DoLS and MCA best practice by attending external workshops with system partners. A full training programme was then organised for staff with regular follow-up meetings to reflect on and embed learning.

The combined efforts of the manager, her team of staff, and the local health and care system, led to substantial improvements in DoLS and MCA practice at the home.

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