



The state of health care and adult social care in England 2018/19

Care Quality Commission

**The state of health care and
adult social care in England
2018/19**

Presented to Parliament pursuant to section 83(4)(a)
of the Health and Social Care Act 2008.

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Foreword

People should be able to get high-quality health and social care when and where they need it. When people can't access the services they need, the risk is that they are pushed into inappropriate care settings – ending up in emergency departments if they can't access GP care, or in crisis because they can't access mental health services quickly enough in the community.

Generally, when people can access care, the quality is good. In most health and care services, the hard work and dedication of staff has helped to maintain quality. But people's experience of care is seriously affected when it is hard to get the care they need. People have told us about the day-to-day difficulties they, and those who care for them, face in accessing services.

This year, we are highlighting mental health and learning disability services because that's where we are seeing a particular impact on both quality and people. Ratings are starting to deteriorate in mental health services. While our inspectors have seen good care, they have also seen too many mental health and learning disability services with people who lack the skills, training, experience or clinical support to care for patients with complex needs.

Increased demand, combined with challenges around workforce and access, risk creating a perfect storm. People who need support from mental health, learning disability or autism services may receive poor care from unqualified staff; they may have to wait until they are at crisis point to get the help they need; they may be detained in unsuitable services far from home; or they may be unable to access care at all.

We are strengthening our approach to how we look at these services so that we can move more quickly to spot and act on poor care. However, providers having the right staff to deliver good care is crucial to turn the tide, as is having better integrated community services to prevent people ending up in the wrong place. We've seen some excellent care where services collaborate and we want to see more local services working together. We are calling for system-wide action on workforce planning

that encourages more flexible and collaborative approaches to skills and career paths for staff. The ambitious plans to expand the mental health workforce to meet an increase in demand must be accelerated.

Access to care and staffing issues are creating challenges across all care settings, with geographic disparities – as highlighted in last year’s State of Care – presenting particular barriers in some parts of the country. People sharing their experiences with us have described having to ‘chase’ care in order to receive basic services or experiencing worsening health as they move from service to service, unable to access the care they need.

Where patients struggle to access non-urgent services in their local community, particularly GP and dental services, this can have a direct impact on secondary care services. Figures for emergency admissions after attending the emergency department are continuing to rise year-on-year. Of all attendances, the proportion requiring admission peaked at 31.2% in December 2018, and in July 2019 it was 28.9% – the highest figure for July in at least the last five years. There has also been an increase in referral to treatment times over the last year, with 4.4 million people at the end of June 2019 waiting to start treatment – an increase of 40% since June 2014.

In adult social care, funding and workforce issues continue to contribute to the fragility of the sector. 2018/19 saw providers continuing to exit the market and in 2018, we twice exercised our legal duty to notify local authorities that there was a credible risk of service disruption because of provider business failure. These were the first notifications of this type that we have issued in four years of running our Market Oversight scheme.

Last year, we warned that the continuing lack of a long-term sustainable funding solution for adult social care was having a damaging impact on the quality and quantity of available care. The failure to find a consensus for a future funding model continues to drive instability in this sector – there is an urgent need for Parliament and government to make this a priority.

This report points to examples that show how providers are working together more effectively – often using technology to help – to ensure that people get the care they need when they need it. But their efforts must be supported by commissioners, national and local leaders, and Parliament, to see real change in how and where people are cared for, and how they are supported to stay well.

Modern local services need to be designed around people’s needs that reflect society as it is in 2019 – not as it was in 1948. More and better community services will help to stop people ending up in the wrong place for their care – having the right staff in the right place is crucial to achieving this.



Ian Trenholm
Chief Executive



Peter Wyman
Chair

Summary

Most of the care that we see across England is good quality and, overall, the quality is improving slightly. But people do not always have good experiences of care and they have told us about the difficulties they face in trying to get care and support. Sometimes people don't get the care they need until it's too late and things have seriously worsened for them.

This struggle to access care can affect anyone. Too many people find it hard to even get appointments, but the lack of access is especially worrying when

it affects people who are less able to speak up for themselves – such as children and young people with mental health problems or people with a learning disability.

Too often, people must chase around different care services even to access basic support. In the worst cases, people end up in crisis or with the wrong kind of care.

The care given to people with a learning disability or autism is not acceptable

Some people are struggling to get access to the mental health services they need, when they need them. This can mean that people reach a level of 'crisis' that needs immediate and costly intervention before getting the care they need, or that they end up in inappropriate parts of the system. Some people are detained in mental health services when this might have been avoided if they had been helped sooner, and then find themselves spending too long in services that are not suitable for them.

Too many people with a learning disability or autism are in hospital because of a lack of local, intensive community services. We have concerns about the quality of inpatient wards that should be providing longer-term and highly specialised care for people. We have shone a spotlight this year on the prolonged use of segregation for people with severe and complex problems – who should instead be receiving specialist care from staff with highly specialised skills, and in a setting that is fully tailored to their needs. Since October 2018, we have rated as inadequate 14 independent mental health hospitals that admit people with a learning disability and/or autism, and put them into special measures.

This is an unacceptable situation. A better system of care is needed for people with a learning disability or autism who are, or are at risk of, being hospitalised, segregated and placed in overly restrictive environments. We must all work together to make this happen.

We also know that people with the most severe and enduring mental ill-health do not always have access to local, comprehensive rehabilitation services and are often in inappropriate placements far from home. This weakens support networks and the ability of family and commissioners to stay in close contact, sometimes with devastating consequences.

We are seeing issues with the availability of care. There has been a 14% fall in the number of mental health beds from 2014/15 to 2018/19. While this is in line with the national policy commitment to support people in the community, it is vital that people in crisis can access support when needed.

All of this is underpinned by significant issues around staffing and workforce. Our inspectors are seeing too many mental health and learning disability services with people who lack the skills, training, experience or clinical support to care for patients with complex needs. In the majority of mental health inpatient services rated as inadequate or requires improvement since October 2018, the inspection reports identified a lack of appropriately skilled staff as an issue.

Other types of care are under pressure

There is pressure on all health and care services in England. Waiting times for treatment in hospitals have continued to increase and, like many areas in the NHS, demand for elective and cancer treatments is growing, which risks making things worse.

In hospital emergency departments, performance has continued to get worse while attendances and admissions have continued to rise. July 2019 saw the highest proportion of people spending more than four hours in A&E than any previous July for at least the last five years. What used to be a winter problem is now happening in summer as well. While other hospital services improved slightly this year, the quality of care in NHS urgent and emergency services in hospitals has deteriorated.

The stability of the adult social care market remains a particular concern. There is still no consensus on how adult social care should be funded in the future. Twice in 2018, we had to exercise our legal duty to notify local authorities that there was a credible risk of service disruption because of potential failure of a provider's business. An estimated 1.4 million older people (nearly one in seven) do not have access to all the care and support they need.

There are consequences, knock-on effects and extra pressures when people cannot easily access the care they need. In the 2019 GP Patient Survey, almost one in eight people who did not take the appointment offered to them went to an emergency department instead.

More and better community care services are needed

More and better community services are needed to help people avoid crisis situations.

In our report on segregation, we described a common picture where people with a learning disability or autism had not had access to the help they needed as children from health, care and education services. When they encountered a crisis in their lives, there was nothing available locally to avoid going into hospital. For many, their hospital stay was prolonged because of delays in setting up the package of care they needed after they were discharged.

In many cases, crises could have been averted if local health, care and education services had worked in unison to provide an integrated package to support them when they were young.

In all sectors, there is pressure on the availability of services to maintain people's health and wellbeing. We have heard about the increasing concerns in getting care and support in the community – a lack of prevention services, early stage or low-level support, community-based NHS services and social care.

Care services and organisations must work more closely together

The challenge for government, Parliament, commissioners, national organisations and providers is to change the way services work together so that the right services are being commissioned to deliver what people need in their local area. Leaders need to have a more urgent focus on delivering care in innovative, collaborative ways.

Some places have better care than others. There are parts of the country with concentrations of relatively poor quality care – people living there may find it more difficult to access good care. Although there

seems to be some narrowing of regional variations in quality, there are still considerable differences.

Around the country there are a number of shared commissioning budgets between health and social care. In some areas, our staff have seen more evidence of joint commissioning approaches. For example, joint commissioning is part of the Greater Manchester Health and Social Care Partnership plan; in Manchester (one of the 10 Greater Manchester localities), there is joint commissioning governance across all health and social care. However, such

integrated approaches to commissioning are not yet widespread.

When local health and social care providers work well together, people's experience of care can be improved. We highlighted last year, in our in-depth reviews of care for older people, the urgent necessity for change and that the barriers to working together

can be broken down. Although progressing unevenly in different parts of the country, we have begun to see evidence of more integration and/or joint working emerging. Some local areas that we revisited have shown improvements.

More room and support need to be given for innovations in care

Innovation is at the heart of some of the high-quality care we see – sometimes this is technological and specialised, or it might be the way in which services use smarter workforce planning to meet people's needs.

We encourage and support innovation that improves the quality of care for people and puts their safety first. However, where we see innovation happening, it is still more likely to be driven and supported by individual leaders or as a result of the determined efforts of local services.

Care staff are working in challenging and stressful working environments, and our work has highlighted regional variation in the ability of services to recruit and retain staff. We have seen providers and other care organisations adopting new approaches to tackling workforce issues, with a particular focus on retaining staff.

Increased demand on services has prompted the development of new roles and an emphasis on upskilling existing staff. In primary care, there are increasing numbers of advanced nurse practitioners, nursing associates, physician associates, pharmacists, district nurses, mental health practitioners and social prescribing workers, all working in GP practices. The introduction of the nursing associate role has the

potential to create development opportunities for staff in both adult social care and health care.

We have encountered a range of technologies being used to deliver care in more effective ways and to help people get a better experience of care. We have also seen some positive examples of technology being used to improve the experience of people with protected equality characteristics, but these have not been commonplace. This tends to be in those services with effective management and leadership, where it meets a specific need and is used to make care more person-centred.

The challenge for providers and the wider local health and social care communities is to consider technology in a broader strategic sense, as an enabler of high-quality care. There is no doubt that good things are happening in many places that are benefitting people, but projects are often piecemeal. We do not yet find enough examples of joined-up thinking between commissioners and providers where new technology is central to improving the quality of care for people.

Evidence used in this report

This report sets out the Care Quality Commission's (CQC's) assessment of the state of care in England in 2018/19. 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 2019.

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

- Quantitative analysis of our inspection ratings of almost 32,000 services and providers, drawing on other monitoring information including staff and public surveys, and performance:
 - 22,949 adult social care services
 - 146 NHS acute hospital trusts
 - 244 independent acute hospitals
 - 71 NHS or independent community health providers or locations
 - 10 NHS ambulance trusts
 - 33 independent ambulance locations
 - 200 hospices
 - 55 NHS mental health trusts
 - 234 independent mental health locations
 - 6,706 GP practices
 - 1,033 dental practices^a
 - 144 urgent care and out-of-hours GP services.
- A programme of primary qualitative data collection and analysis to gather evidence to inform the messages of this report. Through this work, we have heard from 138 people through interviews or focus groups, including CQC staff, health and social care providers, people who use services and representatives of voluntary organisations representing people who use services. All interviews and focus groups took place from February to June 2019. The following are the methods adopted and the objectives for driving this work:
 - Thematic analysis of 11 focus groups and two interviews with CQC inspection, policy and intelligence colleagues working in primary medical services, adult social care, mental health and hospitals teams. This work aimed to gather participants' views and experiences of the issues affecting health and social care in England based on their work at CQC, with a focus on what had changed over the previous 12 months. The discussion focused on predefined themes: access and accessibility, workforce, technology, funding and commissioning, and local services working together.
 - Thematic analysis of 10 interviews with representatives of voluntary organisations representing people who use services that work with us as partners on public voice projects. The aim of the work was to explore what these organisations knew and understood about what matters most to people who use services, their families and/or carers when accessing and receiving health and social care in England.
 - Thematic analysis of 10 interviews with members of our inspection teams with a specialist interest in human rights and equalities. The aim of this analysis was to explore current and changing practice in health and social care for people in equality

^a Dental practices are not rated, and data on these is for inspections in the year ended 31 March 2019. We inspect around 10% of dental practices each year.

groups and to highlight any new or emerging equality issues encountered through inspection activity during 2018/19.

- Thematic analysis of three focus groups and two interviews with inspection staff in the Hospital and Adult Social Care directorates with a particular knowledge and interest in Deprivation of Liberty Safeguards (DoLS). The work aimed to gather feedback on what – if anything – was new or different about DoLS practice in 2018/19 and to seek views on three factors that can support good and improved practice: embedding staff training into practice; involving families and carers; and local area partnership working.
 - Qualitative case study analysis of eight services that have demonstrated one or more areas of innovative practice. For each case study, interviews were conducted with at least the inspector and/or inspection manager responsible for the service and a representative of the service. The analysis aimed to understand what made innovation possible and how it was having an impact, so that others could learn from it.
 - Interviews of 12 members of the public and/or Experts by Experience. This work aimed to understand experiences of accessing health and social care services and personal experiences of care in England. Data is anonymised, and any names used in the report are not the real names of the people who contributed. We commissioned a proportion of this work from a partner organisation.
- Mixed-method analysis of ‘Share Your Experience’ comments submitted through our website between 2016 and 2019. This online form can be submitted by people using the service, family members and/or carers, as well as care professionals. We used topic modelling to group just under 60,000 comments into 10 ‘topics’ for each care sector. Five of the 10 topics were analysed in detail for each sector. The 100 highest weighted comments in each of the five topics were then analysed for emerging themes.
 - Secondary qualitative analysis of inspection reports and/or evidence appendices for NHS trusts regarding the implementation of Workforce Race Equality Standards. This analysis included all inspection reports and/or evidence appendices for every NHS trust (acute, community, mental health and ambulance trusts) published from 1 April 2018 to 31 March 2019. This includes representation from trusts rated as outstanding, good, requires improvement and inadequate for the well-led key question.

Analytical findings have been corroborated, and in some cases supplemented, with expert input from our chief inspectors, deputy chief inspectors, specialist advisers, analysts, and policy and strategy teams to ensure that the report represents what we are seeing in our inspections.

Where we have used other data, we reference this in the report and, unless otherwise stated, it relates to the year ended 31 March 2019.

Part 1

THE STATE OF CARE IN ENGLAND

2018/19

1. People struggle to get access to the care they need and want

People's overall experience of health and social care is a combination of things, including whether they can access the services they need and the quality of the care that they receive. We know that good personalised care is what matters to people and to their families and loved ones. They want to be able to access care that is tailored to them – when and where they need it – and for it to be high-quality when they do.

The overall quality of care that people receive in England has improved very slightly from last year. When people are receiving care, it is mostly of good quality. As at 31 July 2019:

- 90% of GP practices were rated as good and 5% as outstanding
- 80% of adult social care services were rated as good and 4% as outstanding
- 65% of NHS acute core services were rated as good and 7% as outstanding
- 71% of NHS mental health core services were rated as good and 10% as outstanding.

There was notable improvement in NHS acute hospitals, with a rise of 5% in core services rated as good, up from 60% at 31 July 2018. There were small 1% improvements in the proportion of adult social care and NHS mental health services rated as good. The proportion of GP services rated as good fell by 1%. (See appendix for ratings charts.)

A substantial number of people receive care from services that we have rated as requires improvement: 4% of GP practices, 15% of adult social care services, 25% of NHS acute core services and 17%

of NHS mental health core services were rated as requires improvement at 31 July 2019.

For a small minority of people, the care they receive is inadequate: 1% of GP practices (82 practices), 1% of adult social care services (285), 2% of NHS acute core services (43) and 3% of NHS mental health core services (15) were rated as inadequate at 31 July 2019.

But even where care services are of good quality, many people can struggle to get access to the care they need and want. This can include everything from the speed at which they get that very first important conversation with a GP, to the availability of a care home bed, a hospital appointment or a mental health service.

For this year's State of Care report, and for the first time, we have been able to analyse in depth the comments and concerns raised with us daily from people using services, members of the public and care workers. We analysed just under 60,000 comments that were shared through our online Share Your Experience form over a three-year period between 2016 and 2019, focusing in detail on 2,000 of these where there were most similarities in what people were telling us. In addition, we talked to a range of organisations that represent people who use services about what they are hearing from the people they support. Together, this gives us a good picture of how people are affected by the workings of the health and care system in this country.

People have told us they can face a myriad of challenges in getting access to the care that they need, when they need it. These challenges range across a spectrum. At one end, people may face

inconveniences in getting appointments, chasing referrals and following up on previous visits. At the other end, people may be unable to get any help or service at all, compounded by difficulties in navigating their local health and care services and knowing where to turn. For those with mental health needs or a learning disability, this can mean being treated in the wrong place and in the wrong way, because the model of care is wrong.

Age UK estimates that 1.4 million older people (nearly one in seven) do not have access to all the care and support they need.¹ There has been large regional variation in adult social care provision in recent years. The number of care home beds in some local authorities has fallen substantially in the five years to 31 July 2019: Tower Hamlets by 30%, Southwark by 27% and Waltham Forest by 26%. On the other hand, some local authorities have seen substantial rises: Bexley by 29%, Central Bedfordshire by 18% and Peterborough by 17% over the same period.

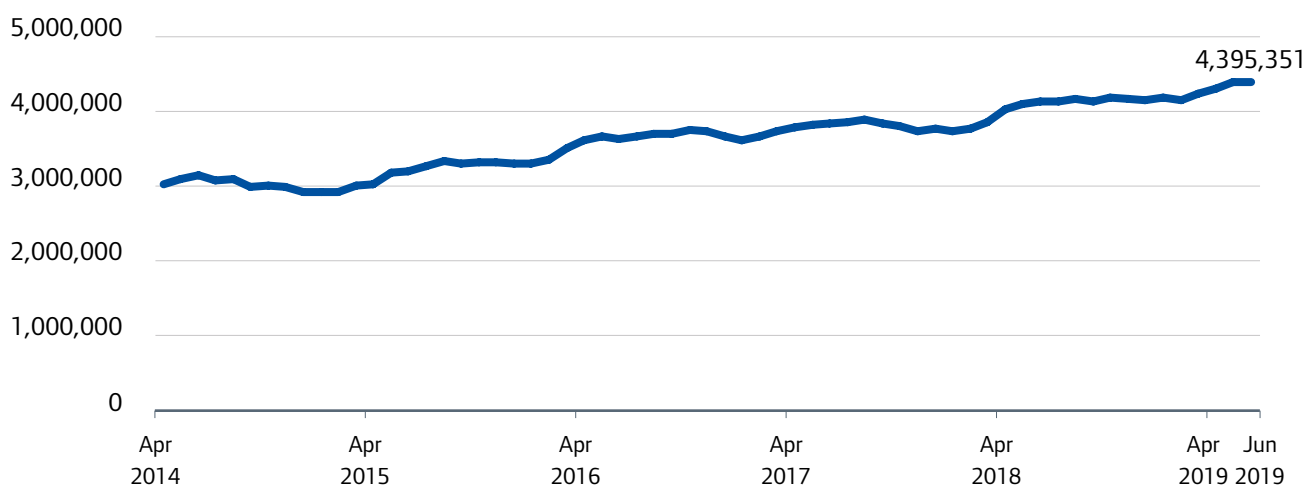
Healthwatch England has suggested that fewer than half of all people with dementia, who use social care, are getting the regular care reviews they are entitled to as part of the support they receive from councils.²

In hospitals, waiting times for treatment have continued to increase (figure 1.1). The waiting list for elective care grew by almost 1.3 million from June 2014 to June 2019, when it stood at nearly 4.4 million people (a rise of 40%). Of these, more than 600,000 had been waiting more than 18 weeks. The Public Accounts Committee has highlighted that, in November 2018, fewer than half of NHS trusts were meeting the 18-week waiting time standard for elective treatment, and only 38% were meeting the 62-day standard from referral to treatment for cancer patients.³

In emergency care, performance against the four-hour target has continued to decline while attendances and emergency admissions have continued to rise. July 2019 saw the highest percentage of patients spending more than four hours in the emergency department than any previous July, alongside the highest number of people attending in any month, for at least the last five years (figure 1.2).

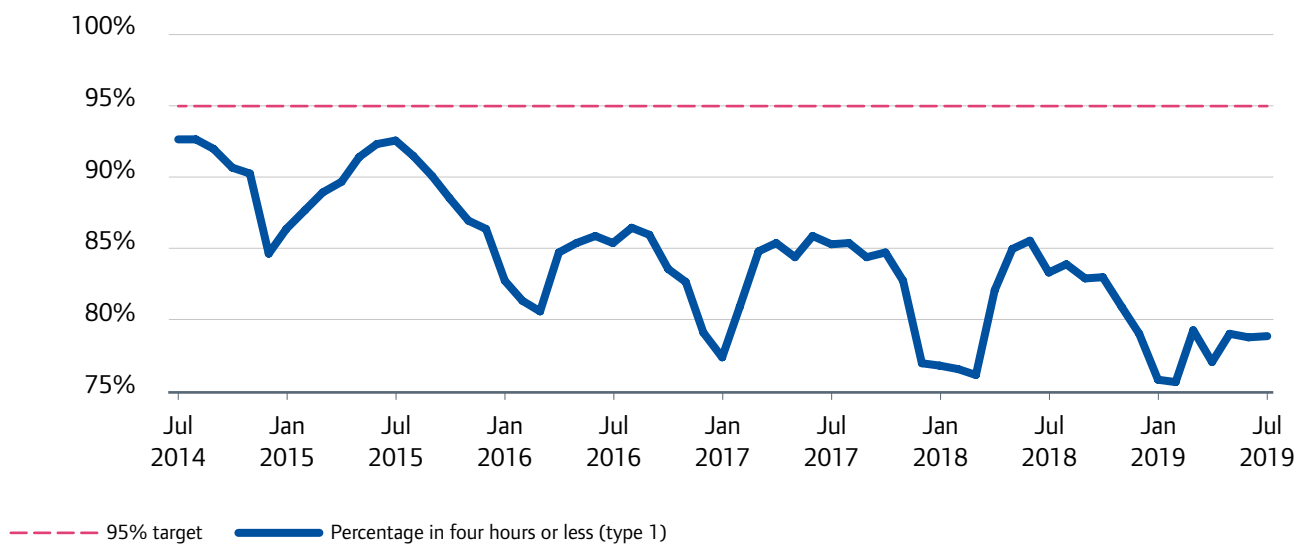
Space in acute hospitals has become harder to find, as bed occupancy rates have gradually risen over the last few years (figure 1.3), although pressures appear to have eased slightly in 2018/19.

Figure 1.1 Total 18-week waiting list size, April 2014 to June 2019



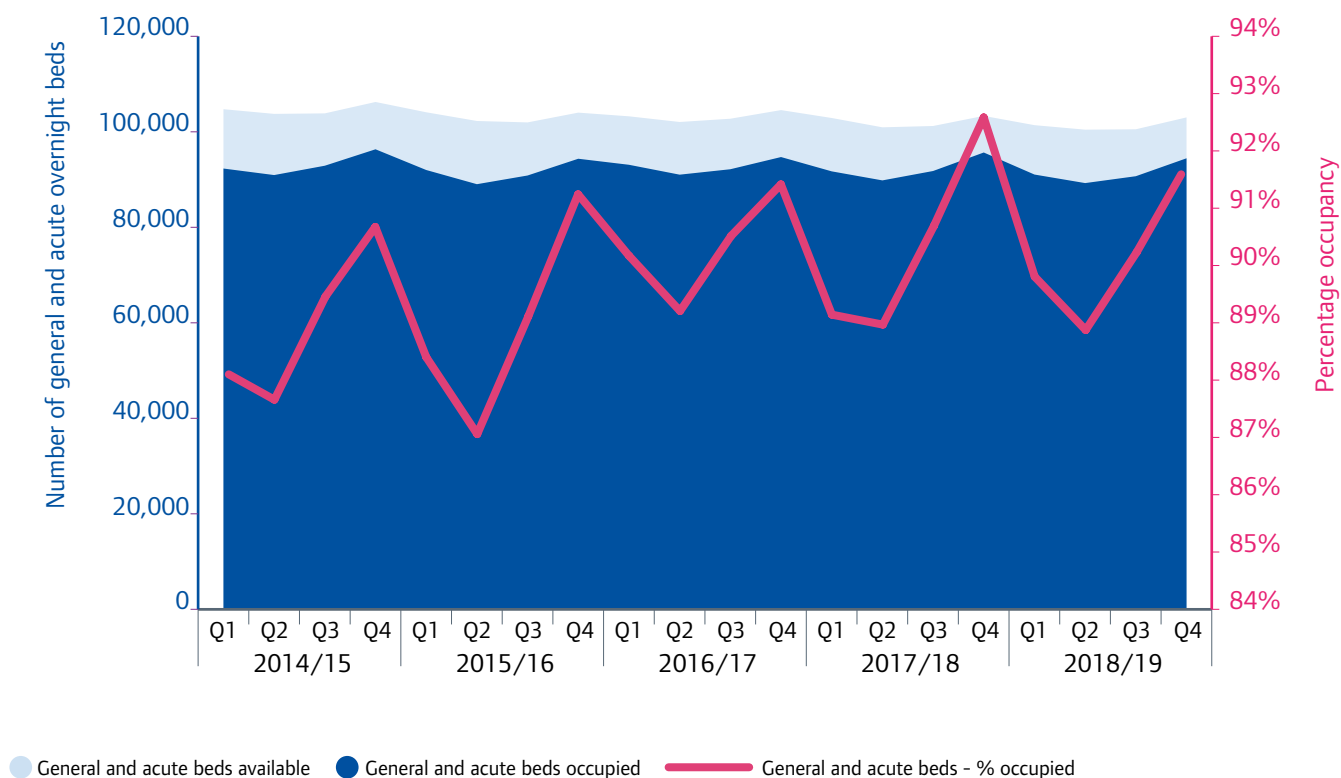
Source: NHS England and NHS Improvement, monthly referral to treatment times (commissioner level)

Figure 1.2 Monthly performance against the four-hour target in major emergency departments (type 1), July 2014 to July 2019



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

Figure 1.3 General and acute overnight bed availability and occupancy, 2014/15 to 2018/19



Source: NHS England, average daily available and occupied beds

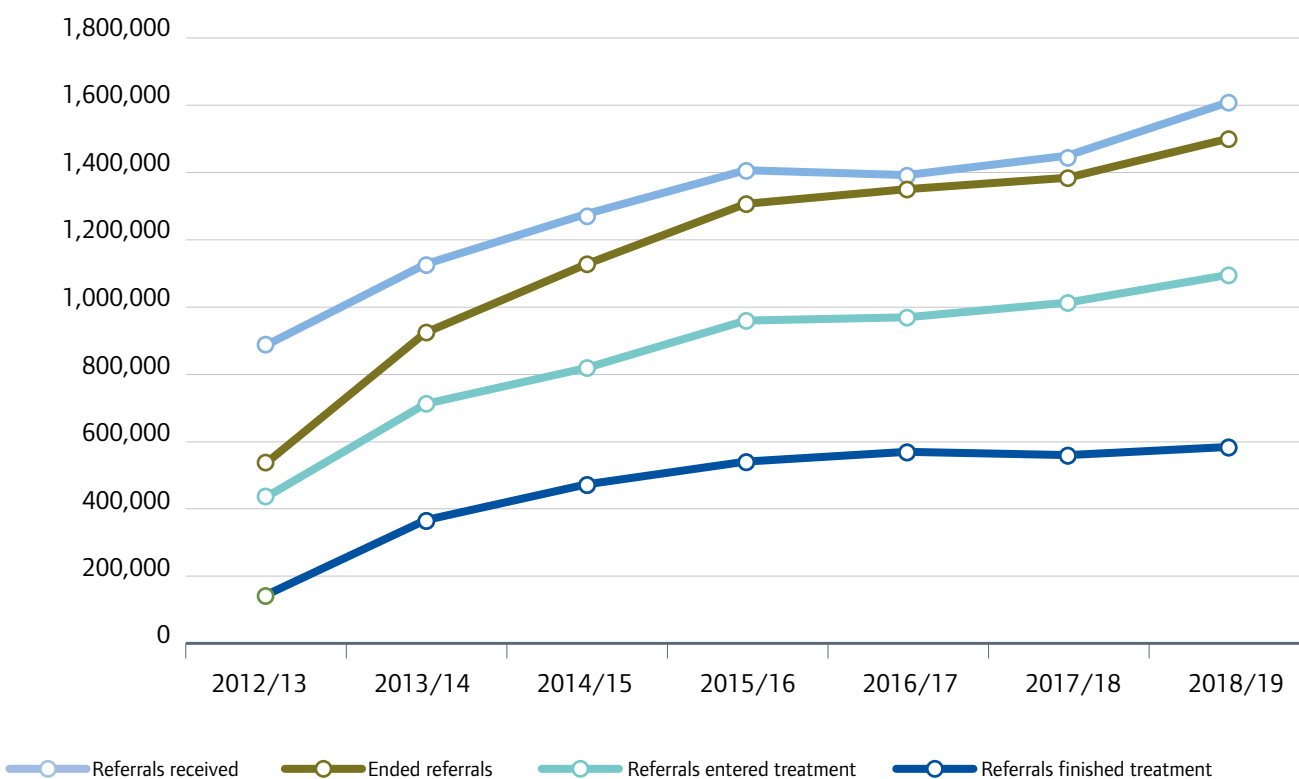
We have concerns about access to mental health services. Young people continue to experience difficulty in accessing community child and adolescent mental health services. This is reflected in the fact that 21% and 10% of community-based mental health services for children and young people are rated as requires improvement or inadequate for the responsive key question. Access is a particular concern for children and young people with an eating disorder.

The Local Government Association reported in July 2019 that social services were seeing more than 560 cases of children with mental health disorders every day – an increase of more than 50% in four years. Their figures showed there were 205,720 cases where a child was identified as having a mental health issue in 2017/18, compared with 133,600 in 2014/15.⁴

People with the most severe and enduring mental illness do not have access to local, comprehensive rehabilitation services. In March 2018, we published a briefing in which we drew attention to the high number of people placed in mental health rehabilitation hospitals who are a long way from home.⁵ In response to our findings, NHS England and NHS Improvement have set up a team to work with local health and care communities to develop local services capable of meeting these people’s complex needs. We have repeated our request for information from providers to monitor progress.

In some areas of mental health care, challenges with access can be seen to relate directly to rising demand. For example, there has been a sharp rise in referrals for psychological therapies over the last few years, and while the number of people entering treatment has also risen, it has been exceeded each year by the number of referrals (figure 1.4).

Figure 1.4 Improving access to psychological therapies (IAPT): trends in referrals and treatment, 2012/13 to 2018/19



Source: NHS Digital, Annual report on the use of IAPT services England 2018/19

Organisations that represent people who use services have told us about the barriers that people are coming up against when trying to get diagnoses and assessments, particularly for dementia, autism, mental health conditions and social care. These include long waiting times, the need to be persistent, eligibility for assessments and the timing of assessments.

We also know from our staff and organisations that represent people who use services that some groups of people, especially those with multiple needs, can face greater challenges accessing the care and treatment they need. For example, recently published research shows that Gypsies, Roma and Travellers may still face barriers to registering with a GP practice or making an appointment⁶ and asylum seekers may also face barriers to registering, which has a particular impact on those who are pregnant or disabled.⁷ This is despite NHS guidance that should enable both groups to register. GP practices are an important gateway into community-based healthcare services. In our local system reviews, we also found older people in some minority groups struggling to access community health and social care services.

Chasing up care – people feel they have to fight to get a quality service

People who have contacted CQC to share their experience of care have told us that they feel they have to ‘chase’ to get the care they need – the cumulative effect of long waiting lists, cancellation of appointments, lost referrals, or not being able

to see the medical professional that they needed because of service gaps (such as aftercare). We see in their comments and we hear from representative groups that people can feel exhausted by this, and can be left feeling responsible for managing their own care and treatments. They can also feel frustrated by having to repeat their story to multiple health and care professionals.

This also raises concerns about some groups of people who are in particularly vulnerable situations, who might be less able to chase – they face hurdles rather than a system that takes them by the hand.

People using services, their families and their carers are not always aware of what services are available to them and can lack the support they need to navigate the health and social care system. We have heard from representative groups that there is not enough signposting or information about which services are available and the support people may be entitled to.

Our 2018 review of services for children and young people experiencing mental health problems found that many do not get the kind of care they deserve. The system is complicated, with no easy or clear way for them to get help or support or to find their way around once they are getting help. There are great examples of services with caring and dedicated individuals who put children and young people at the centre of what they do. But these people are often working long hours, with limited money and an increasing demand for their services, which cannot be maintained in the long run.⁸

“Heard nothing, chased it up...nobody knows anything about it”

“An individual had been in hospital, her sister had come to look after her and had been told that yes, she was eligible for reablement, ‘there will be services put in place, if you could basically look after her at home for a week or so, we’ll sort that out’.

A few weeks later... had heard nothing, chased it up, the GP knows nothing about it, nobody

knows anything about it, no services available, no services in place. So, she was obviously calling us to see what we could do to help because she could no longer stay in the situation herself. That sort of story is relatively common.”

Age UK

People who contacted CQC to share their experiences of primary care described having to repeatedly explain their situation, as samples and test results had been lost, prescriptions had not been signed or printed, visits had not been made by GPs, or receptionists had not called back. Other examples of chasing included regular early morning phone calls trying to book appointments, waiting for a long time on hold, or phoning every day for prolonged periods after being told all appointments had been taken.

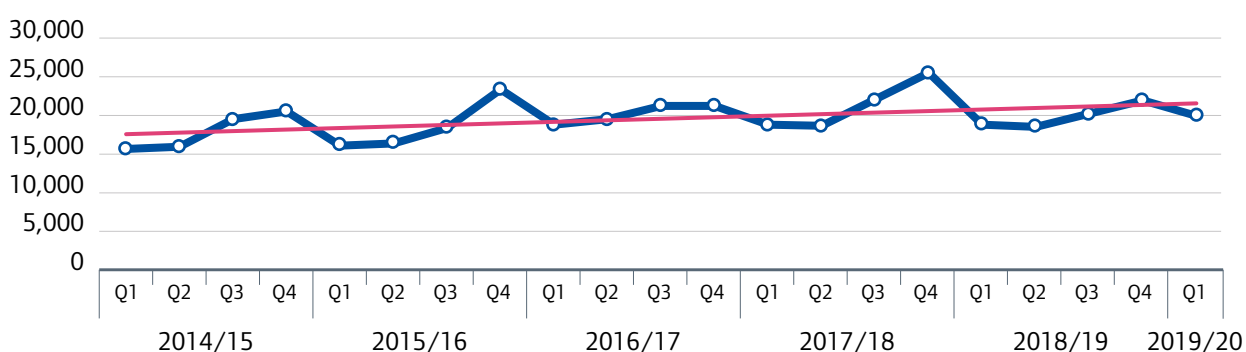
Similarly, in stories shared with us about acute hospital care, there was evidence of frustration at difficulties in getting appointments. A range of issues were described, including appointments being cancelled at short notice or rearranged multiple

times, lost referrals, delays to test results, and poor communication between services and with patients and their family members.

Experiences shared with us have also highlighted that access to appropriate care can be particularly difficult for people in vulnerable situations, such as some older people or those with mental health conditions. These groups can experience poor care and treatment because of insufficient coordination between services and a lack of understanding of their specific needs.

The number of elective operations cancelled each quarter has seen an upward trend over the last five years, although the most recent winter did not see as many cancellations as in winter 2017/18 (figure 1.5).

Figure 1.5 Number of cancelled elective operations per quarter, 2014/15 to 2019/20



Source: NHS England, Quarterly monitoring of cancelled operations

The burden is shared by families and carers

The health and care system relies heavily on the work of millions of unpaid carers, as well as the voluntary sector. There are increasing pressures on this vital support network.

In its annual survey of more than 7,500 people currently caring unpaid for family or friends (the majority of whom provide well over 50 hours of care every week), Carers UK found that two in five carers (39%) said they were struggling to make ends meet.⁹ More than two-thirds (68%) of carers

were using their own income or savings to cover the cost of care, equipment or products for the person they care for, such as nutritional supplements and mobility equipment.

Carers UK has also published research that highlights an increase in the number of people juggling work and unpaid care. This also found a rise in the number of people giving up work to provide care.¹⁰

They have also found that only 8% of unpaid carers responding to a survey said they had been able to take a sufficient break from caring. Of those who did manage to take some time off, 44% used it to attend a medical appointment.¹¹

Amal supports his mother, who was born in Bangladesh, to access GP and hospital services to receive treatment for arthritis. In the past, his mother has received good care from her consultant – he told us that the consultant treated his mother very well, and they felt welcomed and listened to by the service. However, over the past year, following the retirement of his mother’s consultant, they have experienced poor continuity of care. In particular, Amal explained how delays to his mother’s regular injections for arthritis has left her “suffering quite a lot”. Amal feels that he has often had to “argue” or “complain” to get the care his mother needs.

Analysis of experiences of care shared with CQC have highlighted that relatives and loved ones can share the burden of having to ‘chase’ services and coordinate care and treatment, often feeling a sense of responsibility to care for and support people when services were not available. People have told us about the exhausting nature of this and raised concerns about people in vulnerable situations who might be less able to chase.

Organisations that represent people who use services have highlighted to us the key role that family and friends can play in the coordination of care, because services aren’t necessarily working together. Age UK explained how this can be stressful and detract from spending quality time with loved ones.

“There was a case recently... what they were reporting back to us was, that when their mother was seriously ill and at the end of their life they spent more time chasing stuff across the system, prescriptions and appointments than they felt that they did supporting ... their loved one and engaging with the fact that they were dying.”
(Age UK)

Friends and family provide a crucial role in supporting their loved ones. For example, the Deprivation of Liberty Safeguards are a positive

measure to protect the rights and needs of people and, from our case studies, we know that involving family members in the process can be key to making sure the rights and needs of their relative are kept at the forefront.

People have to turn elsewhere or reach crisis level

Without adequate access to care, people may find they have to go elsewhere for care, which adds further complications, or that they have to reach a level of ‘crisis’ that needs immediate and costly intervention.

People with poor mental health who contacted CQC to share their experiences have told us that they have been unable to access appropriate services when they needed them in primary care, hospitals and mental health services.

This is supported by data that shows while around three-quarters of people starting treatment for early intervention in psychosis each month have typically waited less than two weeks (77% in May 2019), there are more than 1,000 people each month who are still waiting (1,268 in May 2019), and many who have been waiting more than 12 weeks (178 in May 2019).¹²

People sharing their experiences have also told us that struggling to get access to the right mental health care meant they ended up in inappropriate parts of the health and social care system. This included people living in unsuitable housing, becoming homeless, presenting at an emergency department (A&E) or being picked up by the police – all situations that cause great distress for people and their families and loved ones.

Similarly, we have heard that people with specific needs and communication difficulties have found themselves in seemingly inappropriate services in which staff were not able to meet or care for their complex needs because of training gaps, staff shortages and general restrictions of the service. This can be particularly challenging for people with autism requiring specialist services, with some of these people telling us that they experienced a deterioration in their mental health and that their relatives experienced increased distress as a result of inappropriate care.

People who have contacted CQC to share their experiences have told us that, in some cases, in primary care, they felt forced to consider taking an emergency appointments route for a non-urgent condition, or to go without important medicines due to delays or errors. In hospitals, we have heard that the struggle to get appropriate appointments can lead to delays to treatment, leaving people without appropriate support and worsening conditions, and sometimes leading to people reaching crisis point. The effect this can have on people's mental health and wellbeing is also clear in stories shared with us, with people expressing stress, anxiety and anger.

Across all care sectors, people using services can find their needs are dealt with in isolation – the composite parts are not working together to deliver 'whole person care' – with nobody understanding or considering the whole picture. The result of this is people using services, their families and carers falling through the gaps of the health and social care system.

One example is the importance of support for the physical health of those with long-term mental health conditions. People want to be treated as a whole person and not have their conditions treated in isolation. Research has shown that people with severe mental illness are more likely to die 10 to 20 years earlier than the general population.¹³ Risk factors such as smoking, physical inactivity, obesity and the side effects of medicines highlight the importance of regular physical health checks.¹⁴

Overall, we have heard from a range of sources that:

- information is not shared effectively, and people are frustrated when they feel they have to repeatedly explain their conditions
- people's experiences of care and treatment is that it is not joined up, and they have to fill the gaps or join the dots
- people with multiple complex issues can experience more challenges, including when they move between services, such as being discharged from hospital
- people need more holistic help, including social support, advice and signposting for reablement,

help with medicines, finances and housing, and befriending services if loneliness is likely to be a problem

- more prevention services are needed, as well as more support in the early stages of illness.

More and better community care services are needed

To start to change the situations outlined above, more and better community services are needed.

For example, too many people with a learning disability or autism are in hospital because of a lack of local, intensive community services. Many of the people still in hospital have been there for a long time and are in a hospital that is out of their local area.

In December 2018, the Secretary of State for Health and Social Care asked us to carry out a thematic review of restraint, seclusion and segregation. The first phase of this work focused on people who are cared for in segregation on a learning disability ward or a mental health ward for children and young people. Most of the people that we visited had autism.

Maria told us about her experiences of accessing mental health services and specialist services for an eating disorder. Her experience has often been that her physical and mental health care is not joined-up, and treatment plans are not coordinated. On some occasions, this has meant that her condition has deteriorated while waiting to access the care she needs. Maria feels that her care could be improved if services worked better together and communicated more effectively: "People being able to deal with different issues, rather than just 'well we'll deal with your depression, anxiety, PTSD, we'll deal with that and they can deal with your eating disorder' whereas actually the eating disorder is how I cope with everything else, that is my control, they are so entwined, they need to work together to solve both of them."

In our interim report, we described a common picture of these people not having had access to the help they needed as children and throughout their lives from health, care and education services.¹⁵ Often, when they encountered a crisis in their lives, the right care was not available locally to avoid going into hospital. For many, their hospital stay was prolonged because of delays in setting up a package of care to support the person following discharge, or because that package of care did not even exist.

In many cases, crises could have been averted if local health, care and education services had worked in unison to provide an integrated package of support to the person when young. Our report also concluded that, once a person was in segregation, there were then challenges in finding suitable accommodation, and the accompanying bespoke package of care. This may have been made more difficult by the challenge of coordinating the inputs of the various provider and commissioner organisations involved – and perhaps by disagreements about who should fund the care.

In all sectors, there is pressure on the availability of services to maintain people's health and wellbeing. The Association of Directors of Adult Social Services, in their annual budget survey, found that more than 7,000 people had been affected by care home closures and home care providers closing or ceasing to trade in the previous six months – more than double the number affected the year before.¹⁶

An Age UK report found that people assessed as being eligible for domiciliary care services in the community were unable to get care because of issues with the local social care market; for example, no services available, long waiting times, offering only a reduced service, or by providers exiting the market. They also found that those privately funding their own care were experiencing similar challenges.¹⁷

We have heard that people continue to face barriers to accessing non-urgent services in their local community, for example GP and dental services. There is wide variation across the country in the number of full-time equivalent GPs for the size

Nobody saw the whole picture...

A man had had polio when he was a child; he'd been left with a deformed arm and had already lived his life with limited mobility. He was also diabetic and had several other conditions, as did his wife.

They didn't have any children. They supported each other at home until his wife had a fall and broke her hip. She ended up in hospital. On discharge, it was felt that she wouldn't be able to cope at home, so she was admitted into a care home. This left her husband at home alone.

And nobody knew. Although he was in contact with the GP, with the district nurse, and various services, there was nobody who had really understood that he and his wife were supporting each other. He quite quickly became malnourished alone.

On one occasion he had an accident when he was going to visit his wife in the care home, that resulted in injury to his leg. There was a district

nurse coming in to dress the wound but because he was diabetic and malnourished, the wound wasn't healing. Nobody really picked up on these issues. The district nurse knew the wound wasn't healing, the GP knew he was diabetic, but nobody understood the whole picture.

The focus is often on the transition point, for example, when somebody leaves hospital to be supported by a community provider or by social care. But it's worth remembering that the number of people living in that quite precarious situation where general services, those day-to-day services don't connect. And if somebody does, it's usually a family member or a partner who's joining the dots and keeping an eye on everything. And if people don't have that, they're in a very difficult position. But even for people who do, that's a huge source of stress. It's a huge burden to put on that individual.

Age UK

of the local population. While we have found a tendency for areas with fewer GPs to provide more appointments with practice nurses and other non-medical professionals, there are areas with low numbers of GPs and low numbers of non-medical appointments.

Organisations that represent people who use services have told us about the increasing concerns they hear about the availability of care and support services in the community – a lack of prevention services, early stage or low-level support, community-based NHS services, and social care services. Some organisations also highlighted the absence of wider community support, for example buddying and befriending services, and an example was given of how autistic people without a disability can find themselves falling between the gaps of traditional services when seeking both social care and mental health support.

Variation in quality across the country

As we explored in last year's report, there are parts of the country where relative concentrations of poor quality care, as shown by ratings, mean that people living there may find it more difficult to access good care. Despite being able to detect some narrowing of differences in quality at regional level, there are still considerable differences that will affect people's experiences.

Among residential homes for example, the poorest quality area (as measured by the proportion of locations rated as good or outstanding at 31 July 2019) is Portsmouth, where only 18 out of 30 rated homes (60%) are good or outstanding. This contrasts with 14 local authorities where more than 95% are rated as good or outstanding.

Among nursing homes, there are eight local authority areas where only up to half of the locations are rated as good or outstanding, all of them London boroughs.

The picture among GP practices is also worthy of note: while nationally 95% of practices are rated as good or outstanding, there are five areas where less than 80% of practices achieve that level of rating, with the poorest being Peterborough, where only 11 out of 16 practices (69%) are rated as good or outstanding, and which includes two of the 82 practices in England currently rated as inadequate. All the inadequate practices are distributed across

only 49 local authority areas. Two-thirds of local authorities have no inadequate GP practices, whereas Northamptonshire hosts four practices rated as inadequate, and Waltham Forest, East Sussex, Birmingham, Barnsley, Swindon and Lincolnshire each host three.

Funding and commissioning challenges

Providers, commissioners and others continue to operate in a challenging environment. We understand that the availability of funding and/or the financial security of services can underpin many of the issues facing providers. While not always the sole or primary driver of the quality of care, strong funding and commissioning arrangements are important in creating the conditions for high-quality, person-centred care.

The stability of the adult social care market remains a particular concern. The percentage of services rated as good or outstanding has improved very slightly this year, but there are fewer beds in nursing homes and care homes, and staff turnover has risen for the sixth year running.

In 2018, we were twice required to exercise our legal duty to notify local authorities that there was a credible risk of service disruption because of providers' businesses failing. The second of these referred to one of the largest domiciliary care providers in England. These were the first notifications of this type that we have issued in four years of running our Market Oversight scheme, pointing to increasing fragility in the market.

In last year's State of Care report, we highlighted issues with funding in adult social care, saying that "a sustainable financial plan for adult social care will be an important element of the forthcoming social care green paper". There have been repeated delays to the green paper and there remains no consensus about how to adequately fund social care in the future.

In the absence of a long-term, sustainable funding solution for the sector, the Association of Directors of Adult Social Services said this year that only one in 10 directors are optimistic about the financial state of the health and social care economy.¹⁸

Our staff have reported that the complexity of commissioning and funding arrangements is a

key issue in both mental health and adult social care. As we found in our local system reviews, local commissioning arrangements can lead to fragmented, confusing pathways and people not accessing the right service in the right place and at right time. This can be particularly evident in services for people with a mental health problem, a learning disability or autism, where a lack of local services, including for people in crisis, can result in people receiving care a long way from their local community, often in a setting that is not conducive to them returning to their community as quickly as possible.

Around the country there are a number of shared commissioning budgets between health and social care. In some areas our staff have reported

seeing more evidence of joint commissioning approaches. For example, joint health and social care commissioning is part of the Greater Manchester Health and Social Care Partnership plan; in Manchester (one of the 10 Greater Manchester localities), there is joint commissioning governance across all health and social care.

However, such integrated approaches to commissioning are not yet widespread. Also, in engaging with emerging integrated care systems, we have observed that there is less focus on social care than might be expected to deliver good system outcomes.

2. Integration and innovation are at the heart of better care

In 2018, we published our findings from in-depth reviews about the way care organisations work together to meet the needs of older people in different local areas. These showed that people experience the best care when people and organisations work together to overcome the fragmentation of health and social care and coordinate personalised care around people's individual needs.

Our report, *Beyond barriers*, shared examples of health and care organisations working well together – and of individuals working across organisations to provide high-quality care.¹⁹ But the reviews also found too much ineffective coordination of health and care services. This was reinforced by funding challenges, commissioning arrangements, performance management and regulation that encouraged organisations to focus on their own performance rather than working together to secure positive outcomes for people.

We highlighted the urgent necessity for change and called for the barriers that prevent collaboration and joined-up working to be broken down.

Although progressing unevenly in different parts of the country, we have begun to see evidence of more integration and/or joint working emerging around the country. Some local areas that we have revisited have shown improvements. Stoke-on-

Trent, for example, was one of the least effective areas we examined in 2017, but on our return at the end of 2018 the culture had shifted and leaders in the health and care community, including elected members, shared the same vision and were supportive of each other.²⁰

We have been seeing a growing number of primary care services working more collaboratively, in particular GP practices working more as part of a larger GP network or federation, as well as with community health and other services. Our early reflections from our work in this area are that there is great variation in how services are provided – in terms of organisational structure, maturity and objectives for working in this way.

In its NHS Long Term Plan, launched in January 2019, NHS England set out how the NHS will increasingly be more joined-up and coordinated in its care. The aim is to break down the traditional barriers between care institutions, teams and funding streams to support the increasing number of people with long-term health conditions, rather than viewing each encounter with the health service as a single, unconnected 'episode' of care.²¹

The Long Term Plan included an objective that, by April 2021, integrated care systems (ICSs) will cover the whole country. In an integrated care system, partnerships of NHS organisations, local authorities

and others take collective responsibility for, and make shared decisions about, managing resources, designing services and improving the health of the population they serve. By June 2019, 14 ICSs were established, which means more than a third of the country's population is now covered by one.

Factors for better integrated care

We are looking at how regulation of providers could tell us more about how well systems are working in partnership to provide integrated care and how we can support them. To do this, we have been working with Frimley Health and Care, Greater Manchester Health and Care Partnership, and Surrey Heartlands Health and Care Partnership, and developing relationships with other systems to develop our regulatory approaches for the future.

What we have learned so far is that, while systems are developing at different rates, there are some conditions that make success more likely.

The most advanced integrated care systems have a history of organisations working together. This has built relationships and trust, and helped leaders understand each other's challenges.

Good leadership, and collaborative leadership, has been instrumental in building and maintaining relationships. Where leaders work well together, others will follow.

We have seen that it is important for systems to have a shared vision of what they are aiming to achieve for local people. Insight on local needs and the performance of local services, particularly at the boundaries between services, should underpin the vision. Delivering the vision often requires cultural change, to give staff the confidence to work together in teams focused on people's needs irrespective of their parent organisation. There is also a need to engage staff, local people and other local organisations in the system's plans and progress.

Integrating teams seems to work best at a local level. While systems cover large geographic areas, smaller localities are more meaningful to people. But they need to make sure that local work aligns with the objectives of the wider system.

To be successful, integrated care systems must contend with certain challenges. One is that progress relies on 'coalitions of the willing' as there is no legislative framework to support them. 'Rules' that are in place relate to the accountability of individual

New shared vision in Stoke-on-Trent

A new transparency between leaders meant they could address issues together, which helped them to make progress and improve people's experience of care.

Before

- Organisations and individuals were designing and delivering their own services and not working to an agreed, shared vision.
- There was a lack of whole system strategic planning and commissioning, with little collaboration.

We shared these findings and discussed them in detail with the partners in the local community, highlighting where they needed to make improvements.

After

- There was good joint strategic work to develop plans for winter, and the patient flow through the Royal Stoke Hospital had improved considerably.
- The quality of independent social care, and the way that those who commission services work with providers of care, had improved.
- There were no care homes, nursing homes or domiciliary care services rated as inadequate and the percentage of nursing homes rated as good had increased from 32% in July 2017 to 76% in July 2019.

Case study: Farnham integrated care service

This federation of five NHS GP services in Surrey provides a proactive case management service that is reducing hospital admissions and attendance.

The service brings together community nurses, mental health practitioners, voluntary sector organisations, GPs and social workers. It aims to identify patients known to the team who have been in hospital with the aim of getting them out of hospital as quickly as possible. And it identifies patients who are at risk of hospitalisation, intervening to prevent them becoming ill or needing hospital admission.

Using a proactive case-finding model, a home visiting manager became aware of a husband and wife with significant NHS 111 and ambulance activity connected to the couple. The manager used his mixed clinical/management position to bring the couple to the attention of the integrated care team.

The husband has Parkinson's Disease and had been admitted to hospital three times following falls. The home visiting manager met the couple

– it transpired that the wife was the main carer for her husband, and she had Alzheimer's Disease.

A case meeting concluded that while different services had been involved in each of the couple's care, many of the care services' actions occurred in isolation – the two people had not been considered as a couple.

The team also found that the wife's dementia was more advanced than had been realised, so the team brought in a dementia specialist to help her. Social services assessed the couple's care needs and put support in place. A timed medication dispenser ensured the husband would take his medication, avoiding the issues that had led to his falls and preventing other health problems.

As a result of the team intervention, the health and quality of life of all family members improved and ongoing pressures on services reduced.

More recently, both the couple have moved into the same nursing home so they are still able to be together.

organisations and can be a disincentive for them to work together. Different funding flows between provider sectors are also a challenge, particularly in moving investment into preventative services.

Health and care communities, and the organisations in them, must also manage day-to-day pressures and deliver services as they transform those services; they need 'headroom' to try new things.

Working with the local community

Organisations that represent people who use services have shared with us examples of good partnership working, community support and links to local services – where there was commitment to working together to improve outcomes for people using services, their families and carers. They highlighted how good providers view the health and social care system as a joint responsibility and work with others to find innovative solutions, even when resources are

limited, as seen in the following examples:

- The Surrey Carers Prescription Service has a longstanding online support resource to enable GPs to connect carers with a range of services in their area, including social care and community services.
- The British Red Cross, with Co-op, has established its 'community connector' services in different parts of the country to help people who are lonely or at risk of loneliness – volunteers and staff give person-centred support for up to 12 weeks to help people reconnect with communities, offering practical and emotional support to people returning home from hospital.
- The Dementia Connect service has been piloted in some places, offering free-of-charge support from specially trained advisers, helping people to

Working together to transform care

People are benefiting from different approaches to health and care delivery in some places – and through organisations’ willingness to work together.

Localities are different, but some of the challenges faced by local care communities will be similar. Collaborations are often a crucial part of the successes that make a difference for people who use services.

One such project is in Hildenborough, Kent called Holly Lodge. It was instigated by the provider MCCCH (later merged with the provider Choice Support) and further developed by Avenues South East, the provider that now runs Holly Lodge.

This supported living service has made a great difference in people’s lives – it became a reality when there was recognition by multiple organisations of a shortage of suitable accommodation for people to move into when leaving hospitals and secure units.

Local health and social services worked with providers to release the government money that enabled Holly Lodge to be built. It comprises six specially designed, eco-friendly homes for people with a learning disability and/or autism.

Once people moved into these homes six years ago, challenging behaviour declined. One person used to be restrained three or four times a day, but by 2018 restraint had been eradicated for him and everyone else, and medication reduced. Two of the six people are now planning to move to live more independently. None of the people has been back into hospital.

This is part of NHS England’s ‘Building the right support’ and there are 48 transforming care partnerships.

Choice Support is a charity and voluntary sector care provider working nationally to support people with autism, learning disabilities and mental health needs. A commissioner in West Yorkshire is now working with them for a similar project that is underway in Batley – it is another three-way collaboration, including health and social services and with a £1.8 million NHS England transforming care grant.

Choice Support describes a current health and social care landscape where commissioners “need to think more broadly about where they get services”. They say the challenge is that “most people want to solve problems, they just have to work out what a collaboration looks like and then work collectively”.

navigate the health and care system and remain connected to their communities. Provided by Alzheimer’s Society, people are contacted regularly to make sure they have the support they need when they need it, in the way they need it.

- The Bristol Autism Spectrum Service provides support for people when they are first diagnosed – the service is provided by an NHS mental health trust but also has input from social care. The National Autistic Society praised the initiative for linking up services and “getting people up and running” after a diagnosis.

Integration and partnership working are everyone’s business: delivering change involves focusing on how to improve care and outcomes for the

population, for people who use care services and for individual people, rather than focusing on individual departments or organisations in isolation.

To improve care, health and care communities need to make more room for innovation

Our health and social care system is no stranger to change and in this time of increasing demand on services and constrained resources, some providers are being innovative in the way they approach people’s care needs. There is nothing intrinsically innovative in providers and services working together to improve services for people, but the services that do this, sometimes reimagining how

Home care helps ambulance service

Domiciliary home care provider, Home Instead Senior Care Exeter & East Devon, had been keen to find ways to support local ambulance services in reducing hospitalisations from falls. The provider used the traffic light system and post-falls assessment guidance from the South West Ambulance Service Trust and adapted this to develop a training programme for its staff. This helped to reduce pressure on the ambulance service and cut hospital admissions. Home Instead also purchased a special chair with a lifting device to help people off the floor, and the ambulance service trained staff how to use it. Between December 2018 and April 2019, the chair was used more than 30 times and most people avoided hospital.

Intensive home support in East Lancashire

East Lancashire Hospitals NHS Trust has worked with commissioners to transform community services since 2015, by providing integrated care, coordinated around the needs of individual people in the community. The trust commissioned the Intensive Home Support Service (IHSS), which includes the social care element of the Intermediate Care Allocation Team (ICAT).

ICAT is a multidisciplinary community-based team that delivers fast access to crisis intervention services and care for people who need support

after illness. Care is based on the needs of patients and their carers, who are supported in their own home or care home.

The team takes referrals from a range of health and social care disciplines in both the community and acute hospital sector. It allocates short-term community care using a 'trusted assessment' focusing on patients with the greatest needs. This can be both step-up for people at risk of hospital admission and step-down for those requiring intensive support following discharge from hospital.

Initially, the Intensive Home Support Service involved nurses, physiotherapists and occupational therapists working alongside social care staff. A mental health practitioner then joined the service as patients with long-term conditions often manifest mental health anxieties. Recognising and managing these anxieties prevents attendances at the emergency department.

This multidisciplinary approach offers advantages in diagnosis and treatment as shared skills and competencies enable people to receive comprehensive care that meets their physical, mental and social needs that they can manage at home. The team is now progressing from multidisciplinary to 'trans-disciplinary', which involves professionals within the team moving out of their own discipline and carrying out other tasks and skills.

they deploy their workforce, can provide local solutions and better routes to high-quality care for localities.

Technology has the potential to transform some aspects of health and care services, and care providers and local communities must be alive to the possibilities that this presents for improvement in services for people. At the moment, where we see innovation happening, it is still more likely to be the result of individual leadership or dedicated local effort, and is only slowly beginning to be embedded at a strategic planning level.

We support safe innovation in care services, and innovation should be a constant checkpoint for providers and communities in their strategic approach to sustainable high-quality services. As newer technologies come into play, it is vital that there is room for innovation.

The transforming power of innovation

Coventry and Warwickshire Partnership NHS Trust created their 'Dimensions of Health and Well-being' tool, a web-based application, to improve referrals of children and young people to appropriate mental health services. The Dimensions app was designed in-house by staff working in the neurodevelopmental service. It was developed in response to the frustration that children, their families and staff were facing about referrals. This included families being directed to the wrong services, experiencing long waiting times and having to repeat information to a number of different services.

The tool covers 28 'Dimensions' that influence a child's wellbeing – for example, engagement in hobbies, family life, school attendance and sleep patterns. Each dimension can be rated on a scale of 1-6 reflecting their level of difficulty the child is experiencing. The Dimensions tool generates flyers that provide information on self-help support and local resources specific to the Dimensions rating.

"On the app, what you'd find is that if you rate somebody with a little difficulty, then you will get the advice which includes any local parent support groups or national ones, any relevant apps, any relevant videos, any reading material – which might be websites or books – for that level of difficulty." (Provider representative)

Registered local professionals will also receive information to help them direct their referrals to the most appropriate service. This includes NHS, local authority and third sector organisations. A strength of the tool and its development has been the involvement and partnership with the parents and carers, young people and local professionals.

"One of the things that they're [people using the service] really keen on is to be able to have a say in something that's being developed and then to help shape it so that it's useful for their friends, their next-door neighbour, rather than it being something that's for the NHS that we impose on people." (Provider representative)

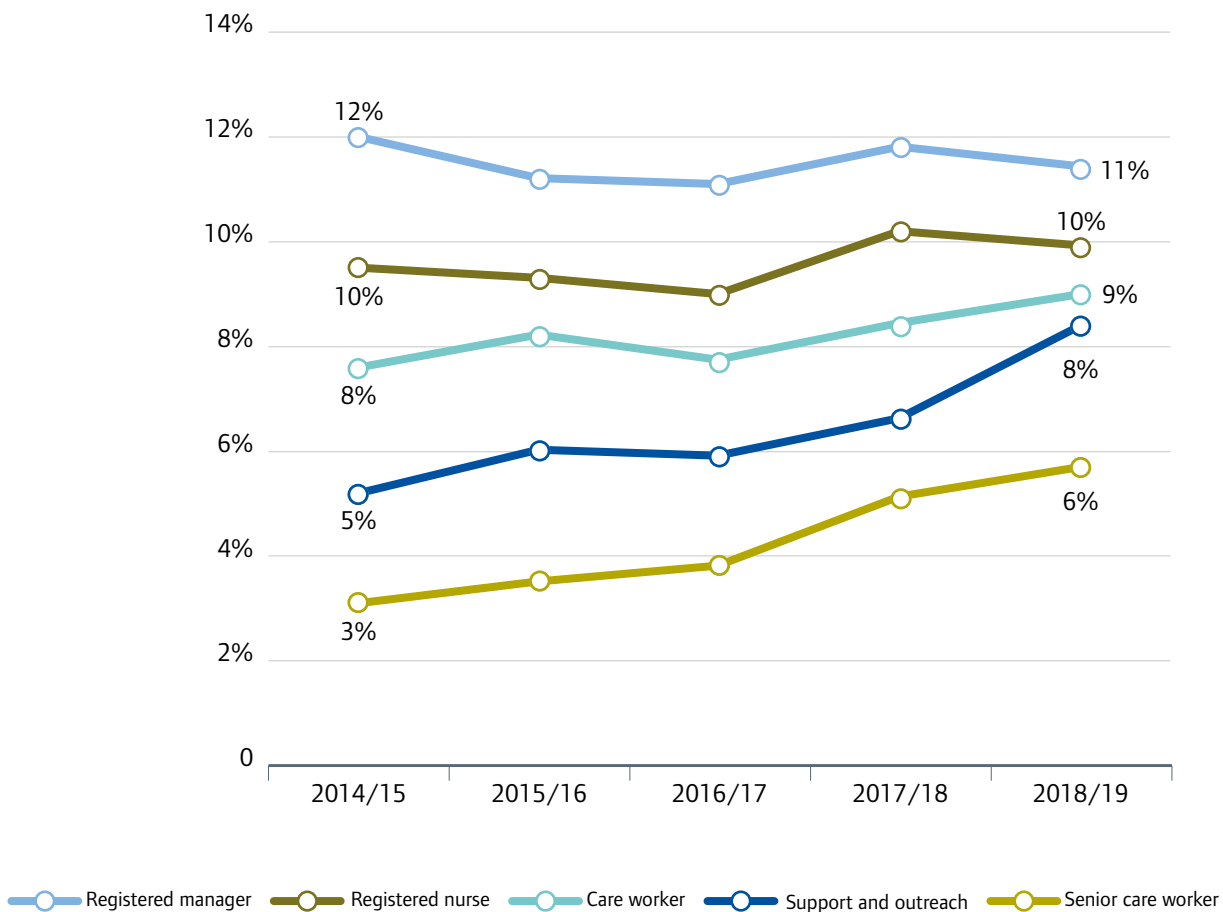
The trust points out that Dimensions has provided an alternative to traditional diagnostic language and aims to use a shared language about wellbeing and mental health. The tool has some analytics built into it to gather data about the users of the tool and the needs of the local population. For example, the tool has shown that there are high numbers of young people accessing mental health services who have reduced school attendance. This data will inform the development of services in the NHS and the wider community to support young people's mental health and wellbeing.

Workforce innovation

Workforce challenges have continued to affect the delivery of health and social care in all sectors, and staff are working in challenging working environments. For example, the 2018 NHS Staff Survey showed that in common with previous years, almost 40% of respondents said they had felt unwell as a result of work-related stress in the previous 12 months.²² Issues facing providers have included concerns relating to staff turnover, difficulty in getting the right skills mix, and competition for staff when recruiting, both across the health and care community and with other industries.

Health and social care have seen demand for services rising, combined with greater complexity of people's needs. Staffing shortages can further increase the strain on the workforce. For example, the rate of vacancies in adult social care services has continued to rise in recent years across most job roles (see figure 1.6).

Figure 1.6 **Adult social care vacancy rate by job role, 2014/15 to 2018/19**



Source: Skills for Care, State of the Adult Social Care sector and workforce in England, 2019

Our staff have described seeing regional variation in the ability of services to recruit and retain staff, with geography and local area factors playing a role in shaping workforce challenges. A study commissioned by Age UK highlighted problems in some of the areas it looked at, including recruiting staff for services outside of major urban centres or a reliance on overseas workers.²³ Different localities and parts of systems face different workforce challenges. Working within national policy, the challenges will need local solutions from local communities.

Our staff have reported that in hospitals and mental health care, areas in and next to London face specific issues linked to higher costs of living and pay disparities caused by the London weighting. In primary care, there are areas of the country that have struggled to attract and retain GP staff, driven by their relative rurality or attractiveness as a place to work and live.

Workforce issues are of course also linked to funding constraints. The withdrawal of nursing bursaries has led to a reduction of people able to train. Independent data published by Universities and Colleges Admission Service (UCAS) shows that there has been a marked fall (of 24%) in the number of applications to study nursing (from 66,730 in 2016 to 50,805 in 2018).²⁴ However, the acceptance rate has risen, which has meant that the total number accepted into training each year has remained fairly stable at over 28,000.

Our staff have also reported the effect of disparities in pay on staff turnover, noting how competition between independent, agency, NHS services, care services and other industries can affect staffing levels. They also said that, in adult social care, staff are affected by the lack of value given to social care by society and disproportionate levels of pay, considering the skill and level of responsibility demanded by their roles.

Our staff have reported providers and system partners adopting new approaches to tackle workforce issues over the last year – for example, by having more emphasis on retaining staff. In hospitals and mental health services, we have seen examples of services trying to limit staff turnover and shortages by investing in the wellbeing and improving the morale of staff. In primary care, we have seen some providers encouraging the retention of staff through more flexible working arrangements.

Where we have seen adult social care providers improve how they retain staff, this has often been as a result of working with other social care and healthcare

providers to create career progression opportunities – for example, local authorities, providers and other partners coming together to pool resources, reduce costs and create smoother career pathways.

Similarly, our staff have reported seeing hospital providers working together to address staffing issues. Examples include services developing joint workforce plans, matching pay across services and introducing rotation posts. In mental health services, there have been examples of providers working with local universities to encourage young professionals into the sector.

Re-imagining the workforce

Social care in emergency departments

Isle of Wight Council placed an experienced social care practitioner (SCP) into the emergency department in St Mary's Hospital. This has prevented unnecessary hospital admissions and helped people to return home quicker with the care and support they need. The SCP is now a full member of the multidisciplinary team based in the emergency department – a team including physiotherapists, occupational therapists, nurses and doctors. People with multiple chronic conditions are appropriately assessed, a care package is procured, and the person is assisted to return to their home. From January to April 2019, the SCP worked with 120 people. Of those people, 81 (67.5%) avoided being admitted to hospital, returning either to their home or a residential placement.

Future-proofing nursing

In the London Borough of Bexley, the introduction of nursing associates is relieving pressure on registered nurses. The Bexley Community Education Provider Network has embraced the role of nursing associate supported by the registered nurse to deliver core services such as cytology and childhood immunisation, as well as the prevention strategy. Registered nurses are

able to focus on more complex care and extend areas of specialism, such as frailty. The nursing associate apprenticeship helps to support people who cannot access a nursing career through an academic route and offers an opportunity for people to enter nursing through work-based learning.

Alternative staffing pool in primary care

GP practices in Mid and South Essex felt they were under-resourced, under pressure and struggling with local demand. Primary care clinicians came together and created an alternative staffing pool within a 'typical primary care setting'. The aim of the approach was to estimate the likely case mix of attendances and get an estimation of alternative staff needed to deliver against that need. This showed that 37% of appointments needed a GP and 63% could be delivered by other appropriately skilled members of the primary care workforce. The model is being used in Mid Essex Clinical Commissioning Group and the Mid and South Essex sustainability and transformation partnership and has received a good response, with staff seeing an improvement in the care they are able to give to their patients.

Responses to increased demand have also included developing new roles and an emphasis on upskilling existing staff. In primary care, there are increasing numbers of advanced nurse practitioners, nursing associates, physician associates, pharmacists, district nurses, mental health practitioners and social prescribing workers, all working in GP practices. In the year to 31 May 2019, there were 307 million appointments, including with other health professionals as well as GPs. Analysis of appointments shows that in May 2019, 44% of appointments were with other practice staff (not the GP), ranging from 25% in Enfield to 62% in South Lincolnshire.²⁵ These initiatives have the potential to ease the traditional workload of GPs.

The introduction of the nursing associate role is intended to bridge the gap between health and social care support workers and registered nurses. The role has the potential to create development opportunities for staff in both adult social care and health care.

In hospitals and mental health services, our staff have reported seeing examples of providers enabling staff to progress within services, rather than having to leave to develop their careers elsewhere. This has included services providing opportunities for nurses and healthcare assistants to attend training and/or take on additional duties. For example, we have seen services sponsor their healthcare assistants to train as registered nurses.

We have seen some providers taking a new flexible approach to workforce challenges. In June 2019, we published a series of case studies showing how providers have redesigned services to make the best use of the range of skills and disciplines available to them.²⁶ They all show action to manage workforce challenges based on ensuring the overall safety of care, rather than rigid staffing ratios. They also highlight how taking an alternative approach to staffing can have a positive effect on people using services.

Among the examples, we see how healthcare professionals from different sectors have come together to maximise capacity and provide more integrated care, and services that have adapted their existing staffing model to help prevent unnecessary hospital admission and better support timely discharge.

Technological innovation

Technology has the potential to improve people's health outcomes and the care that people receive. We have encountered a range of technologies – some of it new and innovative and some now standard and mainstream – being used to deliver care in more effective ways and to help people get a better experience of care.

Technology has a variety of aims:

- Improving people's access to mental health, primary and acute hospital care, including apps, virtual therapies, and online and video consultations. We have seen examples of video software being used to enable people receiving adult social care to have GP appointments without having to physically attend a GP surgery.
- Helping staff to deliver care more effectively, for example community nurses using an app to photograph a patient's ulcer and sending the photograph for diagnosis; this empowers staff and avoids a hospital visit or GP appointment. In adult social care, electronic record systems and tablets have helped staff to access care plans easily and involve people more in their own care planning.
- Improving people's experiences of care. For example in psychiatric inpatient services, monitoring units in patients' rooms have helped them to get a full night's sleep. In dental care, developments such as 3D printing have been seen to improve dental treatment. The use of robotics in surgery and artificial intelligence or machine learning in diagnostic imaging are beginning to make in-roads into hospitals.
- Supporting more effective and more frequent information sharing between services. Our staff have seen examples of how this has helped with safeguarding, enabling flags to be raised if a person was presenting on multiple occasions at different hospitals across an area.
- Supporting people to be more independent. Voice-activated and interactive technologies have helped to bolster people's independence, helping them to access information and entertainment independently.

Research from Healthwatch England has shown that there is broad support for more technological solutions for accessing health and care services. People have come to expect digital interactions in other areas of life and are often happy to carry out a range of admin activities online, including booking appointments, ordering repeat prescriptions and checking results.²⁷

People fed back to Healthwatch that online systems could also be used more effectively to direct people to alternatives such as local pharmacies, walk-in centres, NHS 111 and even other surgeries in the area that may have capacity. People also said that they would be happy to see a greater range of health professionals at their GP practice, particularly where this offers greater continuity of care, but that online booking systems are not yet developed enough to support this.

For all its possibilities, we have found some barriers in the way of adopting new technology. Our staff have highlighted that cost can be one, as can be the knowledge and attitudes of staff towards technology. We have seen staff who have been sceptical of new technologies for example, because of the poor performance of previous systems.

The perceived complexity of adopting new technologies can also be a barrier. Our staff have highlighted concerns about the ability of existing IT infrastructures to support new technologies, and

whether different systems could 'talk' effectively to one another between different organisations.

Our staff have said that issues around data protection and the ethics of information sharing can also pose a challenge to the uptake of technology, particularly for smaller services.

While technology has the potential to bring great benefits, it is important that certain groups are not left out in the roll-out of digital solutions and tech-enabled care, and that some get additional support in accessing and using technology. It is also vital that technology should enhance, rather than replace, human support.

In addition, organisations that represent people who use services told us that tech-enabled care should not be implemented as a 'blanket' solution and were wary of the potential for technological solutions to be driven by a cost-cutting agenda.

Our staff have seen some positive examples of technology being used to improve the experience of people with protected characteristics (for example to improve communication for disabled people) but these have not been commonplace. When it does happen, it tends to be adopted by those services with effective management and leadership, and when it meets a specific need and is used to make care more person-centred.

Wider communities – including people with English as an additional language – need to be better

Supporting people with autism to cope with stress

There is an app that supports people with autism to make decisions and improve their coping strategies. It also provides access to trained professionals through a 'checking-in' process.

"With this kind of app, you input what you do day to day and what your coping strategies are: it's on your phone, so you have them to hand if anything goes wrong and it will talk you through your strategy, if there's any situation where you can't do that yourself. And also, it has a traffic light system for checking in on you. So if you are particularly stressed and you press red, within, I think it's about half an hour, you get a call from

something called the facilitation service, which for some people we provide, so someone from our helpline will ring you, chat with you, talk you through your steps of your strategy for coping with it and make sure you're all right. It means that they don't need a support worker and they can go out and about and do all the things that some autistic people find very difficult because of the anxiety or the unexpected change that may come along with it."

National Autistic Society

supported with tech-enabled care options, including supporting equipment that could increase access and engagement (for example, online translation tools that can help access online booking systems for GP services).

Language and cultural differences are one barrier to accessing tech-enabled care, alongside practical issues such as needing to have access to a computer and network connection to access online services. These practical issues also affect equality groups differently, for example older people are less likely to have access to online services.

Amal supports his mother who was born in Bangladesh to access GP and hospital services to receive treatment for arthritis. He told us that his mother experiences problems using telephone systems to make appointments because of language barriers. He also feels that appointment systems aren't designed for people of her age: "Communication for elderly people, something needs to be done, they can't use modern technology, they have to wait for somebody, their son or daughter, who knows about it to be in the house to be able to communicate."

Carers UK highlighted to us the advantage of digital resources for carers,²⁸ which they could use to fit around their caring responsibilities:

"We've got a digital resource for carers, for example, which includes all sorts of different things such as an app called Jointly, learning tools, information tools to tailor knowledge for carers more precisely – core things carers have told us they find helpful. It's also diversity positive in that traditional services for carers tend to have been organised around groups meeting during the working day, face to face, and in particular places. That's often not possible if you're working. And you can't

do that unless you've got alternative care or means of getting there. So, while face-to-face services are really good for some people, highly valuable and really positive, they are not for everybody. Digital offers another solution and can reach much further into populations to provide support." (Carers UK)

What enables innovation, and what holds it back?

In developing case studies of eight innovative services for this report, we looked across them to understand some of the common factors in enabling and supporting innovation.

- Bravery, vision, and a willingness to take risks: leaders needed to be willing and able to take risks (often financial, but also reputational) to pilot or implement new ways of working. Sometimes this manifested itself as a leadership-led vision in making innovative changes, while other innovations were led by staff; in either case, leaders were seen to have the imagination to take these ideas forward.
- Empowering staff and building teams: leaders listened to ideas from their staff, allowed them to test things and helped them to work together and feel part of a team. Closely related to this was an ability to build the right team – whether by taking steps to bring existing staff on board with their vision, or by recruiting new staff who share these values (or a combination of the two).
- Building strong relationships: leaders were able to build strong relationships with other organisations. In some of the case studies this was a collaborative or partnership approach between leaders from different providers, and in others innovation appears to have been more clearly led by one provider. Transparency, openness, thinking beyond traditional boundaries, and respect for colleagues from other sectors or organisations were involved.
- Using data and evaluating new practices: having a plan for evaluating innovative work was important. Services used data and took

opportunities to make sure that they measured impact and success, identified learning, and made changes in response.

- Focusing on people's experiences: a person-centred approach to making changes was very prominent in our case studies. Putting the needs of people using the service at the heart of innovative design was a keystone in creating a positive impact.
- Opportunities for changing funding arrangements: almost all the innovations in the case studies needed some change in funding arrangements to succeed. What this looked like in practice was varied but often meant that additional funding was procured.
- A change in leadership: this was sometimes part of the trigger for innovative change, whether at executive level in a trust or at registered manager level in an adult social care setting.

We also looked at the challenges that these organisations faced in putting innovative work into practice and continuing that work, and what difficulties they thought others might face in trying to do something similar.

- Policy changes and financial arrangements: a prominent theme was that of short-term or one-off funding for innovative work, for example stemming from a wider initiative such as a Vanguard or a Sustainability and Transformation Plan, or from bidding for a tender. This type of funding source can be precarious – making it more difficult to recruit permanent staff or allow protected time for innovative work – and is vulnerable to policy change from central or local government and commissioners. In the private sector (including GP services), the need to remain profitable could mean that policy changes such as a reduction in NHS tariff for a procedure or changes at a local authority make some innovative practices unsustainable.
- Changes to leadership: where leaders have been instrumental in bringing about innovative change, a risk arises when that manager or executive team changes. Succession planning and cultural change were seen as important ways to mitigate

this risk, but the loss of a charismatic and visionary person would likely be a challenge to the sustainability of the innovation.

- Risk-averse cultures: we saw a strong theme that taking risks – inherent in most innovative projects – can be more difficult for some organisations (particularly NHS trusts). Having clear evaluation plans can help mitigate these risks. Financial risks can be hard for public sector organisations to justify, and reputational risks can also arise if a project fails or is imperfectly implemented.

The strategic challenge for innovation

We are encouraging innovation and an open debate between people who use services, providers of care, and technology industries and entrepreneurs. We want to understand what it means to ensure high-quality and safety in care while on a journey of radical change: how do we balance the benefits of technologies while mitigating the risks, and what does it mean for regulation?

This is fast-moving change and we know the way we regulate has to evolve alongside technological progress, so we can do everything we can to keep people safe and encourage better care through innovation at a strategic level.

The wider challenge for providers and health and social care communities is to now consider technology in the broader strategic sense, as an enabler of high-quality care. There is no doubt that good things are happening in many places that are benefitting people, but projects are often piecemeal. We do not yet find enough examples of joined-up thinking between commissioners and providers that has new technology central to improving the quality of care for people.



Part 2: Adult social care

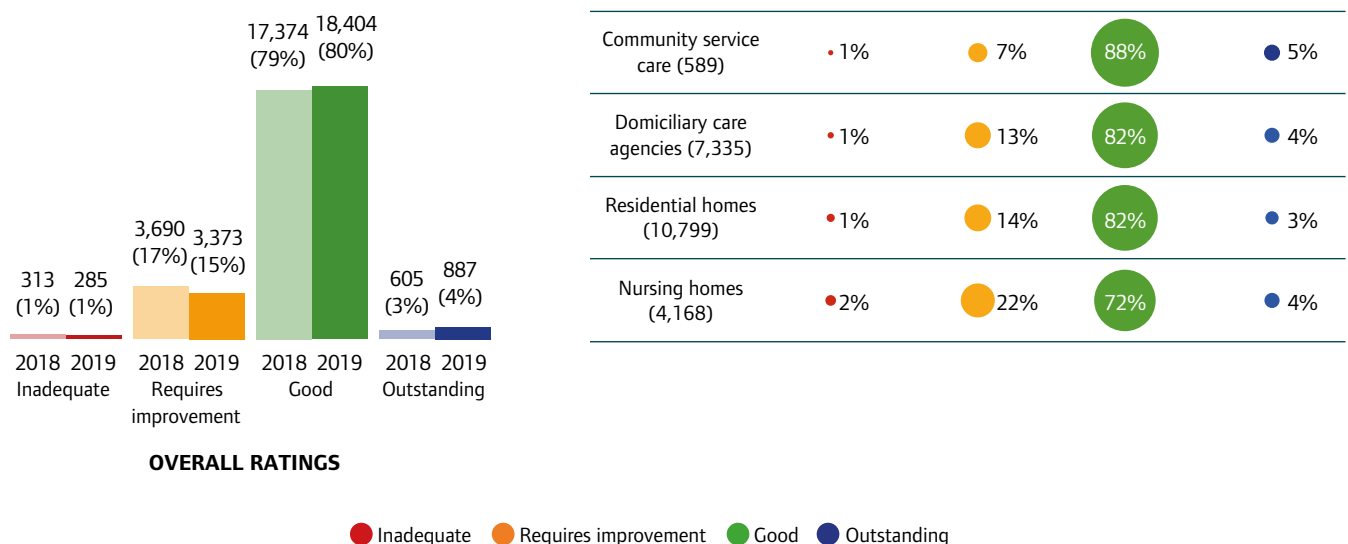


Current picture of quality and provision in adult social care

Four out of five adult social care services are rated as good, which is very similar to 2018 (figure 2.1). We are pleased to see that, compared with last year, a further 282 services are providing care for people that is rated as outstanding. The quality of care in community social care services is particularly high, especially Shared Lives and specialist colleges. However, 22% of nursing homes are rated as requires improvement.

Throughout England, we are pleased to see that the percentage of services rated as good or outstanding has improved in every region since last year. There is less variation in quality – in 2018, the difference between the region with the highest proportion of services rated as good or outstanding and the region with the lowest was 8.3 percentage points, and is now 6.6 percentage points (figure 2.2).

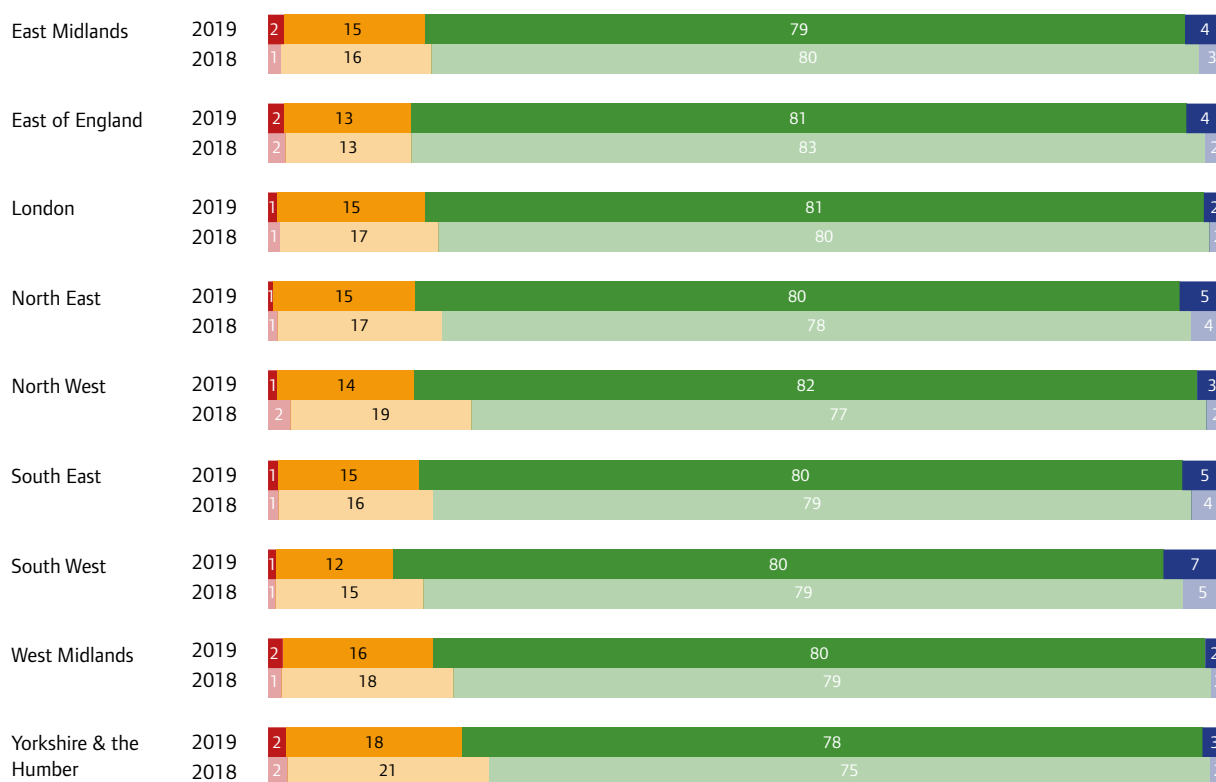
Figure 2.1 Adult social care, overall ratings, 2018 and 2019 and by type of service, 2019



Source: CQC ratings data, 31 July 2018 and 2019

Source: CQC ratings data, 31 July 2019

Figure 2.2 **Adult social care, overall ratings by region, 2018 and 2019**



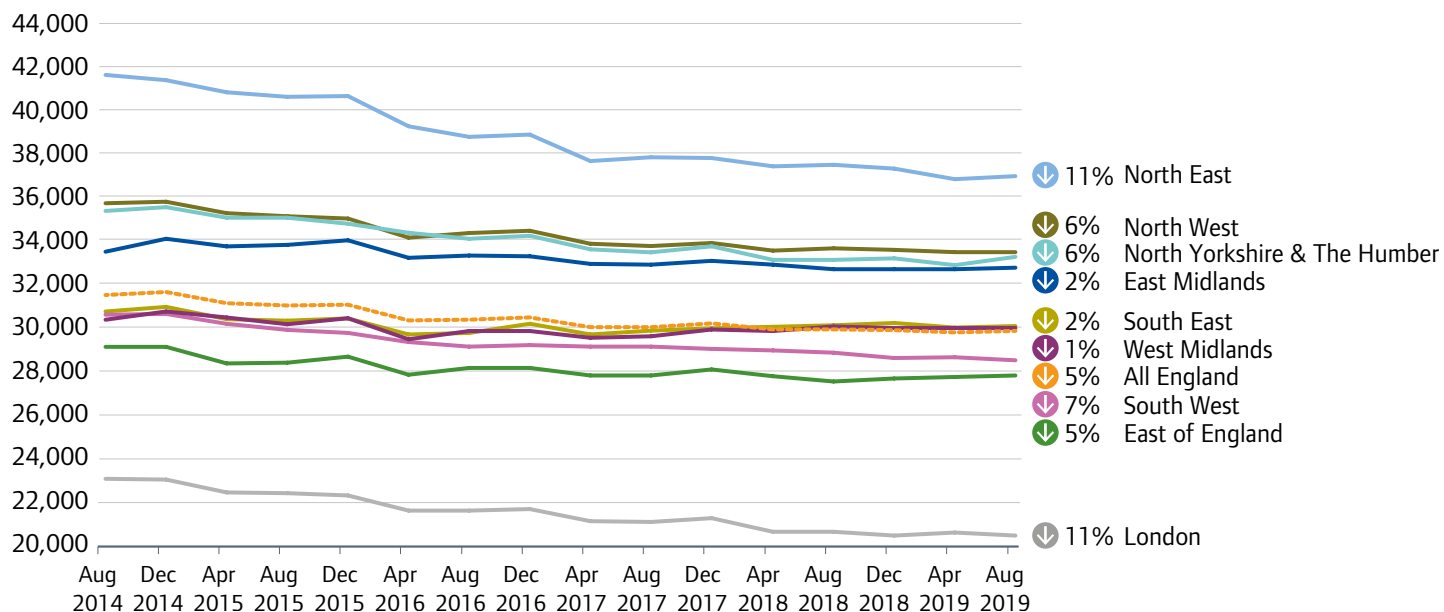
● Inadequate ● Requires improvement ● Good ● Outstanding

Source: CQC ratings data, 31 July 2018 and 2019

Looking at capacity, the number of residential and nursing home beds has been falling steadily in all regions over the last five years, which reflects a national and local ambition to support people to remain at home for as long as possible (figure 2.3). London has a much lower number of beds per 100,000 people aged 85 and over compared with the North East, but both have seen their bed numbers decrease by 11% over the period – the highest decrease of all regions.

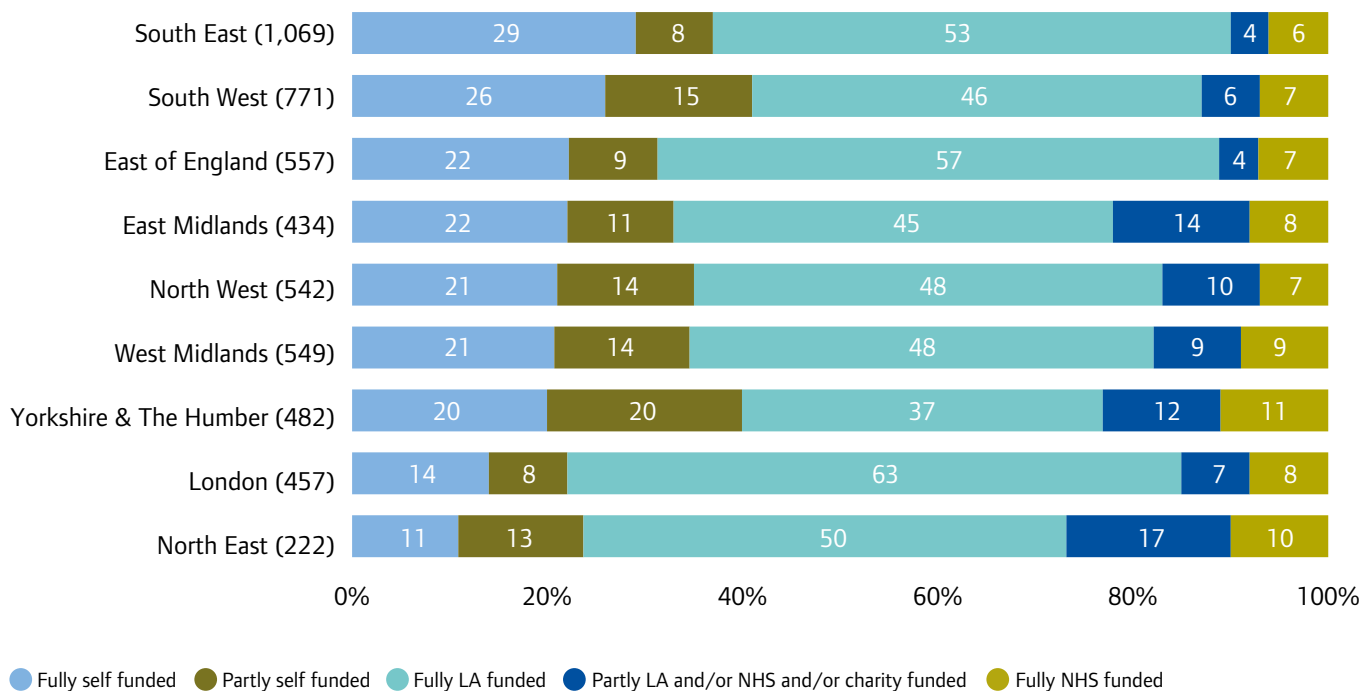
London and the North East also have the lowest proportion of people who fully fund their own care in care homes, with London having the highest proportion that is fully funded by the local authority (figure 2.4).

Figure 2.3 Care home beds per 100,000 people aged 85 and over per region, 2014 to 2019



Percentage labels show the change from August 2014 to August 2019.
 Source: CQC HSCA locations data, ONS mid-year population estimates, August 2014 to August 2019

Figure 2.4 Types of funding in care homes by region, 2019



Source: CQC provider information return data, July 2019

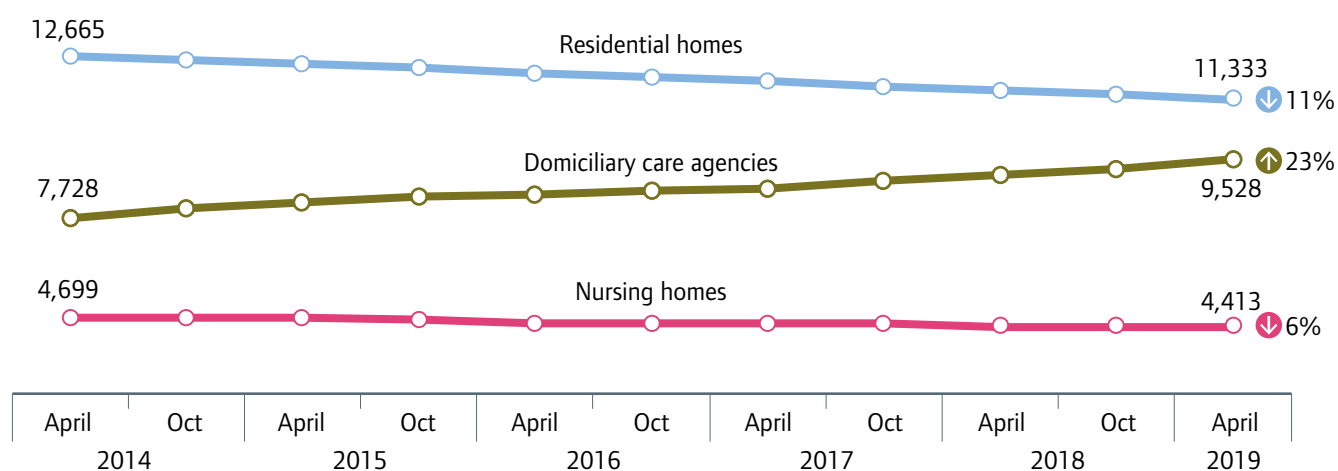
As the amount of care home provision has reduced across the country, the number of domiciliary care agencies has continued to increase – by 23% in the last five years (figure 2.5). However, we highlight below issues with the sustainability of the domiciliary care market, which can have an impact on people’s access to care.

The increase in domiciliary care agencies is largest in London (37%), where they now outnumber care homes (figure 2.6). In July 2019, there were just

under 36,000 care home beds in London, compared with over 52,000 people being cared for by domiciliary care agencies.

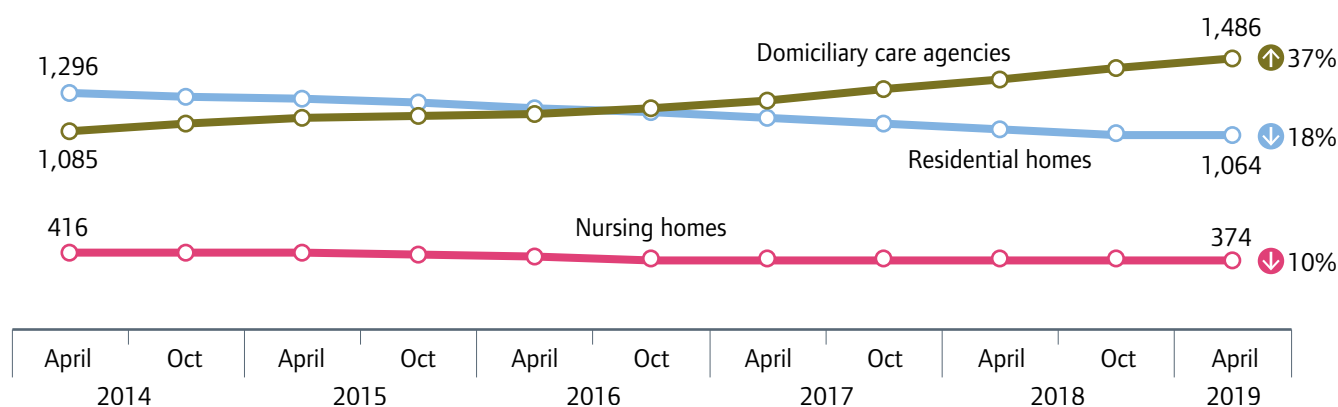
Workforce issues remain a pressure for the sector. Staff turnover in all roles has risen over the last six years (figure 2.7). Care workers have the highest rate, at 40%. By comparison, the national turnover rate for nurses in NHS acute trusts at September 2018 was 11.9%.²⁹

Figure 2.5 Change in numbers of residential and nursing homes and domiciliary care services in England, 2014 to 2019



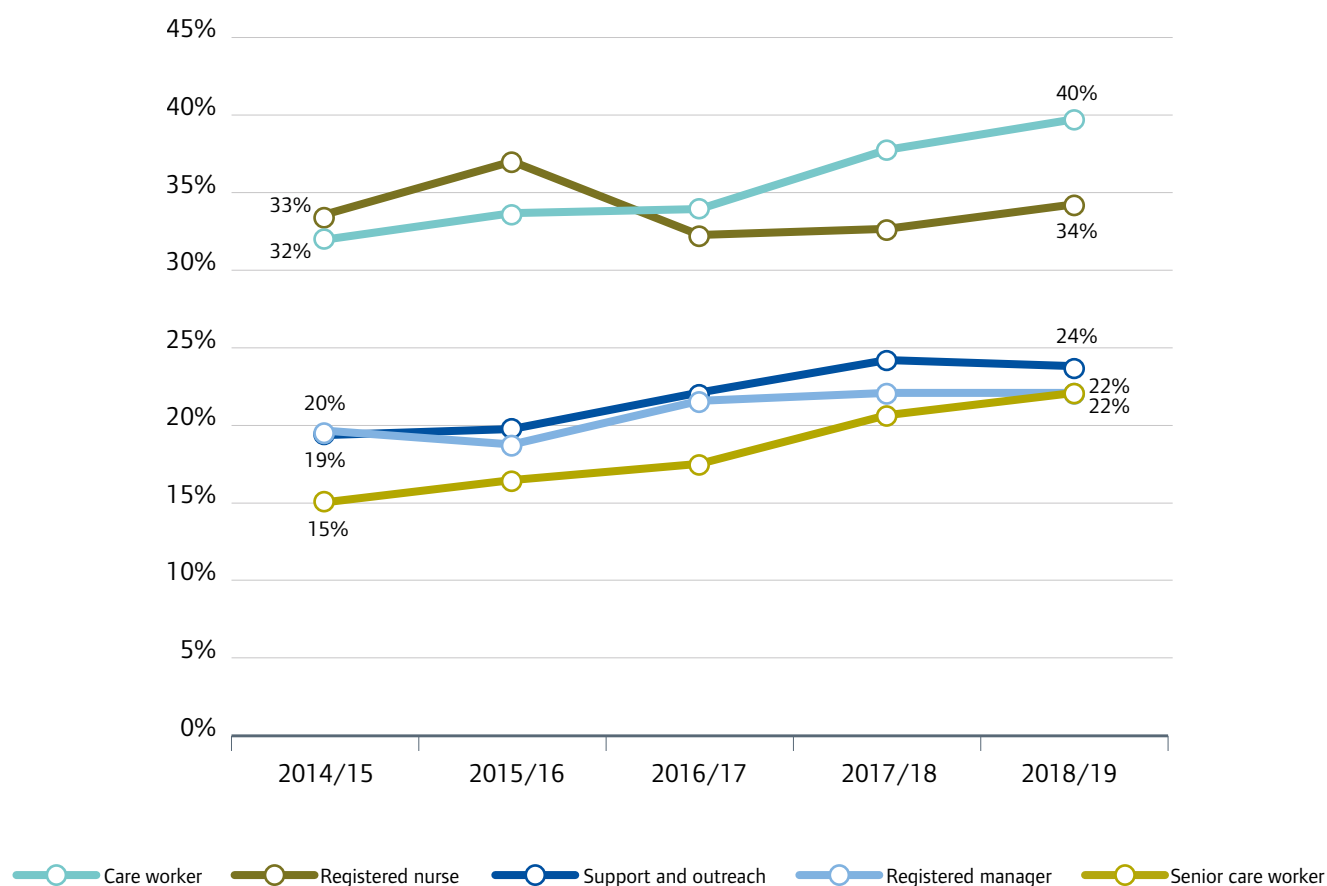
Source: CQC registration data, April 2019

Figure 2.6 Change in numbers of residential and nursing homes and domiciliary care services in London, 2014 to 2019



Source: CQC registration data, April 2014 to April 2019

Figure 2.7 **Adult social care staff turnover by job role, 2014/15 to 2018/19**



Source: Skills for Care, State of the Adult Social Care sector and workforce in England, 2019

Key issues in adult social care

Paula's experience of adult social care

Paula has had secondary progressive multiple sclerosis for many years and uses a wheelchair. She receives support in her home through a domiciliary care agency.

Although she recognises the quality of the staff, she told us of her frustration with the agency.

"My carers are very good, but the agency is not necessarily good. They have a tendency to make up stories and just leave you. For example, one of my carers said, 'See you tomorrow', but then I got a call saying, 'She won't be able to come tomorrow.' I said, 'I have to have someone'. I phoned the carer who checked her

phone and she noticed that they had removed me from her list and added four or five people at 10 o'clock at night. I was worried that I would have to stay all evening, night and day the next day in bed with no-one getting me up."

Despite such challenges, Paula feels fortunate that she can speak up for herself.

"I've just been very lucky I can verbalise things. I won't accept that they will put anybody in. It fits in with what I need to do. My carers know exactly what to do."

We have changed names to protect privacy.

Funding pressures

In last year's State of Care report, we highlighted issues with funding in adult social care, saying that "a sustainable financial plan for adult social care will be an important element of the forthcoming social care green paper". The green paper has still not been published and pressures caused by funding and workforce issues are affecting people's ability to access services.

This is a message that has been clearly echoed to us by organisations that represent people who use services: they have said that the challenges faced by people, their families and their carers in getting the care and support they need are strongly related to pressures on local authority budgets and a lack of social care funding.

Understanding the number of people with social care needs that are not being met, and how these numbers are changing over time, is a difficult and imprecise exercise. Age UK estimates that 1.4 million older people – nearly one in seven – do not

have access to all the care and support they need from either formal or informal sources, and are therefore living with an unmet need. Of those 1.4 million, Age UK estimates that 300,000 people need help with three or more essential daily tasks.³⁰

Caring for older and disabled relatives is described by Carers UK as "an increasing issue for our time". The charity has published the results of a survey that suggests that around one in six adults in the UK may be providing unpaid care.³¹

An Institute for Fiscal Studies report found that overall spending by local authorities on adult social care fell by 5% from 2009/10 to 2017/18.³² The government's response to funding pressures was to give local authorities access to around £10 billion dedicated to adult social care over the period 2017/18 to 2019/20, with further funding announced in the 2019 Spending Round. The 2017-20 funding was welcomed, but the Local Government Association described it as a short-

term measure for tackling issues, such as easing winter pressures on the NHS.³³ Analysis by the Health Foundation forecasts that, without additional funding, the money available for adult social care will rise at an annual average rate of 1.4% a year from 2017/18 to 2023/24.³⁴ They point out that this is lower than the 3.4% a year the government has committed to the NHS and the rising demand of 3.6% a year.

The Association of Directors of Adult Social Services (ADASS) budget survey shows that, in 2019/20, only 35% of directors are fully confident that their budgets will be sufficient to meet specific statutory duties, such as assessing the needs of carers and people using services. For later years, very few directors (under 5%) are fully confident of their ability to meet these duties.³⁵

In 2018, we were twice required to exercise our legal duty to notify local authorities that there was a credible risk of service disruption because of provider business failure. The second of these referred to one of the largest domiciliary care providers in England. These were the first notifications of this type we have issued in four years of running our Market Oversight scheme, pointing to increasing fragility in the market.

Our staff have highlighted issues with the sustainability of the domiciliary care market, referencing increasing numbers of agencies handing

back contracts to local authorities. The United Kingdom Homecare Association reported that only one in seven councils in the UK was paying their local domiciliary care providers the rate it estimates is necessary to comply with National Minimum Wage regulations and the costs of running the service in a sustainable way.³⁶ Our staff have noted seeing more care services of all types choosing not to support people funded by local authorities, because their contracts do not cover the true cost of delivering people's care.

Our staff have also seen examples of providers asking families to pay top-ups or ending placements when private funding runs out. They have suggested that, when trying to access care, those with personal finances have greater choice and can access better quality of care than those who rely on state funding, with one staff member stating, "I do think if you're not privately funded, we are operating a two-tier system of accessibility."

Issues with funding are partly fuelled by the rising proportion of people of working age approaching local authorities for support, with a rise of 4% – over 23,000 people – from 2015/16 to 2017/18. The support costs for this group of people are considerably higher than for people aged 65 and over. The percentage of people of working age reporting a disability has also increased – from 15% in 2010/11 to 18% in 2017/18.³⁷

Workforce challenges

Overall ratings for all services have slightly improved since last year. Feedback from our staff has remarked that so many providers have continued to operate and at least maintain the quality of care.

Our staff have said that when providers valued and cared for their staff team, it can create the conditions for both high-quality care and an engaged and loyal workforce. Examples included successful values-based recruitment campaigns that involved relatives and residents in the interview process for new staff. One inspector summed it up: "A good home that is well-led has a really lovely culture about it. You can see the passion and the enthusiasm coming from staff. When you go to other homes that have a staff problem, they feel

a bit suppressed, it's just a job. They're just task-orientated."

Other providers are not managing to cope so well with workforce pressures. Some people who use services and care professionals who shared their experiences with CQC through our online form have said they were worried about care homes being inadequately staffed to safely support and care for the people living in them. Care workers have told us they were working chaotic and unorganised shift patterns, at times without breaks, causing many to feel dissatisfied, stressed and undervalued in their caring role. A similar picture has been given in domiciliary care services, with feedback about managers taking on new care packages at times

when care workers' existing rotas were already too challenging for them to manage safely.

We have heard of situations being made worse when care workers have decided to leave and were not replaced, or were replaced by inexperienced or unskilled staff. We have seen in comments shared with CQC through our online platform that some of those staff that stayed felt dissatisfied and wanted to leave, but didn't, because they were concerned for people's safety and didn't want their care to be jeopardised as a result.

A similar message has come across from our staff. They have highlighted a range of challenges facing the sector, including a lack of qualified nursing staff, not enough high-quality registered managers, and high vacancy rates and staff turnover leading to a high use of agency staff. The issues that they have said affected staff themselves were low pay, high pressure, clearer career pathways offered by the NHS, and a lack of value given to social care by society. Ensuring that services have good quality staff with the right skills mix is, as one person described, "a long-standing battle and challenge" for adult social care providers, affecting both frontline staff and registered managers.

Data from Skills for Care shows that the vacancy rate for registered nurses working in social care more

than doubled from 2012/13 to 2018/19 (4.1% to 9.9%).³⁸ A study commissioned by Age UK also noted that in some areas of the country, the lack of specialist workers is severely limiting the care that providers are able to offer. As part of a detailed analysis of five local areas, the study found that in Devon there were cases of care homes reducing their bed capacity because of a lack of available staff.³⁹

The pressures caused by funding and staffing are reflected in analysis of the data we receive about care providers in our Market Oversight scheme, which represents around 25% of the adult social care market in England. Providers' profits have decreased by one percentage point from September 2016 to September 2018, driven mainly by increases in staff costs of 9.6%, which in turn are driven by a 28% increase in costs of using agency staff.

The causes of these increases include a rise in the national living wage – according to the ADASS budget survey 2019, 86% of directors of adult social services believe the national living wage will be the biggest driver of increases in unit costs for residential, nursing and domiciliary care.⁴⁰ Other causes include automatic enrolment into workplace pensions, a levy on UK employers to fund new apprenticeships, and staff shortages.

Access to services

Organisations that represent people who use services have told us how getting access to some services is challenging. For example, people assessed as eligible for domiciliary care services in the community were finding that they were unable to get these services because of issues with the local social care market; for example, there were no services available, or people were waiting a long time or being offered a reduced service.

Then, once receiving domiciliary care, we heard that people using services, their families and carers can experience issues with staffing and a lack of continuity of care, as the following shows:

"Issues around personal care seem to come up on a regular basis. Sometimes it's to do with the matching of the worker with the person who needs the personal care; but sometimes you're never quite sure who's going to come through the door – certainly from week to week, but sometimes from day to day. Really, personal care is one of those things where you do need to develop and maintain a relationship for it to work and if there's that kind of variability, you do worry." (Race Equality Foundation)

Partnering to achieve efficiencies

Thistle Hill Hall is an adult holistic nursing care service in Nottinghamshire for adults with complex mental health needs. It is taking an innovative approach to move away from a traditional nursing home care model to a recovery and therapy-led model of care. The approach aims to enable people to stay out of acute care by supporting them to plan a meaningful life and to stay in control of it.

The approach is supported by a new integrated pathway of care, which was created by an NHS care coordinator who liaises between the home, external NHS mental health services and other statutory providers. The integrated pathway was

developed in response to inefficiencies in the local mental health system. Before this, up to 12 different care coordinators would come in to see 23 people at the service. This meant that the people using the service were not always able to establish a relationship with them.

The dedicated coordinator, who was responsible for developing this innovative collaboration between the private and NHS sectors, now holds a clinic every week at the service to help staff with queries about treatment options. They are now part of the service's multidisciplinary team, and advise on an individual's suitability for admission to the service.

Local services working together

Engagement with other organisations is key to ensuring that people receive the best care and support in adult social care, which is why we look at this as part of our inspections. Skills for Care notes this in its *Guide to improvement*, quoting a registered manager of a care home who says, "I meet with other local care home managers for coffee. We've learnt that we're not competing with each other – we're all offering similar services and we have lots to learn from each other. We all support each other well."⁴¹

However, people who use services are telling organisations that represent them that different parts of the health and care system are not working together to deliver care effectively. Through the online feedback we receive, families have also raised issues about the lack of communication and collaboration when people using adult social care become unwell.

Our staff have explained that, although we have seen examples of adult social care professionals working together in local system planning, there is less focus on social care than might be expected to deliver good outcomes.

We have seen adult social care providers working with other system partners to create opportunities for career progression – for example, local authorities, providers and other system partners coming together to pool resources, reduce costs and create smoother career pathways. Examples included smaller care homes joining together to deliver staff training, and local authority quality teams promoting mentorship schemes for registered managers and free training for frontline staff.

A new approach to domiciliary care

Caremark is a domiciliary care provider. They have been running a pilot of a new approach, which was evaluated by West Sussex County Council.

Caremark developed the PatchCare® model in response to widespread issues facing domiciliary care in England, including loneliness and social isolation of older people, and the recruitment and retention of the workforce. It also aimed to tackle the 'time and task' mindset, which can prioritise the delivery of tasks over positive outcomes for people.

The PatchCare® model divides areas into small geographical 'patches', with a maximum of 10 people per patch. Usually, two PatchCare Assistants, communicating through a messaging app called Slack, are allocated to each small patch and provide responsive visits based on the people's changing needs. For example, there may be more fixed visits, such as a morning wake-up call, or more variable ones, such as being able to 'pop back' to see if people needed support, going on shopping trips, or supporting social visits between two or more people in the same 'patch'.

There is evidence of people experiencing positive outcomes by achieving their individual goals, as well as enjoying the benefits of flexible visits.

"We had one customer who had a double hip replacement. When we first went to see her, she was immobile. She used to like cooking for her husband, but she hadn't been able to. Through PatchCare®, because staff were popping in and out, she was supported to regain her

confidence and her mobility, which enabled her to cook him meals again."
(Representative of Caremark)

A further example shows the result of matching people in the patch to allow relationships to develop. This means that PatchCare® is not just about connecting carers to individuals, but also connecting people for friendship and shared interests.

"A man hadn't painted for about 20 years. Caremark matched him with a lady who had chronic anxiety who was phoning primary services many times a day. He started painting pictures for her, and painted her Christmas cards. They developed a strong friendship as a result of PatchCare®. Those are really meaningful connections."
(Inspector)

Improvements for staff included better communication during shifts, stability of working conditions and salary through a regular salaried wage, and the ability to upskill. For the provider, this improved staff retention. By investing in a more preventative model of care, there is some evidence of a reduced burden on other services.

The key factors that enabled PatchCare® to be developed were strong leadership, funding opportunities from the local authority, and effective partnerships. For example, partnership work between the local authority and Caremark included evaluating the wellbeing of people using the service and measuring outcomes.

Innovation and technology

Innovation and technology are making inroads into the way care is delivered. For example, our staff pointed to a trend towards ‘micro-providers’, where umbrella organisations support groups of personal assistants to meet people’s care needs. This is one response to changes in the social care sector. We are working with these new models to consider what, if any, is the role of regulation in ensuring that people are receiving safe, high-quality care.

Generally, the perception of our staff is that the adult social care sector has faced more challenges in its adoption of technology. They attribute this to five key barriers:

- a lack of funding to invest in technology and ability to make economic returns, particularly for smaller providers
- a low level of knowledge and awareness among providers and staff – adoption of technology tends to rely on confident individuals
- fear that technology could replace personal support
- the perception that people who use adult social care are not interested or will respond badly to technology
- concerns about ethical or data protection implications in adopting technology that uses personal information, or GPS and surveillance techniques.

Organisations that represent the public have also stressed to us that technology should not replace human support. While acknowledging that technology can make it easier for people to access health and social care and support, it has to be tailored to an individual’s specific needs.

Our staff have seen technology being used to support staff and improve care delivery. For example, electronic recording systems can make it easier to access people’s care plans, freeing up staff time to focus on the person they are supporting. One inspector also noted that electronic care plans make it easier to involve people in their own care, as staff

can sit with them and talk through their care plan and add selfies or photos from their day.

Our staff have also told us that social media has been playing a growing role in recruitment, with examples of providers using social media campaigns, rather than traditional methods, to attract new staff. We are also seeing that providers are encouraging the use of online communication platforms and social media to help residents connect with loved ones and to participate in family life. As people’s familiarity and expectations of technology increases, we are seeing greater use of digital devices, such as virtual assistants, tablets and apps to improve people’s quality of life.

Online communication platforms were also seen being used to improve access to healthcare services in residential nursing homes in Buckinghamshire. The clinical commissioning group introduced an initiative to provide direct access to GPs and specialists for first line appointments through the internet, supported by on-site nurses. While nursing homes were initially resistant to the introduction of the service, it was successful in reducing hospital admissions and visits to a GP. An inspector reflected, “Most of the nursing homes didn’t want to touch it when it first came, but by the end, they all absolutely loved it.”

These examples, as well as those in our *Driving improvement through technology* resource, show how some providers are using technology and innovation to offer significant benefits to people who use services and also drive efficiency.⁴² By sharing such examples, providers are able to consider whether similar approaches could benefit their services.



Part 2: Hospitals, community health and ambulance services

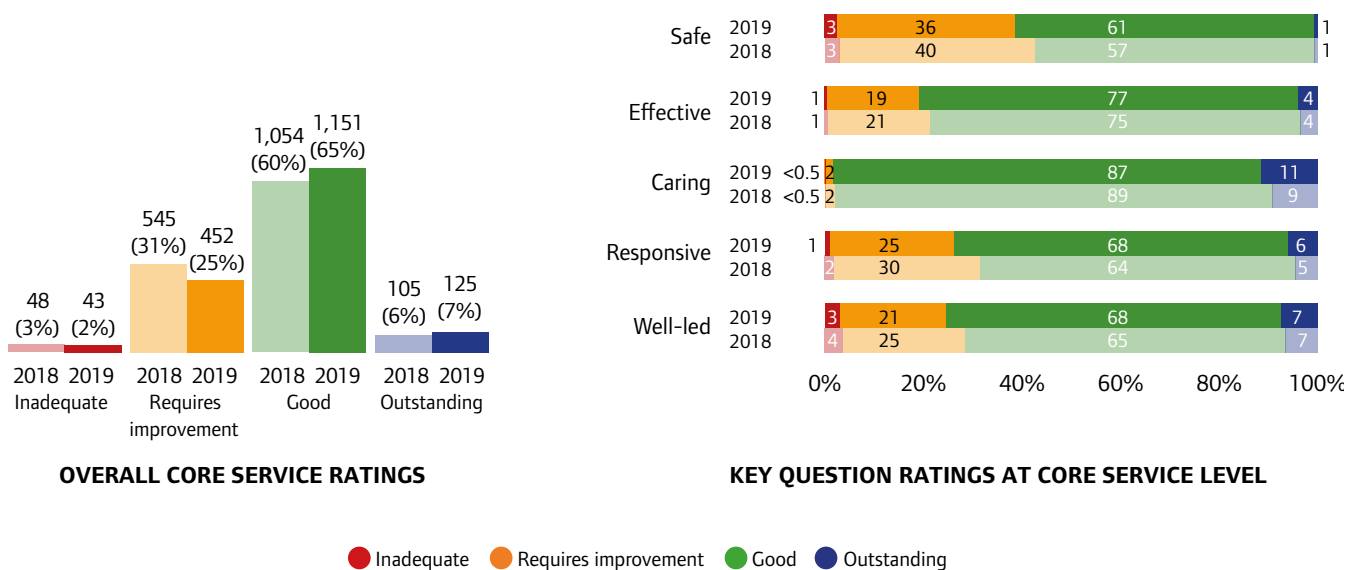


Current picture of quality and provision in hospitals, community health and ambulance services

In last year's State of Care report, we noted the relentless year-on-year rise in attendances at emergency departments and acute hospital admissions. This trend has continued unabated over the last year, with urgent and emergency services bearing the brunt of this demand and struggling to provide high-quality care, with 44% rated as requires improvement and 8% as inadequate

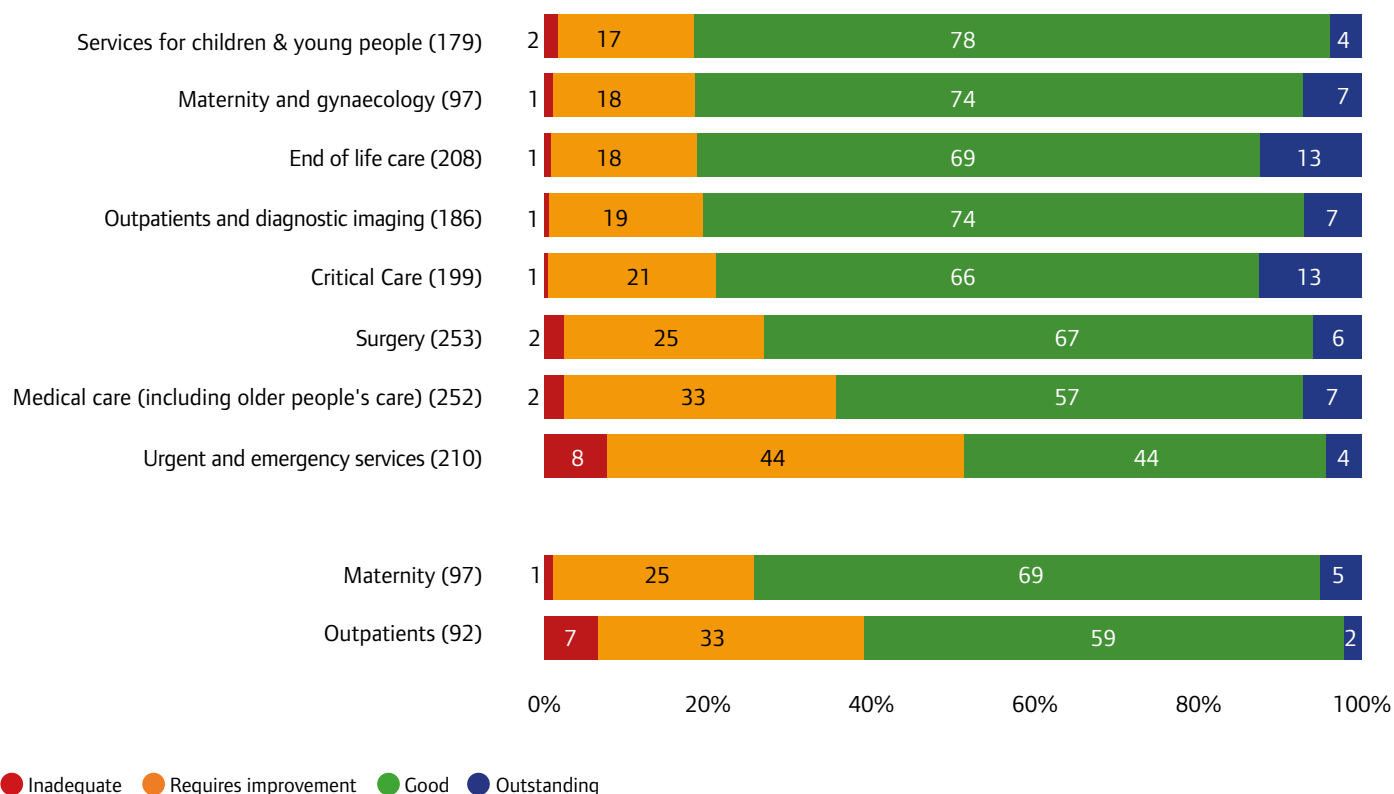
(figure 2.9). Despite this, overall the majority of NHS hospitals have continued to provide good care during 2018/19, with 65% of core services rated as good and 7% rated as outstanding (figure 2.8). However, safety remains the area of most concern as 36% of services are rated as requires improvement and 3% as inadequate.

Figure 2.8 NHS acute hospitals, overall core service and key question ratings, 2018 and 2019



Source: CQC ratings data, 31 July 2018 and 2019

Figure 2.9 NHS acute hospitals, core service ratings, 2019



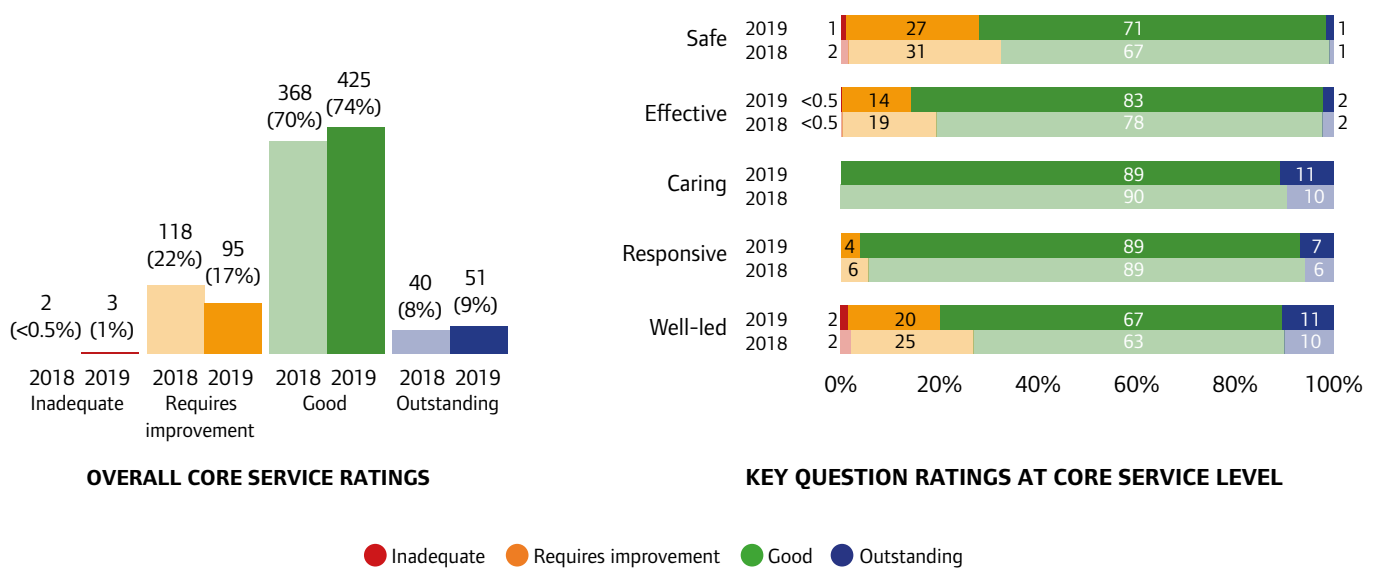
Note: Since June 2017, the core service of maternity does not include gynaecology and the core service of outpatients does not include diagnostic imaging, which are now inspected as additional services. We show ratings for both the previous core services and the new core services separately as they are not comparable.

Source: CQC ratings data, 31 July 2019.

In the independent hospitals sector, services continue to provide a good quality of care with 74% of core services rated as good and 9% rated as outstanding (figure 2.10). Over the last year, we have seen a slight improvement in the quality of leadership of independent organisations, with 79% rated as good or outstanding for the well-led key question, compared with 73% last year. This echoes

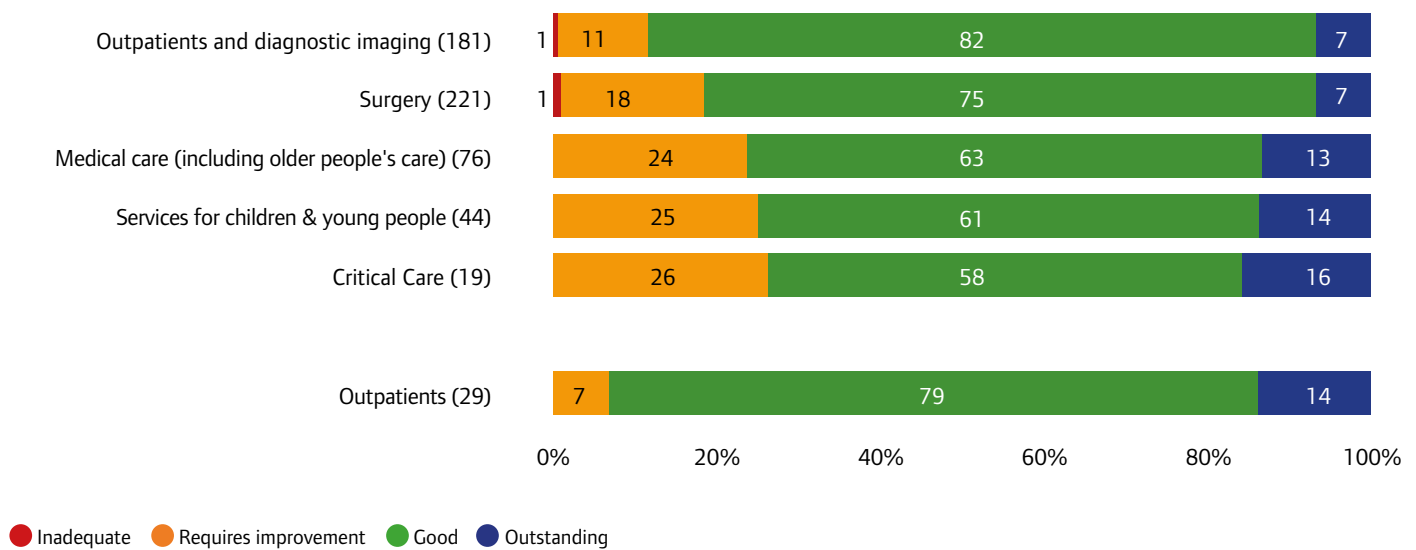
the key themes emerging from our report *Driving improvement: case studies from eight independent hospitals*, which highlighted the important role of leaders in their organisations. Despite this progress, things still need to improve, particularly in the core services of critical care, medical care and services for children and young people (figure 2.11).

Figure 2.10 Independent acute hospitals, overall core service and key question ratings, 2018 and 2019



Source: CQC ratings data, 31 July 2018 and 2019.

Figure 2.11 Independent acute hospitals, core service ratings, 2019



Note: In addition to the above, the core services of urgent and emergency services, and maternity, both have one good rating each and end of life care has two ratings, one good and one outstanding.

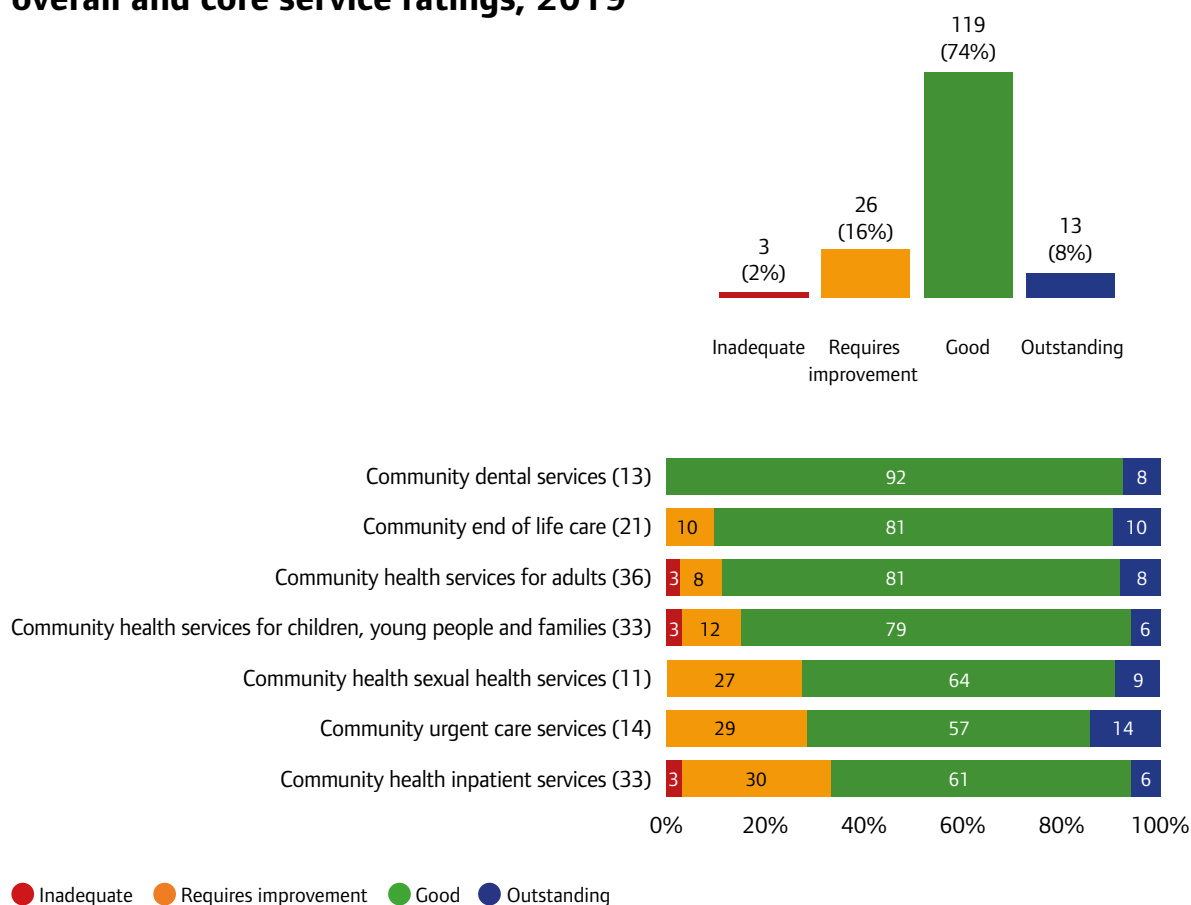
Source: CQC ratings data, 31 July 2019.

We have seen some improvement in the quality of care in NHS ambulance trusts over the last year, with seven out of 10 trusts rated as good, and none rated as inadequate. But as highlighted in our report, *The state of care in independent ambulance services*, increasing demand has led to a rise in the number of independent ambulance services working in partnership with NHS trusts to provide emergency response services. While we generally found independent ambulance services to be caring, our report highlighted serious common concerns around poor medicines management, cleanliness and infection control practices, and a lack of appropriate recruitment checks in these organisations.⁴³ While

we have only been rating independent ambulance services since 2018, early ratings data reflects our concerns, as four out of 14 of those providing emergency and urgent care services are rated as inadequate.

In the community, it is encouraging to see that the majority of services are providing a good quality of care, with 74% of community health core services rated as good and 8% rated as outstanding (figure 2.12). However, improvement is needed in community sexual health services, urgent care services and inpatient services, with around 30% of all these services rated as requires improvement.

Figure 2.12 NHS and independent community health, overall and core service ratings, 2019



Source: Source: CQC ratings data, 31 July 2019

Key issues in hospital and community health services

Introduction

Hospital, community and ambulance services are at the front line of health and social care in England, with each sector playing a crucial role. By working collaboratively with each other – and with other health and social care services – people can receive joined-up care that meets their different needs. Working in this way is vital to providing high-quality care. This mirrors how people who use services regard the system – that is as a whole rather than as packages of acute care, community care, primary care and social care.

The NHS Long Term Plan supports more collaborative working and has committed to creating Integrated Care Systems (ICS) everywhere by April 2021.⁴⁴ The intention of ICSs is to bring NHS organisations into partnership with local councils and other organisations, to take collective responsibility for managing resources, delivering NHS standards, and improving the health of the population they serve.⁴⁵ We have observed that the need to work more collaboratively is being recognised, with some services beginning to provide more joined-up care.

While this progress is welcome, the ever-increasing demand on acute services is evidence that integration is not happening everywhere. We have heard that people are still experiencing disjointed care that is not responsive to their needs, with delays, cancellations, and a lack of communication both

within services and across sectors. This is supported by findings from the 2018 NHS inpatient survey, which showed that patients are reporting poorer experience when it comes to the integration of their care.⁴⁶ Analysis of people's experiences of care shared with us highlighted how disjointed care can lead to them feeling frustrated, stressed and anxious.

Hospitals are continuing to face a rising demand on services, difficulties in recruiting and retaining staff, and ongoing financial challenges. Although NHS trusts are managing to improve within this pressurised environment, the pace of this change is not consistent. We see this particularly in the proportion of poorer ratings for the core services of surgery and medical care. Our staff have seen that the way leaders approach these challenges, and the culture they create, is a key influence on their capacity to improve. The findings of our report *Opening the door to change* highlighted that leaders are integral in driving change within the NHS, and creating an open culture where patient safety truly is a priority and people feel able to be open and honest when things go wrong.⁴⁷

However, working jointly with other organisations to address the needs of the local population and improve the access and the quality of care for people is equally important. We explore these issues through the lens of NHS acute trusts throughout the chapter.

Access to services

Access to the right care at the right time is one of the biggest challenges facing health and social care services, and particularly those seeking treatment in NHS acute hospitals.

Urgent and emergency services continue to bear the brunt of increasing demand. Figures for emergency admissions after attending the emergency department are continuing to rise year-on-year.

This peaked at 31.2% of attendances in December 2018, and in July 2019 it was 28.9% – the highest figure for July in at least the last five years. July 2019 also saw the highest ever monthly number of attendances at major emergency departments (1.4 million).

Over the last year, we have also seen an increase in referral to treatment times, with 4.4 million people at the end of June 2019 waiting to start treatment. This is an increase of 40% since June 2014.

Access to care and support in the community is also a concern. Organisations that represent people who use services told us about their concerns around the availability of community services. These concerns were echoed in comments from our staff, who noted the effect of a lack of community services on acute services, as well as other systemic problems such as the pressure on GP services and a lack of mental health services. We explore access to mental health services further in our chapter on mental health care.

When people's access to services in the community is delayed, or they cannot access services at all, their condition could become worse, increasing the need for acute hospital care. However, it is not just about getting access to services, but getting access to the right services that meet the needs of the individual. We have heard that when people are able to access care, they do not always feel that the services are suitable for them because of an overall lack of awareness and understanding about their needs, as well as limited capacity of staff. Where we have seen services that are easily accessible to patients, we have often found a good understanding of demand in the local area and good planning. As discussed

further in the section on workforce, leadership is key in driving improvements.

Technology also has the potential to make it easier for people to access health and social care support and keep people well in the community, as highlighted by our case studies of driving improvement in technology, published in July 2019. However, to be effective technology needs to be tailored to people's needs and should not replace human support.

We have heard from our staff that a lack of treatment options outside of acute settings can have an impact on the availability of hospital beds. For example, we have seen that when people cannot be kept well in their communities, their conditions can deteriorate, which leads them to need urgent treatment through an emergency department or as an inpatient, therefore putting further pressure on beds in acute settings.

Driving improvement in technology: home monitoring of hypertension in pregnancy

St George's Hospital in London has introduced an app that enables pregnant women to monitor their blood pressure at home and alerts them if they need to attend hospital for further assessment.

The app allows patients to monitor and record their own blood pressure using a validated machine, with instructions from a healthcare professional on the frequency of monitoring and when to attend the hospital. It alerts women if they need to attend the hospital, and it also links with a hospital computer system where the data can be monitored by clinicians. The app

also includes 'trigger' questions to help women monitor their condition.

Use of the app has seen a 53% reduction in number of appointments for hypertension monitoring, and the amount of time needed per appointment. One person who has used the app welcomed having the ability to check her blood pressure at home, saving three to four hospital visits a week. Another benefit was that she avoided aggravating her 'white coat syndrome', where just being in the hospital environment raises blood pressure.

During 2018/19, overnight bed occupancy continued to hover above 90%. While NHS Improvement and NHS England have recommended that occupancy should be kept below 92% to support patient flow through hospitals, the Royal Colleges of Emergency Medicine and Surgery have contested that 85% would be a better bed occupancy benchmark to ensure the safety of

patients.⁴⁸ This is all set within a trend of declining bed availability, with 3,229 fewer beds in January to March 2019 than in the same quarter in 2014/15. The impact of this on people is highlighted in the results of the 2018 NHS inpatient survey, with more respondents saying that they felt they had to wait a long time before getting a bed, compared with the previous year.⁴⁹

Local services working together

Our staff have reported that collaborative working has become increasingly important over the last year, with integrated care services providing potential benefits to patients, such as smoother processes for admission and discharge and reducing the number of people on waiting lists. We have seen that integrated care can take a range of forms from acute trusts working with community services to GPs working with hospitals, and can help to address rising demand on services, as well as budgetary issues in the sector.

While we have heard of some good examples of cross-sector working, our staff have seen that it is more developed in some areas of the country than others, and in some specialisms. For example, we have seen a particularly high-level of cross-sector working in the treatment of cancer as a result of policy developments, such as the National Cancer Strategy, and a greater availability of funding:

David's story: when integrated care works well

David is 58 years old and lives in the Midlands with his husband. He told us about his experiences of his local health and care system following a diagnosis of kidney cancer in 2017.

David initially went to his GP in October 2017. He was given an appointment at the GP surgery the same day and was seen as an outpatient at his local hospital four days later. He then had surgery to remove his kidney in December 2017. David told us he was impressed by how quickly he was seen and treated, and with the communication between his doctor and the hospital:

"[It was] so quick, but so efficient. It was quite impressive... the communication between the doctor's surgery, outpatients and then the hospital..."

David also feels that he was kept informed throughout the process and that he had found this reassuring:

"It could have been made a lot more frightening if I was given less information. Everything has been explained at every step."

David is currently free of cancer and has found that his positive experience has continued post-operatively over the last year, with regular check-ups from both the hospital and his GP. However, he noted one area that needed to improve was how test results were communicated, describing how at one point he waited four months to receive some test results by letter. He suggested that this could be "brought up to date" and shared by email, which would be more efficient and sustainable.

We have changed names to protect privacy.

Cambridge University Hospitals NHS Foundation Trust: Improving care for the local population

Cambridge University Hospitals NHS Foundation Trust (CUHFT) is one of the largest NHS trusts in England, providing acute and specialist health care. Following an inspection in April 2015, the trust was rated as inadequate overall and was placed in special measures. Since then, the trust has recruited a new leadership team with a clear vision, who have led a cultural shift in the organisation. CUHFT has made significant progress – at the last inspection in October 2018, the trust was rated as good overall, and outstanding for the caring and well-led key questions.

Another key element of this improvement has been the trust's involvement in the Cambridgeshire and Peterborough Sustainability and Transformation Partnership (STP). The trust's Chief Executive and Chair have taken on the roles of interim STP Accountable Officer and Chair. Working with leaders from primary care, community and mental health services, the voluntary sector, Cambridgeshire County Council, Peterborough City Council and the clinical commissioning group, several members of the trust's executive leadership team have also taken up key leadership roles in the STP.

The trust recognises its broader accountability for the health and wellbeing of the populations it serves and 'working with local communities' is one of the four core pillars of its strategy. Working with patients and partners, the trust is focusing on integrating care for local people to improve quality, outcomes and value for money. A Provider Alliance covering Cambridge city, East and South Cambridgeshire is co-chaired by a CUHFT executive director and a local GP leader. The Provider Alliance is implementing a number of practical changes so that care is more joined-up, more proactive and more personalised, rooted in primary care networks covering 30,000 to 50,000 people.

This approach is leading to improved access, outcomes and use of resources. The trust told us that this approach has enabled more people to receive care closer to their own homes, and that they have seen significant improvements in delayed transfer of care rates, as well as changes to the way that GPs can involve specialists, "It's about making it easier, rather than harder, to do the right thing for patients and meet the needs of the local population."

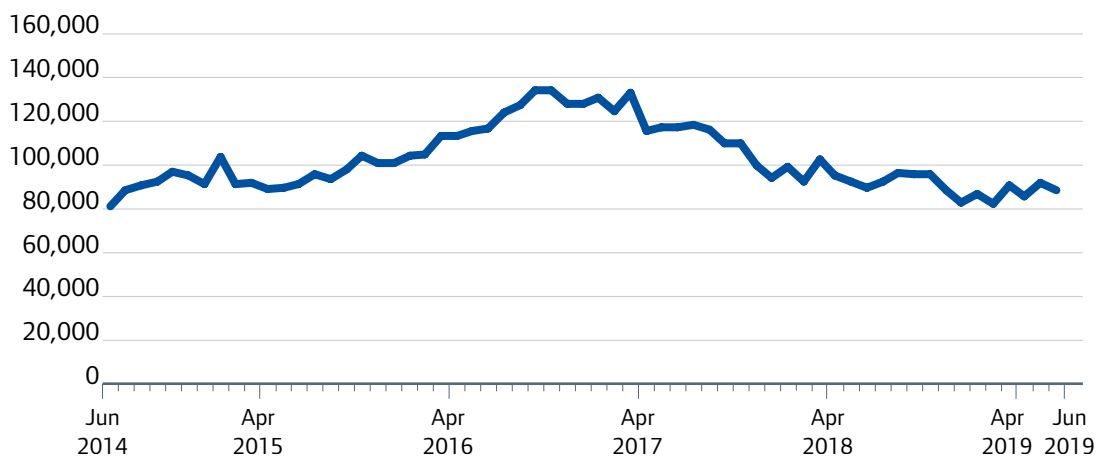
"...as part of the National Cancer Strategy, there have been 19 cancer alliances established across the country... and all the providers from primary care to hospitals and community are being organised to work together to improve patient pathways and outcomes. And there's been a real drive particularly in the National Cancer Strategy to really get those set up; also the infrastructure through which the transformational funding is being delivered."

Organisations representing people who use services have highlighted issues where people feel that the different parts of the system were not working together effectively for the care of the whole person. We heard that coordination of care was poor when people are being discharged from hospital, and that a lack of support in the community was a cause for delays in discharge from hospital. We know that lack of options for ongoing care, or information about it, can leave people feeling unsupported. It can also lead to delays in people being transferred or accessing hospital appointments, meaning that they need more help from other parts of the system.

While figures show that national pressure to reduce delays has led to improvements, the numbers of delayed transfers of care are still high each month (figure 2.13).

For every day of delay, this affects both the individual delayed in hospital, whose condition may deteriorate because of the delay, and others who cannot access hospital as a result.

Figure 2.13 Delayed transfers of care, total acute days delayed each month, June 2014 to June 2019



Source: NHS England, June 2014 to June 2019

Within this context, organisations that represent people who use services have emphasised the important role of family and friends, and voluntary services in bridging gaps between services to support the care of the whole person. This has included families and friends providing important information about their relative’s condition, medication or capabilities to inform their care, and providing support at crucial points such as discharge and recovery. Voluntary services have also played a key role in linking people to services and providing prevention and early stage support. However, families can also face difficulties in ‘navigating the system’, including coordinating their loved ones’ care, and a lack of support. We have heard how this can cause people stress and anxiety.

Where we have heard of examples of good partnership working, the organisations we spoke with described a commitment to working together to provide specific, integrated support, and to improve outcomes for people using services, their families and carers. Our staff have found that the success of partnership working can rely on the quality

of hospital leaders’ relationships with external stakeholders such as commissioners and CQC.

Staff have reported the potential of technology to support better joined-up working across sectors. Our staff have seen an increase in the use of apps and other digital platforms to allow information sharing between acute, community and GP services. However, the use of technology can be hampered by a number of barriers, including funding and the confidence of staff in using new systems and apps.

Workforce challenges

Once people gain access to services, ratings suggest that they are caring, with 87% of NHS acute core services rated as good and 11% as outstanding for the key question ‘are services caring?’.

We know that services are facing continuing challenges around the recruitment and retention of staff. Staffing levels and pressures on staff time can have an impact on the quality of care people receive – for example, we have heard from organisations that represent people who use services that limited capacity can mean that staff are not always able to identify and meet people’s specific needs.

Our report *Opening the door to change* also highlighted how competing demands and pressures on staff can compromise the safety of services. We heard how staff had limited time and space to engage in quality improvement initiatives or to attend relevant training.⁵⁰

In our inspections, we always assess staffing as part of rating the safety of a service. These assessments include observing how care is delivered, listening to staff and patients, and assessing the outcomes of care. We want providers to look at staffing in a flexible way, which is focused on the quality of care, patient safety and efficiency, rather than just numbers and ratios of staff. In June 2019, we published a selection of case studies that showcased examples of providers who have embraced this approach.⁵¹ This included, for example, physiotherapists working as a first contact practitioner in GP services, and placing occupational therapists in emergency departments.

Technological innovations can allow staff to communicate more effectively across services, which can in turn support partnership working. As we have seen in our case study on The Staying Well Pathway in South Staffordshire, this can improve the quality of care. Established by the Midlands Partnership Foundation Trust, the pathway, which supports people with mild to moderate frailty, uses the same IT system as local GP practices. All records for patients on the pathway are maintained and shared on this system. This means that all clinical staff involved in the pathway are able to see the records of patients who have been referred to the service.

The trust described using the same IT system as a key enabler for the pathway.

However, we have heard that problems with existing IT infrastructure, resistance from staff and a lack of funding are significant barriers to collaborative working, and that the implementation of technology has been patchy.

While it is clear that some services are taking steps to mitigate staffing shortages, including embracing the use of technology, our staff have reported difficulties in recruiting and retaining staff as a key issue that continued over the last year. This was seen as exacerbating other staffing challenges, leading to more pressurised work environments and staff leaving the service, further contributing to staff shortages. The potential for short-staffing to have a detrimental effect on staff is illustrated in some of the comments from our online feedback form. Many of these comments highlighted that some people using services are struggling, and they are feeling demoralised, stressed and burned-out.

Services’ ability to recruit has varied across the country, with some CQC staff mentioning areas in and around London as being particularly challenging. This is supported by figures from NHS workforce statistics which show that the highest percentage increase in acute nursing staff across Health Education England’s regions between 2016 and 2018 was in South London (5.6% increase), and the largest percentage decrease was in Thames Valley (4.9% decrease).

The reputation of hospitals, their CQC rating, and the culture and work environment can also be barriers to recruitment. In this context, our staff have been observing an emphasis on retaining staff in the services that they inspect. For example, we have seen examples of a greater focus on staff wellbeing, training and career development. We have also found that investing in staff and empowering them to do their jobs can support staff morale and retention.



Part 2: Mental health care



Current picture of quality and provision in mental health care

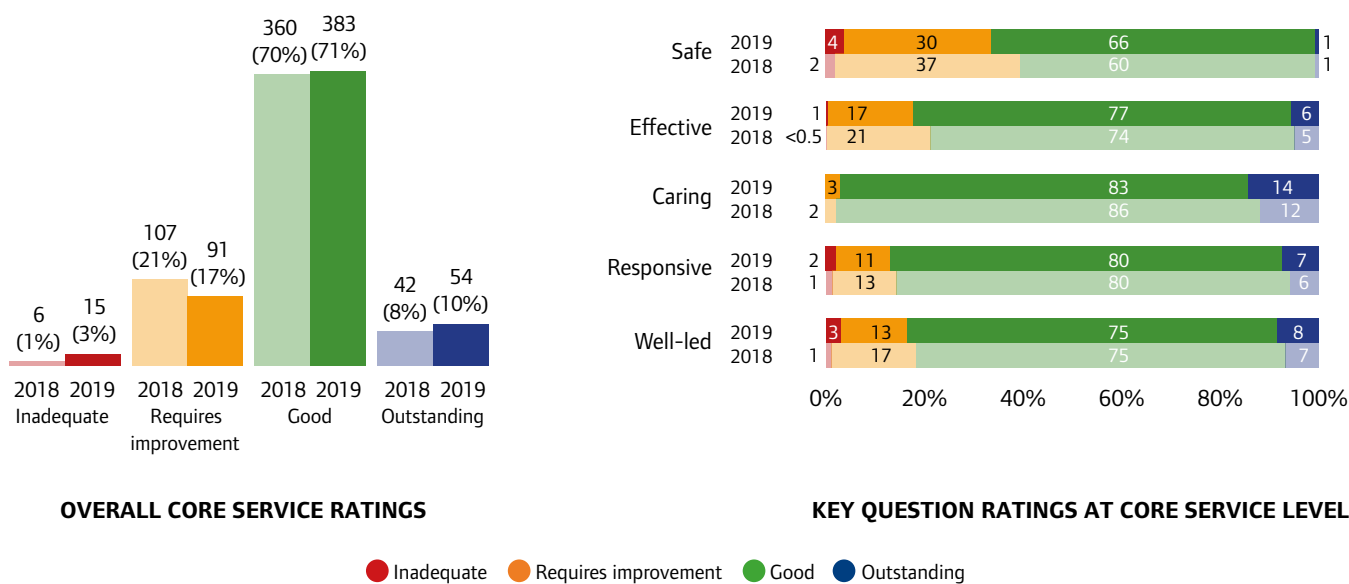
During 2018/19, accessing mental health services has remained a significant problem for many patients. For those patients who did access services there is a mixed picture. The majority of NHS mental health services were providing good care, with 71% of NHS core services rated as good and 10% as outstanding at 31 July 2019, compared with 70% and 8% last year (figure 2.14).

However, in independent hospitals, even though the proportion of core services rated as outstanding has improved from 6% last year to 9%, the quality of care overall has deteriorated, with 21% of core

services rated as requires improvement compared with 19% last year and 3% rated as inadequate (2% last year) (figure 2.15).

We continue to have concerns about the safety of services, with more than a third of NHS and independent services rated as requires improvement and inadequate for the key question 'are services safe?': 30% of NHS core services were rated as requires improvement and 4% as inadequate; in independent hospitals, 33% were rated as requires improvement and 5% as inadequate (figure 2.15).

Figure 2.14 NHS mental health trusts, overall core service and key question ratings, 2018 and 2019

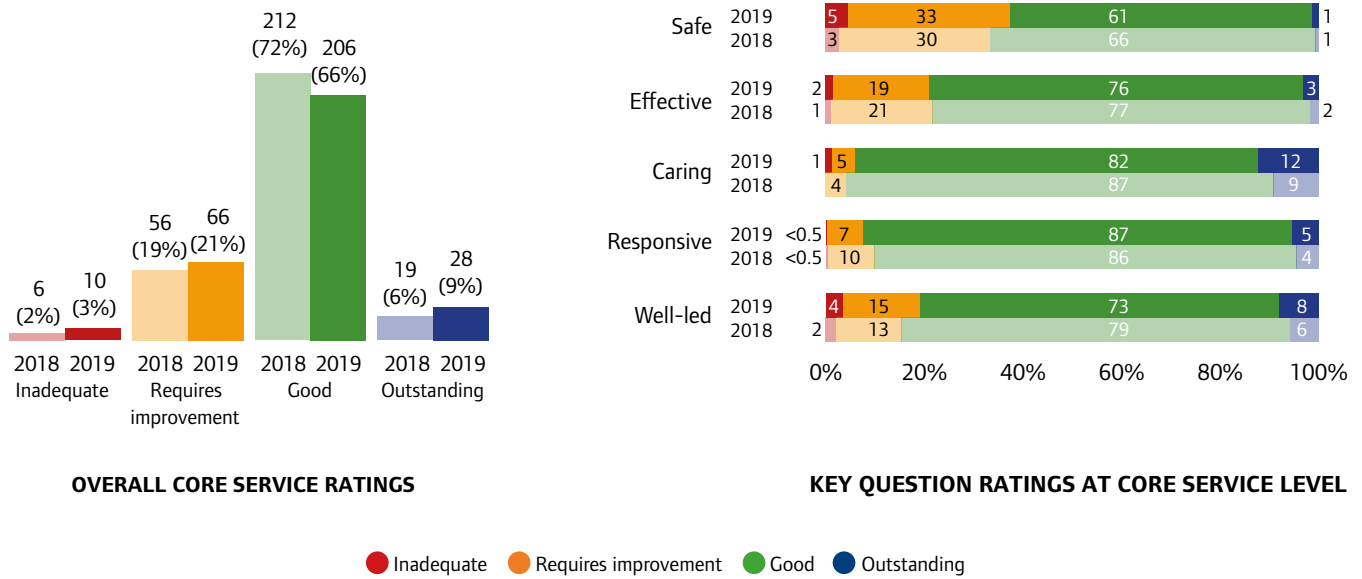


Source: CQC ratings data, 31 July 2018 and 2019

We have seen a general improvement in the quality of community mental health services. But the quality of inpatient services has largely worsened since last year – in particular in acute wards for adults of working age: at 31 July 2019, 6% of these services were rated as inadequate compared with 2% last year, and 38% were still rated as requires improvement. Similarly, in wards for people with

a learning disability or autism, 4% were rated as inadequate compared with 1% last year (figure 2.16).

Figure 2.15 Independent mental health providers, overall core service and key question ratings, 2018 and 2019

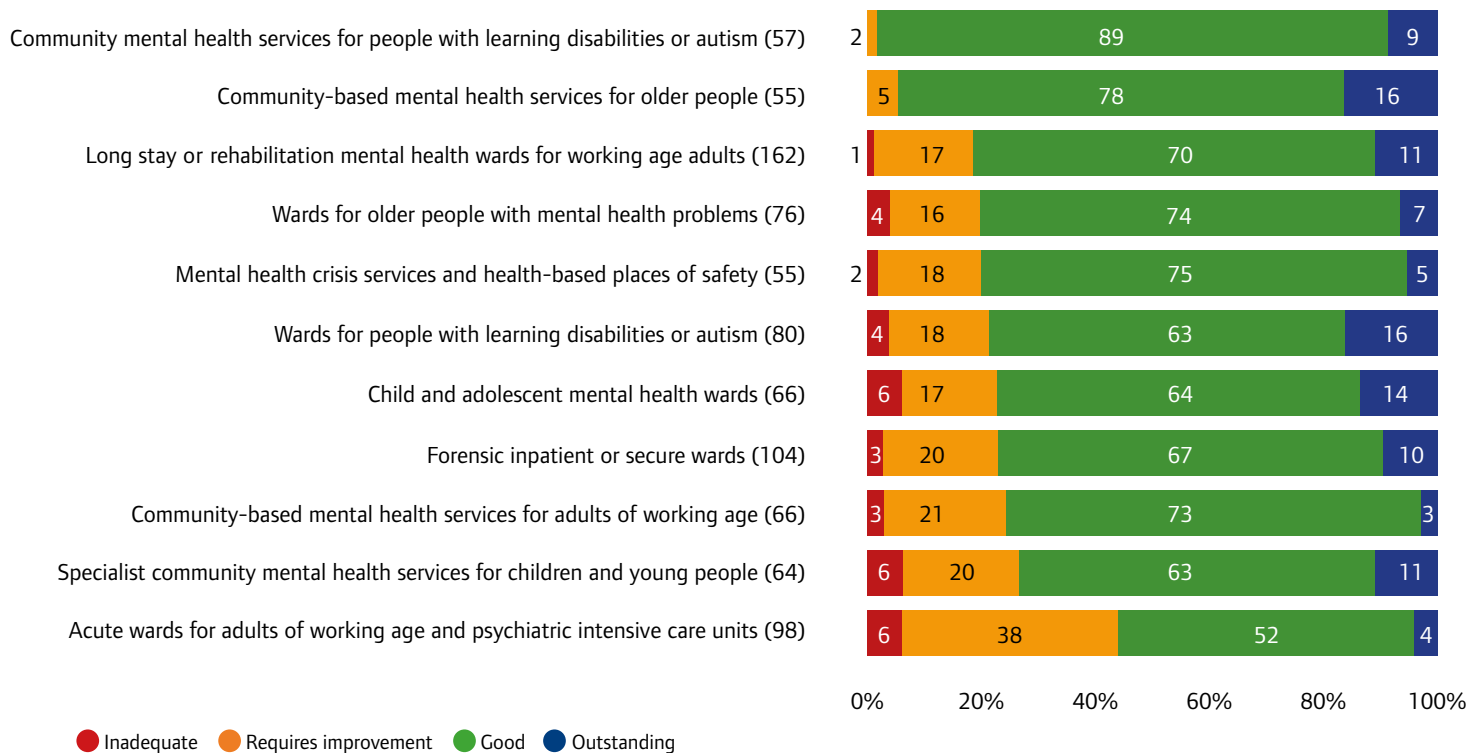


Source: CQC ratings data, 31 July 2018 and 2019

We are particularly concerned about access to inpatient care. From 2014/15 to 2018/19, there was a 14% fall in the number of mental health beds available (figure 2.17). While this is in line with the ambitions of the Five Year Forward View for Mental Health, we are concerned that community mental health provision is not compensating for the reduction in inpatient beds. Continued investment in community services is needed to help people avoid the need for inpatient care.

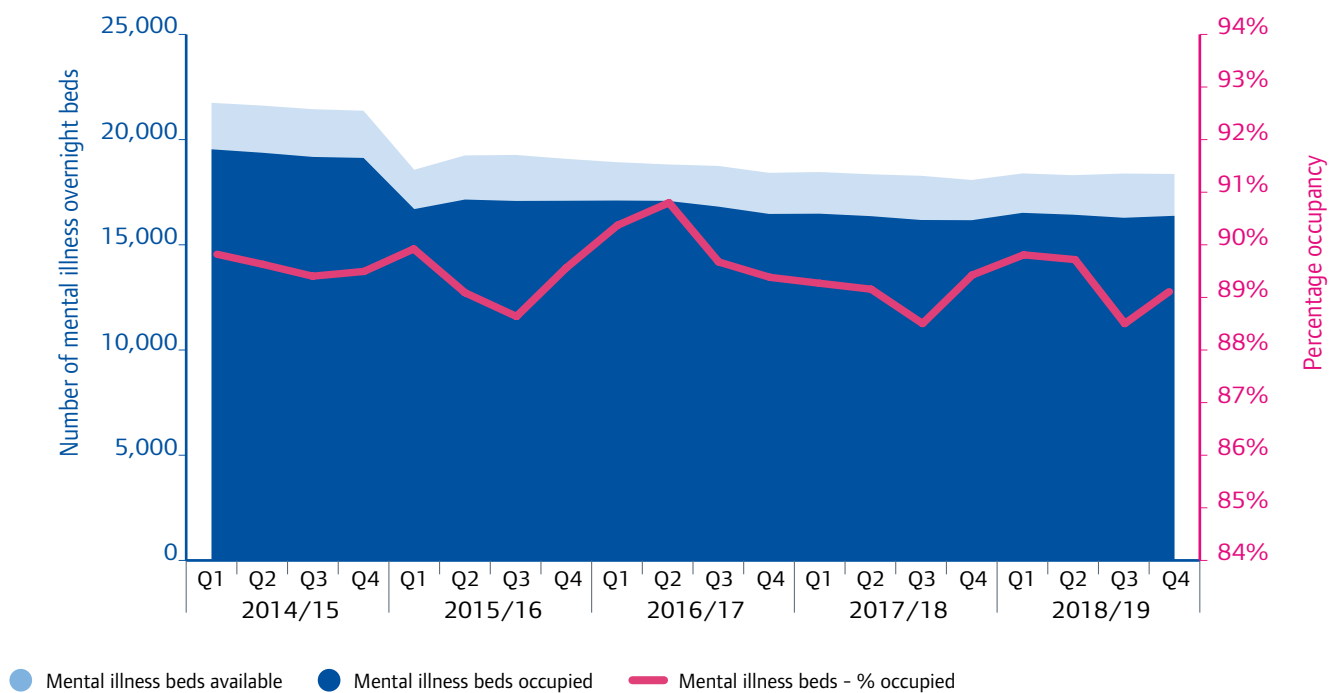
Over the same period we have seen a slight decline in the total numbers of mental health nursing staff and a sharper decline in inpatient mental health nurses ('other mental health' in figure 2.18). While the numbers of community mental health nurses have increased over the same period, feedback suggests that community services are still encountering staff shortages.

Figure 2.16 NHS mental health trusts and independent providers, core service ratings, 2019



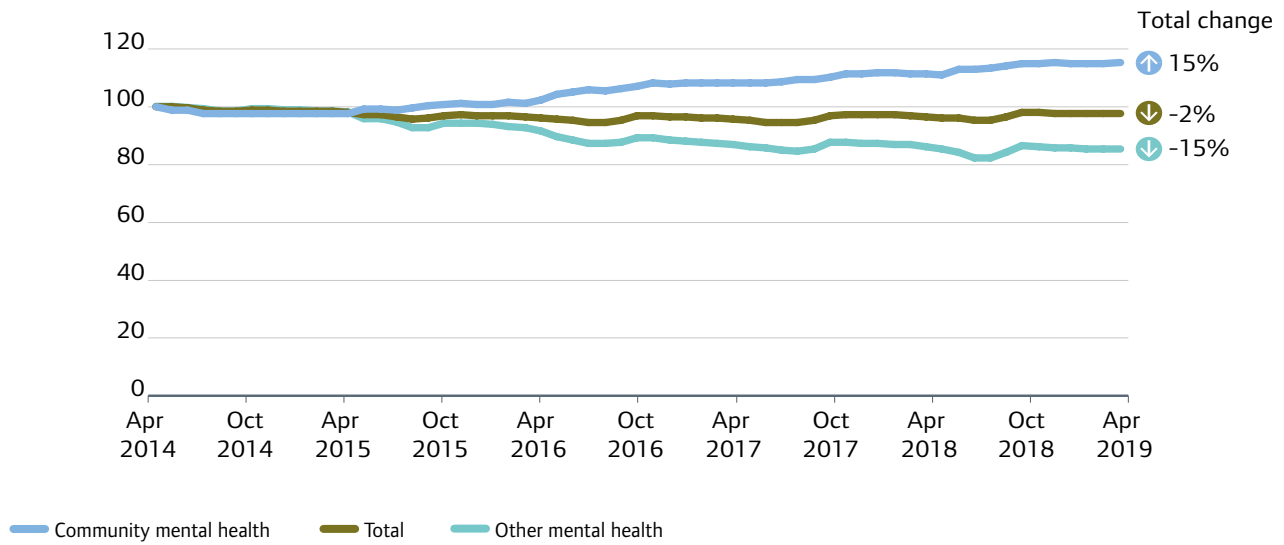
Source: CQC ratings data, 31 July 2019

Figure 2.17 Availability and occupancy of overnight beds for mental illness, 2014/15 to 2018/19



Source: NHS England, average daily available and occupied beds

Figure 2.18 **NHS full-time equivalent mental health nurses, 2014 to 2019**



Source: NHS Digital, NHS hospital and community health service (HCHS) monthly workforce statistics

Key issues in mental health care

Introduction

Mental health remained high on the national agenda during 2018/19. Ambitions for improving mental health services have been set out in national programmes including the NHS Long Term Plan and the Independent Review of the Mental Health Act, which made important recommendations about the rights and quality of care of people who may be detained by mental health services.

In our interim report on seclusion, restraint and segregation, we highlighted the urgent need for

improvements in the way that care is provided to people with more complex needs, and for a commitment to modernising services and support for person-centred care. We shone a spotlight on the prolonged use of segregation for people with severe and complex problems, who should instead be receiving care from staff with highly specialised skills, and in a setting that is fully adapted to their needs.

Access to services

Last year, we reported on our work with NHS England on the development of the NHS Long Term Plan. We recommended a greater focus on improving care for those with the most severe and enduring forms of mental illness, including through safe ward environments, adequate staffing, care near the home, and access to community mental health services.⁵²

It is positive to see that the Plan, published in January 2019, commits to transforming mental health care so that more people can access treatment. There has already been some improvement in access to certain services. For example, 83,000 more people started treatment under the Improving Access to Psychological Therapies (IAPT) programme in 2018/19 compared with the previous year, an increase of 8.3%, bringing the total to 1.09 million.⁵³

Over the next five years, the Long Term Plan sets out plans to increase access for children and young people as well as those with severe mental health needs. This is supported by a commitment to increase funding for mental health at a faster rate than the overall NHS budget – by at least £2.3 billion a year by 2023/24.

While this is a positive development, mental health services have historically suffered from underfunding and, as we highlighted in last year's report, there

remain concerns around real-term spending on these services.⁵⁴ Organisations that represent people who use services have told us about their concerns that challenges with funding are causing issues with access to and the availability of services.

We are concerned about a number of 'pinch points' in the mental health care system: the availability of community services for people with autism and/or a learning disability, people not getting access to the community or inpatient care they need at the time they need it, and difficulties accessing community child and adolescent mental health services (CAMHS).

Services for people with autism and/or a learning disability

In 2015, NHS England set out its plans to develop community services and to close inpatient beds for people with autism and/or a learning disability through the Transforming Care Programme.⁵⁵ This did not result in the closure of as many hospital beds as intended, and too many people with autism and/or a learning disability remain in hospitals far from home because of a lack of local, intensive community services.

In May 2019, in the interim report on our thematic review of restraint, seclusion and segregation, we highlighted that most of the people we visited who

were being cared for in segregation on a learning disability or mental health ward for children and young people had autism. We found that many of these people had not had access to the help they needed as children and throughout their lives from health, care and education services. Often, when they encountered a crisis in their lives, the right care was not available, locally, to avoid going into hospital. For many, their hospital stay was prolonged because of delays in setting up a package of care to support them following discharge, or because that package of care did not even exist.⁵⁶

Our staff have also highlighted how shortages of specialist beds for people with autism has meant that patients are often placed on non-specialist wards where environments can be challenging for them, potentially delaying recovery.

Community and inpatient care for people when they need it

The policy drives of the *Five Year Forward View for Mental Health* aim to support people in the community rather than as inpatients. While this has been a move in the right direction, our staff have expressed concern that community provision is not increasing fast enough to compensate for the reduction in inpatient beds.

One of the organisations we spoke with that represent people who use services told us that they had seen positive developments in community services including an increase in the availability of early intervention services, such as ‘talking therapies’. However, they cautioned that this was having a negative impact on people with more severe mental health issues, as they felt that funding for these services was being diverted away from other community mental health care services. Not being able to access the right care when it is needed can lead to patients’ conditions worsening and in some cases reaching crisis point.

When people reach crisis, but are not able to access inpatient care because a bed is not available, the consequences can be devastating. Between June 2018 and March 2019, coroners made us aware of at least seven deaths of people who were assessed as requiring admission, but for whom no mental health bed was available. We have written to NHS

England to alert them to this finding and other areas of concern including:

- people being held for a prolonged period (over 24 hours) in a health-based place of safety – we question the lawful basis for detaining people under these circumstances
- people being accommodated for a prolonged period in a mental health decision unit – it is unacceptable that people in a state of distress are held for days in a facility that has no beds and which provides no privacy
- the unavailability of a mental health bed, which is one of the most common reasons for patients waiting longer than 12 hours from decision to admit to transfer to inpatient bed.

NHS England and NHS Improvement are addressing these issues through their delivery of the *Five Year Forward View for Mental Health* and Long Term Plan commitments. We will continue to raise awareness of our concerns with local services and, where necessary, with national agencies.

Access to local, comprehensive rehabilitation services is a particular problem for people with the most severe and enduring mental illness. Our staff have reported that in some areas, inpatient facilities are operating at over 100% occupancy. This can lead to people being placed far from home in order to access the care they need which, in turn, can have a detrimental impact on their mental health.

This is not a new issue. In March 2018, we raised concerns about the high number of people placed in mental health rehabilitation hospitals who are a long way from home.⁵⁷ In response to our findings, NHS England and NHS Improvement have set up a team to work with local health and care communities to develop local services capable of meeting these people’s complex needs and so enabling them to be brought closer to home.⁵⁸ We are monitoring progress on this and will report in due course.

The issue of placing people far from home was something we also raised in our evaluation of the Mental Health Act (MHA) Code of Practice that we published in June 2019. In this we found that local areas, including commissioners, local authorities, police and providers, need to work together better to

make sure that people in need of urgent care have timely access to a bed that is close to home, in line with the expectations of section 140 of the MHA.⁵⁹

Services for children and young people

Young people continued to experience difficulties in accessing CAMHS community services during 2018/19. This is reflected in the ratings for community-based mental health services for children and young people, with 21% of services rated as requires improvement and 10% as inadequate for the key question 'are services responsive?'. It has also been identified as an issue by our staff, who described seeing children and young people facing long waiting lists to access services.

As highlighted in the report of our review of children and young people's mental health services,

issues with accessing CAMHS are not only about lack of investment, but also the fragmentation of organisations responsible for providing and commissioning care.⁶⁰

We have heard from our staff how new technologies, in particular the use of online therapies and apps for children accessing CAMHS, have improved patient access to care. For example, we heard about one app that improved patients' ability to access and feedback on their own care records from home, and the use of online therapies for people who find talking face-to-face about their issues difficult. However, organisations we spoke with that represent people who use services cautioned that technology should not replace human support.

Impact of current workforce challenges

Over the last five years, the total number of mental health nurses has continued to fall, with 2% fewer mental health nurses in April 2019 than in April 2014. In keeping with this, our inspections of mental health and learning disability services have frequently identified problems related to staffing.

Over the same period, there has been a national rise in the number of community mental health nurses, reflecting the policy move away from hospital-based care. Despite these figures, our staff have expressed concern that over the last year they have seen staff shortages becoming more pronounced in local community services, which has affected patients' access to care, for example resulting in long waiting

Millie's story: difficulties in accessing CAMHS

Millie is a student from Rotherham. She told us about her experiences in accessing child and adolescent mental health services. Referred to counselling sessions by her GP, Millie had to wait six weeks before getting an appointment, which she was only notified about one week in advance of the appointment time.

Allocated six counselling sessions, Millie told us that after one session she was not deemed "at risk" so was sent back to her GP to discuss other options. This included being prescribed antidepressants, which she did not want. Millie explained how this left her feeling:

"[I felt] angry more than anything because I'd waited so long and I didn't want to go on any antidepressants or anything like that, I wanted to do the counselling to see how that worked..."

Millie felt that she had not been listened to and that she was being pushed down the route of taking antidepressants, and then suffered from their side-effects for three months, which she describes as "having a horrible impact on my mental health".

We have changed names to protect privacy.

Addressing inpatient care: strengthening our regulation of mental health and learning disability wards

In response to our findings on the quality of inpatient care and to the ambitions of the Long Term Plan and the report of the independent review of the Mental Health Act, we are reviewing how we assess all wards in mental health and learning disability services.

We are focusing on our assessment of specific factors that we have identified previously, which are central to the quality, safety and experience of care.

- **Staffing** – there is a need for both a sufficient number to maintain safety and staff with the skills required to minimise the use of restrictive interventions.
- **The quality of leadership** and the extent to which this fosters a culture of engagement, co-production and ‘no force first’.
- Whether patients have access to **the full range of effective treatment and care interventions, other than medication.**
- Compliance with the guidance and standards on **sexual safety on mental health wards** that are being developed by the Royal College of Psychiatrists and the Royal College of Nursing in response to our report on this issue.
- **Minimising restrictive interventions**, drawing on learning from our thematic review of restraint, seclusion and segregation.
- **The physical fabric of wards** including the layout, the safety of fixtures and fittings and the provision of same-sex accommodation and single en-suite bedrooms. For wards with dormitories, we will assess how the provider has mitigated the adverse impact and whether it has a credible plan to eliminate them by a stated date. We expect trust boards to be aware of the quality of the inpatient estate and to have taken action to obtain funding for improvements.

times, particularly for those who need specialist assessments.

Issues with accessing the right community care when it is needed can lead to people’s mental health worsening and their needs becoming more acute and requiring inpatient care. One in four (25%) respondents in the 2018 NHS community mental health survey said that they had not seen workers from NHS mental health services enough for their needs in the past year.⁶¹

The quality of care that patients then receive in hospital when they are at their time of greatest need is crucial to their recovery. As we highlighted in last year’s State of Care, we have serious concerns about the quality and safety of inpatient care, and

the impact that workforce challenges place on it. It remains our greatest concern.

We have additional concerns about wards that should be providing longer-term and highly specialised treatment and care for people with the most severe and complex problems. Since October 2018, we have rated as inadequate 14 independent mental health hospitals that admit people with a learning disability and/or autism, and put them into special measures. Issues with staffing were a common feature across a number of these hospitals. These included our concerns with staff skill mix not reflecting the needs of the people on the ward, and a lack of registered learning disability nursing time being routinely addressed by relying on high numbers of healthcare assistants or other non-

Debra's story: the impact of a lack of specialist care

Debra told us about her experiences of care for her daughter Natalie, a 33-year-old woman with autism, learning disabilities and pathological avoidance syndrome.

For the last 14 years, Natalie has been cared for at a secure hospital within an NHS trust. In August last year, Natalie was moved from the hospital into a community setting, but the placement only lasted three weeks as staff were unable to cope with her challenging behaviour.

Debra believes that a lack of suitable staff was a key reason why the placement broke down. She recalled how staff struggled to manage Natalie's behaviour and often required assistance from the police, who would handcuff her and put her legs

into restraints. The inability of staff to cope with Natalie made the placement too dangerous for it to continue.

"The placement ended because the commissioner who commissioned the service was frightened that if she continued to be there, she wouldn't be here anymore, basically."

Not only has the experience left her daughter feeling "traumatised", but Debra is also concerned for Natalie's future care; the hospital where Natalie currently lives is due to shut down, and Debra is unsure if there will be any specialist care for her daughter when this happens.

We have changed names to protect privacy.

registered roles. We also found issues with staff not having adequate training and difficulties in recruiting and retaining staff.

Our staff have also noted an increase in the use of agency staff and the knock-on impact that this has had. For instance, we heard how this could increase the workload of permanent staff, for example because of more administrative duties, and leave less time to deliver patient-centred care. Feedback from people who use services, particularly those with complex needs, such as those with autism and/or a learning disability, highlighted how understaffing could contribute to a deterioration in mental health because staff were unable to provide the level of

care they are trained to deliver as services were so stretched.

The treatment and care of people with complex needs and challenging behaviour requires skilled specialists delivering evidence-based medical and psychosocial interventions. Debra's story highlights the negative consequences of when people do not receive the specialist care they need, including more use of restrictive interventions.

As part of our work to strengthen our regulation of mental health and learning disability wards, we will look specifically at how we can better assess both the culture on these specialist wards and the steps taken by managers to address workforce and skill mix.

Local services working together

The challenge for all care organisations is to change the way that services work together and ensure that the right services are being commissioned for local needs. There needs to be a more urgent focus from leaders on delivering care in collaborative ways to ensure that people are getting the support they need.

Our staff have reported the increasing importance of how health and social care services work together. Although in their early stages, we have heard how initial examples of partnership working, such as the South London Partnership, are having a positive impact for people.

Where local health and care organisations work together, jointly identifying improvements that make sure people have the right support, care and treatment for mental health conditions, we have seen more effective systems and better outcomes. We saw an example of this in our case study on the Midlands Partnership Foundation Trust in South Staffordshire, where the merger of two community trusts brought many services under one roof and allowed them to take a holistic approach to caring for both the physical and mental health needs of patients.

People with severe and enduring mental health problems must be put at the centre of decision-making, and authorities must work together to

provide the best care for each person. This has the potential to prevent or shorten admissions to mental health rehabilitation beds that are far from home. The shocking abuse at Whorlton Hall put the challenges and potentially dangerous consequences of placing people far from their home, friends and family into sharp focus.

In our interim report on our review of restraint, seclusion and segregation, we concluded that the current system of care, which includes national bodies, providers and commissioners, has failed people with the most complex needs who have a learning disability, mental health problem or autism – in particular, those who end up being segregated in a hospital. We also concluded that, once a person was

Partnership working to improve mental health care

The South London Mental Health and Community Partnership (SLP) is an innovative partnership between Oxleas NHS Foundation Trust, South London and Maudsley NHS Foundation Trust, and South West London and St George's Mental Health NHS Trust. Formed in April 2017, the partnership brings together clinical experience, expertise and innovation to improve the quality of care offered to a combined population of more than 3.6 million people.

Driven originally by the three chief executives' desire to work more closely and collaboratively, the introduction of the NHS England New Care Models programme gave the trusts the opportunity to develop the partnership. The SLP was initially given responsibility for NHS England Specialist Commissioning budgets for forensic (adult secure) services, and then child and adolescent mental health (CAMHS) tier 4 patients in October 2017 via the New Care Models Programme. With this, the trusts sought to work together to address key challenges, including people being placed far from home, extended lengths of stay and limited proactive care management for these patients.

One initial priority was to make best use of the trusts' beds so patients could be brought back to south London, even if there was no availability

in their specific local trust. This work has also delivered cost savings through reduced out-of-area and independent sector placements, and shorter length of inpatient stays. These savings have already been reinvested to enhance existing services and develop new ones, in particular expanding community services, such as the CAMHS crisis team and forensic community services.

Taking this approach has also enabled the trusts to avoid out-of-area placements. In late 2018, the work had led to a 75% reduction in the use of out-of-area beds in CAMHS, and there have been 36% fewer forensic patients placed out of area. Keeping patients in South London means that they can stay closer to the support of their families and friends, and local services.

In addition, the partnership has had a positive effect on the trusts' workforces, particularly through its Nursing Development Programme. This has included increased opportunities for career development, including common career pathways, job descriptions and competencies, joint training programmes, and easier movement to new jobs in South London through an innovative Employee Passport. The overall nursing workforce retention rate improved by more than 5% in the first two years.

in segregation, the difficult task of finding suitable accommodation, and the accompanying bespoke package of care, may have been made more difficult by the challenge of coordinating the inputs of the various provider and commissioner organisations involved – and perhaps by disagreements about who should fund the care.⁶²

As part of the recommendations of our review, we proposed that an expert group should consider what would be the key features of a better system of care for people with autism and/or a learning disability who are at risk of admission and segregation, and that there is a much stronger focus on human rights and the role of advocates. These recommendations were accepted in full by the Department of Health and Social Care and we will be working with them to ensure that these are implemented.⁶³

However, it is important to acknowledge that the landscape of mental health provision remains confusing and complex for everyone seeking mental health care. Complicated commissioning arrangements, with multiple clinical commissioning groups covering the same geographical area, make it difficult for people seeking mental health care. Complex commissioning arrangements can make it difficult for people to navigate and access the services they need. These fundamental issues need to be addressed in order to provide people with safe, responsive and high-quality mental health care.



Part 2: Primary medical services

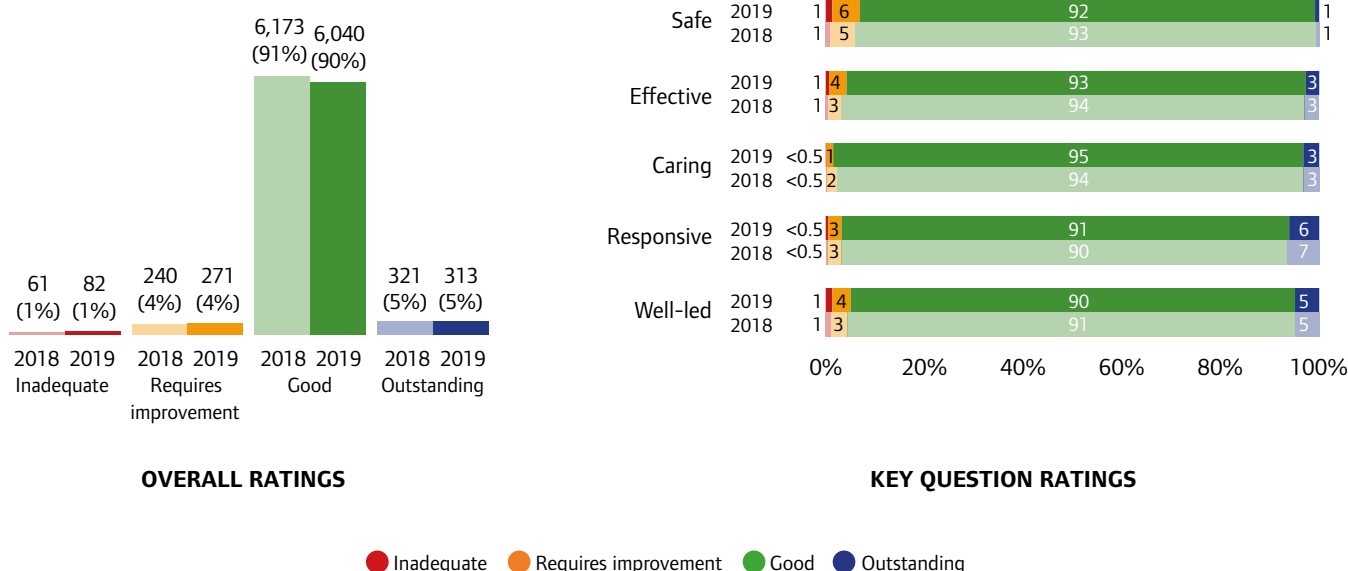


Current picture of quality and provision in primary medical services

The overall quality of services in the primary care sector in 2018/19 is high, which is encouraging news for a sector that is having to evolve in the way it delivers care in response to growing demand and an ageing population. But at the same time, getting access to services can be a challenge, and insufficient integration between different types of services can affect people’s experience of primary care.

Overall ratings for GP practices show that 90% are good and 5% are outstanding, similar to the previous year. However, the rate of improvement seen in previous years seems to have reached a plateau, as 4% of practices still require improvement and 1% are rated as inadequate (figure 2.19).

Figure 2.19 GP practices, overall and key question ratings, 2018 and 2019



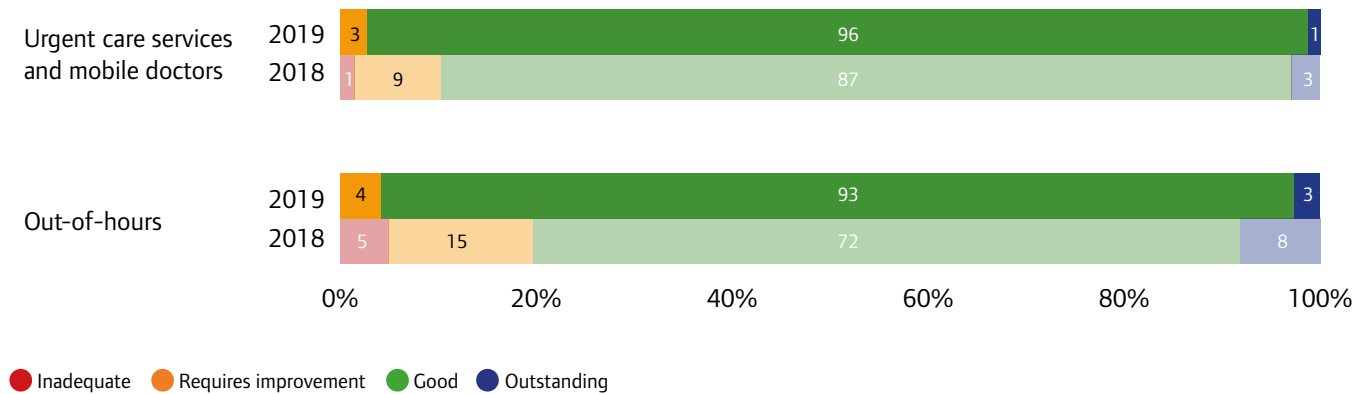
Source: CQC ratings data, 31 July 2018 and 2019

When looking at overall ratings for each of the five key questions, once again the safe key question has the highest proportion of poorer ratings (6% rated as requires improvement and 1% as inadequate), and again, performance is highest for providing caring services (95% rated as good and 3% as outstanding). This shows that, despite the pressures facing general practice, we are still seeing high-quality services for patients, which is testament to the dedicated practice teams. Patients have rated their overall experience of their family doctor highly, with 87% of respondents in the 2019 GP Patient

Survey saying the healthcare professional treated them with “care and concern” and 87% saying there was enough time to listen to their needs.⁶⁴

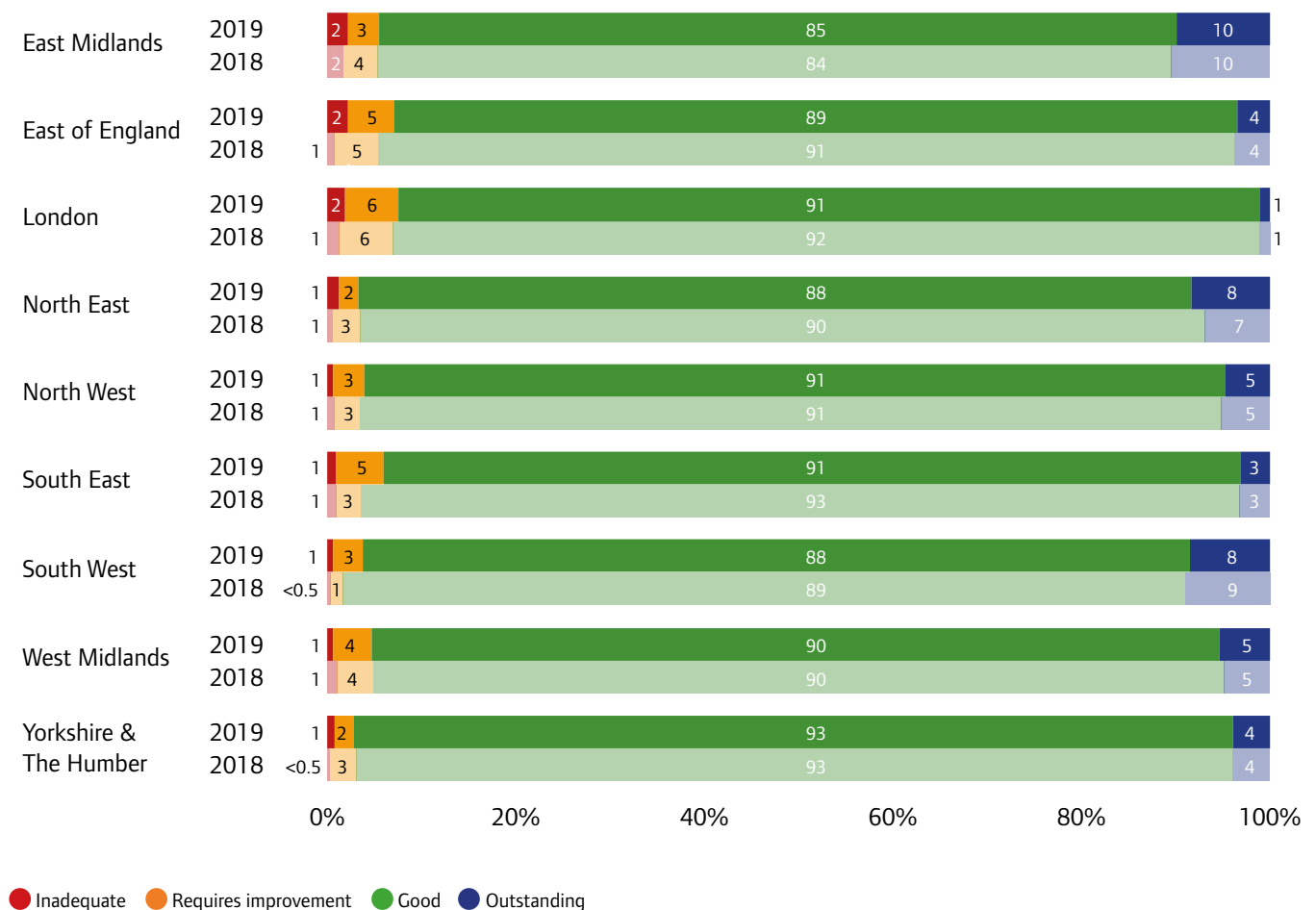
In the primary urgent care services that we have rated, none are rated as inadequate. We have seen a large increase in the proportion of services rated as good and a reduction in those rated as requires improvement and inadequate, although this is offset by fewer ratings of outstanding (figure 2.20).

Figure 2.20 Primary urgent care services, mobile doctor and out-of-hours GP services, overall ratings, 2018 and 2019



Source: CQC ratings data, 31 July 2018 and 2019

Figure 2.21 GP practices, overall ratings by region, 2018 and 2019



Source: CQC ratings data, 31 July 2018 and 2019

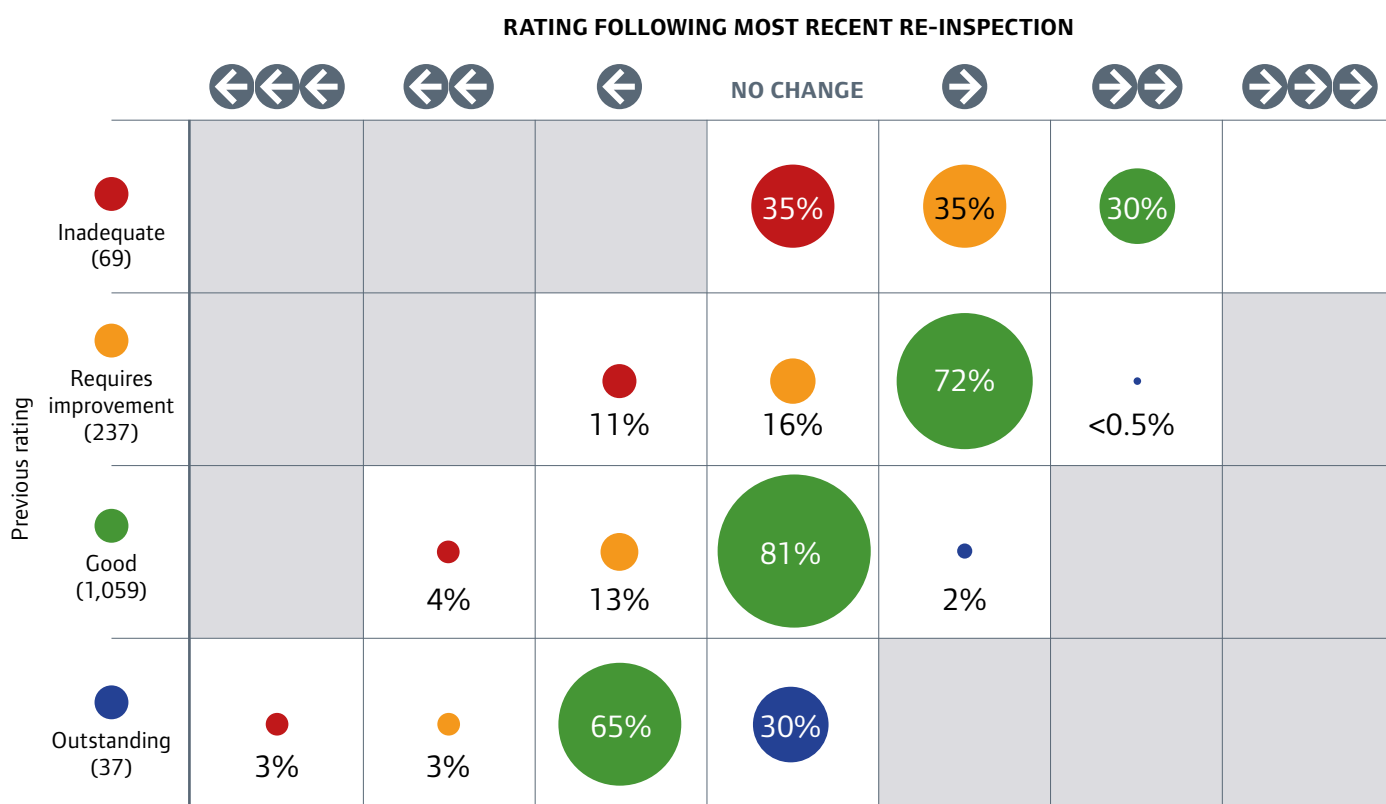
Looking at the quality of GP practices in England by region, the highest proportion of good and outstanding ratings are in Yorkshire and the Humber (97%); but in regions including the South East, East of England and South West, the proportion of practices rated as requires improvement and inadequate has increased since last year (figure 2.21).

Although overall ratings are similar to 2018, re-inspections show that some GP practices are moving down as well as up in ratings, and there are signs that improvement has become harder to achieve and to sustain. The change on re-inspection in 2019 shows that a large group of GP practices have failed

to improve and move out of the lower ratings and more than a third of practices rated as inadequate have not improved on re-inspection (figure 2.22).

We have reported previously that some GP practices have not been able to improve or to sustain improvement because of issues with poor leadership and management,⁶⁵ but ongoing capacity pressures on general practice as a whole may affect the ability to improve. This highlights the need to carry on delivering the commitments made in the NHS Long Term Plan, and to target funding appropriately to support general practice.

Figure 2.22 GP practices, change in rating on re-inspection, year to 31 July 2019



● Inadequate ● Requires improvement ● Good ● Outstanding

➡ 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)

Source: CQC ratings data, re-inspections published in the year to 31 July 2019. Change in rating is from previous to most recent inspection.

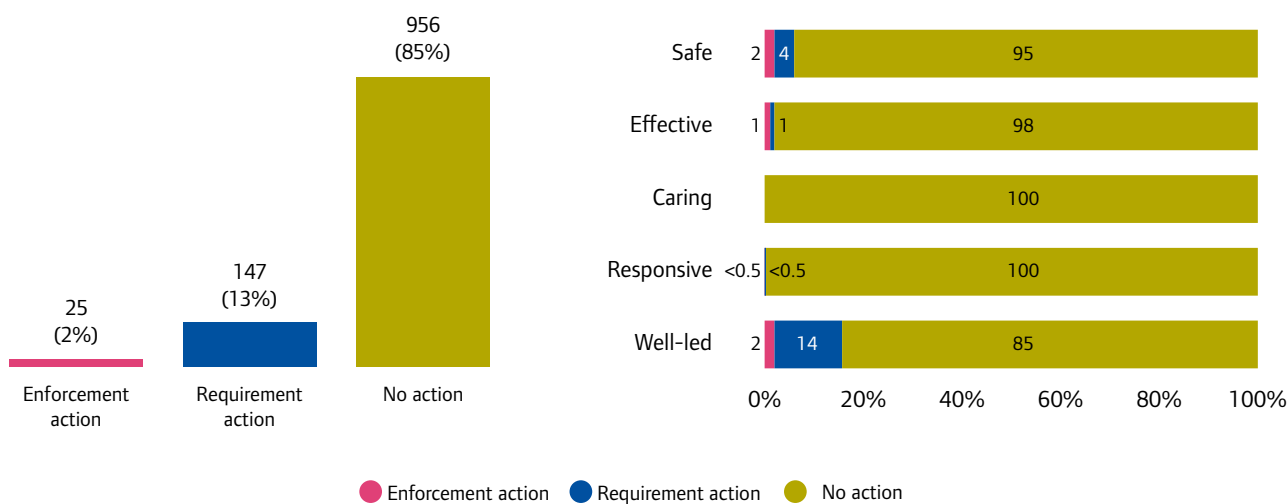
In primary care dental services, the pattern of inspection outcomes is broadly similar to last year. Inspections of 1,033 dental practices represented approximately 10% of all practices in England. For the vast majority of inspections (85%), we took no regulatory action as these services were providing care that met the regulations associated with our five key questions.

However, where we did take action, 13% of inspections resulted in a Requirement Notice and in 2% of cases, we took enforcement action. The

proportion that resulted in either form of regulatory action has risen from 10% in 2018 to 15%. Again, performance was poorest for the well-led and safe key questions, particularly the well-led key question, with action taken following 16% of inspections compared with 10% in 2018 (figure 2.23).

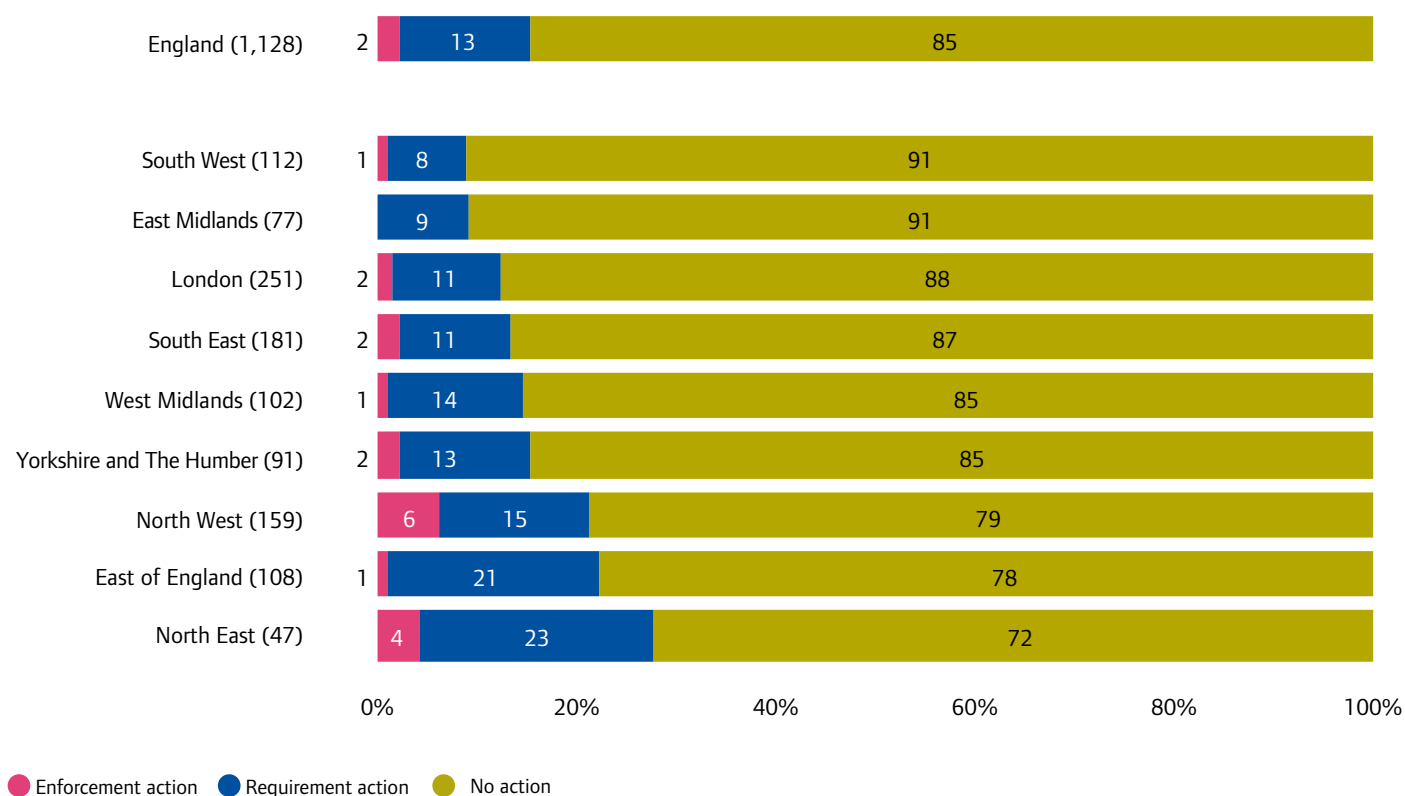
Figure 2.24 shows that there is again some regional variation in inspection outcomes, with the North East having the highest proportion of regulatory action, although based on a smaller number of inspections than elsewhere.

Figure 2.23 Dental practices, inspection outcomes overall and by key question, year to 31 March 2019



Source: CQC inspection outcome data. Comprises active dental practices with inspection reports published in the year to 31 March 2019 (1,128 inspections of 1,033 locations).

Figure 2.24 **Dental practices, overall inspection outcomes by region, year to 31 March 2019**



Source: CQC inspection outcome data. Comprises active dental practices with inspection reports published in the year to 31 March 2019 (1,128 inspections of 1,033 locations).

Key issues in primary medical services

People’s feedback and experiences of primary care are an integral part of our quality assessments. We know that the quality of people’s encounters with services has a profound impact on them, including on their wellbeing, confidence in the service, and

state of their condition. These experiences of receiving person-centred care, or in some cases the lack of it, underpin the areas explored in this year’s State of Care.

Access to care

GP practices

In NHS England’s 2019 GP Patient Survey, of the patients who had tried, the proportion who said it was easy to get through to their GP practice on the phone decreased from 70% last year to 68%. Just under two-thirds of patients (65%) were satisfied with the appointment times available to them, and 62% of patients said they were offered a choice of appointment (time/day, location, and/or healthcare professional).⁶⁶

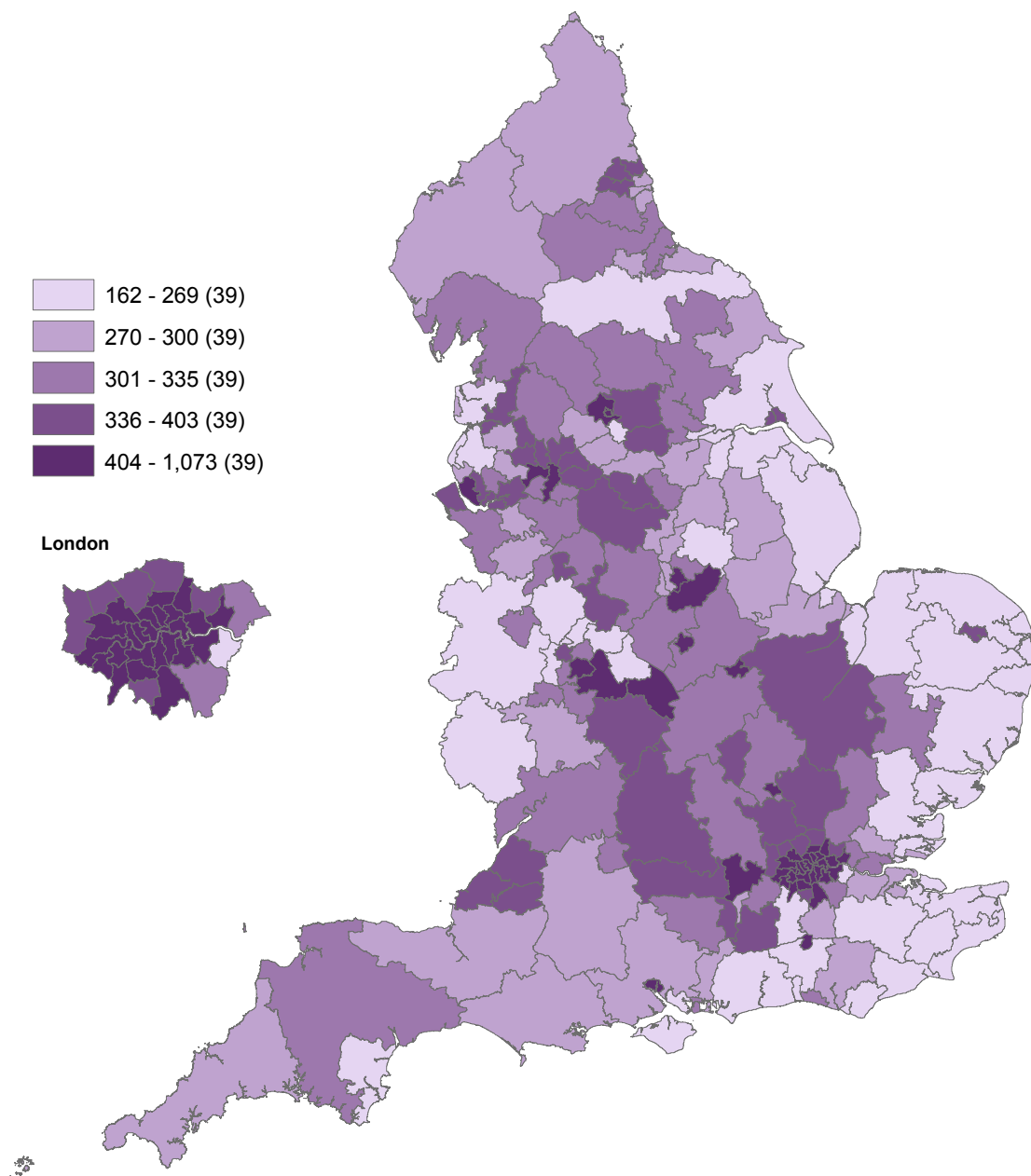
The feedback we have received about problems in accessing primary care appointments reflects these findings. We have heard that people continue to face barriers to accessing non-urgent services in their local community, particularly GP and dental services. People’s concerns about access to care have included getting an appointment when they need it, but also in having their individual needs considered. Difficulty in accessing a GP appointment is widely reported to be a result of an increasing demand for services from an ageing population with more complex health

conditions who need more contact with a GP.⁶⁷

We can see this across the clinical commissioning group (CCG) regions in England: the map in figure 2.25 shows that in the east of the country, there are fewer full-time equivalent GPs than in many other

areas based on the size of the population of older people, who we may assume are most in need of GP care. However, analysing appointments with 'other' healthcare professionals, such as nurses, suggests that there is a tendency for areas with fewer GPs to provide more of this type of appointment.

Figure 2.25 Full-time equivalent GPs per 100,000 people aged 65 and over by clinical commissioning group



Source: NHS Digital, GP workforce data, December 2018; Office for National Statistics, mid-year population estimates, mid-2017

There is also a very wide range in the number of GP appointments for every 1,000 people of all ages on GP lists per month across CCG areas: in May 2019, there was an average of 424 appointments nationally, with the lowest of 241 and the highest of 613.

People who have shared their experience with us have said they are waiting for weeks for a non-urgent appointment with a GP. While people have reflected that they would rather see their usual GP who they recognise and who understands their own history, needs and preferences, they have described a range of difficulties in booking appointments to see any GP. In the GP Patient Survey, less than half of the people who wanted to see a preferred GP said they saw them 'always', 'almost always', or 'a lot of the time'.⁶⁸ When people have shared their experiences with us online, they have said they felt restricted in the systems that services use to make appointments: either by their design (such as only offering online appointments, or a centralised call centre), or when the system failed to work. People have told us that they have felt forced to make contact in a way that didn't suit them or, in some cases, were unable to get the service they needed.

A particular experience highlighted to us was that, when no pre-bookable GP appointments were available, people needed to telephone repeatedly or early in the morning for a same-day appointment. These experiences were frustrating, involving being kept on hold in a queue for a long time, and when they did manage to get through, they would be told that there were no longer any appointments

available. The impact on access was felt most by people who were less willing or able to persist (such as those with working commitments as they may be unable to stay on hold on the phone for long periods, or those without internet access).

Getting registered with a GP in the first place can also be a problem for some people in more vulnerable circumstances, particularly those without proof of address or identification.⁶⁹ Nevertheless, we have seen some excellent examples of responsive care by GP practices that provide bespoke services for certain groups, such as homeless people or those seeking asylum.

We have found that people have chosen to go to an urgent care centre or emergency department when they cannot get a same-day GP appointment. Those who have contacted CQC have described that in some cases they felt forced to consider taking an emergency appointment for a non-urgent condition, go without important medicines because of delays or errors, or turn to other services for help (such as walk-in clinics or emergency departments), as in Millie's experience below. In the GP Patient Survey 2019, just over a fifth of people who did not take the appointment offered to them either went to an emergency department (12%) or another NHS service (10%).

Many practices offer telephone triaging to try to avoid these situations, but these services are not always accessible or suitable to people. We welcome NHS England's review of access to general practice, which will report in autumn 2019.

Accessing GP services across locations: Millie's story

Millie is a student at university, who told us about her mixed experiences accessing GP services, walk-in services, and CAMHS services. As a student, Millie has used GP services in her home town as well as GPs where she attends university. However, she has to wait longer to get an appointment with the GPs near the university so she has re-registered with her home practice. This means she travels back there when she needs to see a doctor, or she uses local walk-in centres.

"It takes two to three weeks to get an appointment when I'm away at university, but it takes about a week in my home town practice, so I travel back home as its quicker to get an appointment"... "walk-in centres are the best option for me, it's a lot easier to get immediate care."

We have changed names to protect privacy.

Dental care

Looking at people's access to primary dental care, 22 million adults (50.2% of the population) saw an NHS dentist in the 24 months to 30 June 2019, which was approximately 100,000 fewer than in the 24 months to 30 June 2018. When we look at visits to a dentist by region, a higher percentage of adults and children in the North of England saw a dentist, with London having the lowest number of visits as a percentage of the population. In the GP Patient Survey 2019, London had the highest proportion of respondents who had never tried to get an NHS dental appointment and who relied on private dental care. Of those who had tried, respondents in the North East and Yorkshire region were most successful in getting an NHS dental appointment in the last two years, while those in the South West had the lowest success rate.⁷⁰

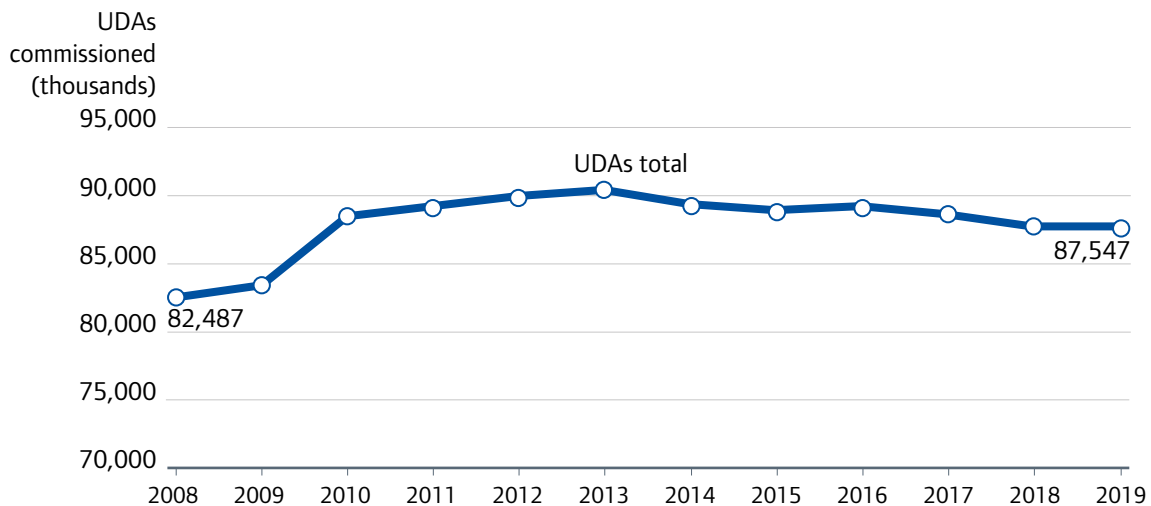
From our inspections, we have seen that increased demand for frontline NHS dental services led to challenges in accessing appointments, but private

patients did not experience the same barriers as NHS patients. We have also heard from inspectors that difficulty in accessing NHS dental care had resulted in patients increasingly relying on walk-in centres. Some inspectors have found several examples of dental providers handing back their NHS contracts to commissioners across England, and unless services are rapidly re-commissioned this will further affect access to NHS dental care.

NHS Digital publishes the number of units of dental activity (UDAs) that are commissioned from providers each year. As at 31 March 2019, 87.6 million UDAs were commissioned, to be provided from 1 April 2019 to 31 March 2020. This is slightly fewer than the previous year, and figure 2.26 shows that numbers have been falling slowly for the past six years.⁷¹

However, the population has continued to rise, which means that fewer UDAs are being commissioned per person, with 1.67 UDAs per person in 2012 falling to 1.56 per person in 2019. This potentially means that it is more difficult to access dental care.

Figure 2.26 **Units of dental activity commissioned September 2008, then March 2009 to March 2019**



Source: NHS England, dental commissioning statistics.

Good oral health is important for people's overall health and wellbeing. But for older people, poor oral health causes pain and difficulty with eating and taking medicine, and is linked to conditions such as malnutrition and aspiration pneumonia.⁷² Regular check-ups at a dental practice can prevent this, but accessing dental care in a care home presents difficulties.

Our report *Smiling matters* focused on oral hygiene for residents of care homes. We found that 17% of those we inspected said they never assessed people's oral health on admission and people were not always able to access routine NHS dental care. A number of the care homes visited had no way of accessing emergency dental treatment and no or limited access to out-of-hours services. Some care home managers said they had to call GPs, NHS 111, or even take the person to an emergency department. The report concludes that residents were not supported to maintain and improve their oral health and that integrating adult social care and health care as part of primary care networks would address this.

We have contributed evidence to the inquiry of the House of Commons Health and Social Care Committee into dentistry services, looking at how dentistry fits within NHS primary care services. The inquiry aims to find out whether the current arrangements create inequalities in access, how to improve access to NHS dentistry, and the opportunities from primary care networks.

Other primary care services

Access to primary care services in the criminal justice sector is variable and depends on a number of factors, some of which are outside the control of the registered provider. Although we have seen services that have been able to improve the quality of care, recruiting and retaining clinical staff is challenging, leading to shortages of staff, or inadequate skill-mix in some areas. This affects both patients' access to appointments and the quality of care. Where teams are fully recruited, or services use regular temporary staff, patients experience more consistent care and treatment.

Availability of suitable clinical space can also restrict patients' access to clinicians, particularly in some of the older establishments, and support from custodial staff is essential to enable healthcare providers

to deliver accessible services. Without this, the number of failed appointments is high, and patients generally receive poorer care.

Joint inspections have found that dental provision improved, but waiting times were still excessive, with some prisoners waiting up to six months for a routine appointment. In adult male prisons inspected, there was a lack of assessment and treatment for prisoners with mental health conditions, learning disabilities or emotional needs.⁷³

Although commissioning issues are outside our regulatory remit, our joint inspections with Her Majesty's Inspectorate of Prisons and Ofsted enable us to report on them. Where there is effective co-commissioning of services (a partnership between NHS England specialist health and justice commissioners, Public Health England and Her Majesty's Prisons and Probation Service, specifically the prison governor), it tends to lead to more effective support for healthcare activity from custodial staff and joint problem-solving – for example, improved supervision when administering medicines and help for patients to attend their appointments.

Appropriate access is not only about getting an appointment, but also about considering individual needs. Groups representing people who use services have told us that services are not always accessible, with barriers such as the physical environment, methods of communication, how information is presented, and the knowledge and skills of staff. We heard examples of a lack of wheelchair access to some primary care services, a person with autism experiencing sensory overload when waiting at GP surgeries, difficulties in communicating if English wasn't a first language, and a lack of flexibility in the length of appointments for people with multiple needs. If people do not feel involved, respected or supported by those providing primary care, there is a risk that they will stop engaging with services. This can affect people's self-esteem and lead to significant health issues and inequalities.

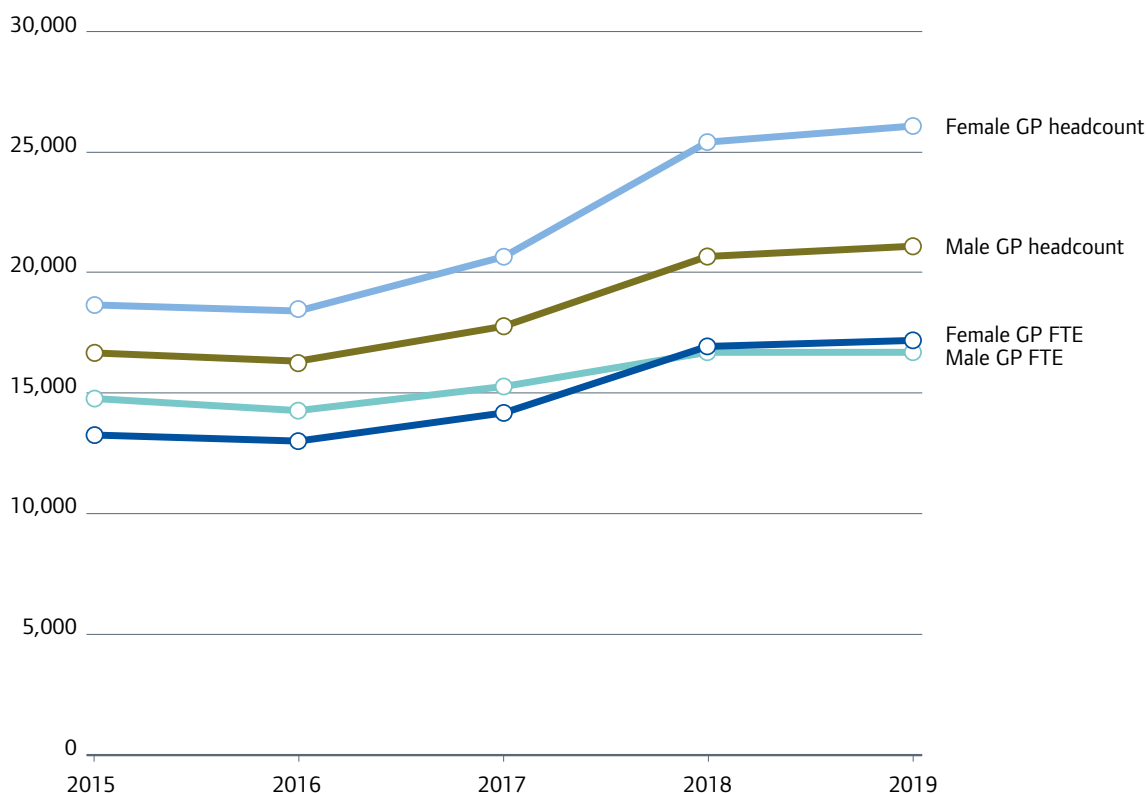
Workforce challenges

We know that a shortage of staff can be a key contributory factor to problems in accessing services and a lack of person-centred care. We have heard that people can feel they get restricted appointment times with GPs or they feel rushed in appointments. However, the majority of people (87% in the 2018 and 2019 GP Patient Surveys) remain satisfied with the amount of time for their appointment.

We have previously reported on shortages of GPs, with the numbers of full-time equivalent (FTE) GPs rising more slowly than the total number of GPs (the 'headcount'). This indicates that an increasing

number of GPs are working part-time. Latest data (figure 2.27) suggests that while these trends have continued, the pace of increase in both FTE and headcount has slowed since 2018. We have investigated whether the trend towards more part-time working reflects the increasing number of female GPs in the workforce. However, while the gap between FTE and headcount for female GPs is wider than that for male (suggesting more female GPs work part-time), over the last five years the size of the gap has widened faster for males than females, suggesting male GPs are also increasingly opting for part-time roles.

Figure 2.27 **GP headcount vs full-time equivalent (FTE) by gender, 2015 to 2019**



Source: NHS Digital: General Practice Workforce Statistics March 2019, practice level.

Our staff have reported that more older GPs are leaving the workforce or adjusting their working arrangements as they are approaching retirement age, and more younger GPs are seeking more flexible working patterns, such as working across multiple providers.

Across all regions in England more female GPs than males are working part-time, but the difference is most pronounced in the South East (Hampshire, Isle of Wight and Thames Valley), South West (South West South), South West (South West North) and East of England.

Our staff have also reported how local factors can shape workforce challenges. For example, how particular areas can struggle to attract or retain staff because of their perception of how urban or rural they are, their attractiveness to work in, and the amount of local demand.

The adoption of new workforce models and multidisciplinary team working in primary care has the potential to ease the workload of GPs. In the year to 31 May 2019, there were an estimated 307 million appointments, including with other health professionals as well as GPs.⁷⁴ Analysis of appointments held in May 2019 showed that 44% were with 'other practice staff'.

Some areas with a lower number of full-time equivalent GPs have been using innovative and efficient ways to enable access to services by offering more appointments with other practice staff. For example, Lincolnshire has some of the highest proportions of non-GP appointments and lowest numbers of GPs. In May 2019, four Lincolnshire CCGs with some very low numbers of FTE GPs per numbers of older people were in the top seven CCGs in the country for providing non-GP appointments.

Innovative working to improve access to care

Whitstable Medical Practice is a large GP practice with 40,200 patients, employing 176 staff (77 clinical and 99 non-clinical roles), and is rated as outstanding.

The practice works from three purpose-built medical centres and an additional branch surgery. It has been developing integrated care for 20 years, by continuously adding services that traditionally would have needed a visit to an acute hospital. Together with 15 other local practices, Whitstable Medical Practice secured funding to become Encompass, a multi-speciality community provider (MCP) Vanguard as part of NHS England's New Care Models programme.

To improve quality and integration, the practice developed a single electronic patient record, which stored all data for an individual patient in the same virtual space. This reduced duplication and effort, in turn improving the accuracy of the patient record across healthcare organisations using data sharing agreements. The technology was also used in the Rapid Home Visiting Service,

which was trialled as part of the Encompass Vanguard, and enabled paramedic practitioners to have read/write access to the patient's full GP record on a tablet. By responding to people quickly, interviews suggested that the majority of issues were completed in those visits. This has the potential to reduce unnecessary hospital attendances or admissions.

Patient satisfaction is improved with more convenient access to secondary care services in a GP setting. An example was offering cataract operations in conjunction with consultant ophthalmologists. This way, people were able to spend less time at the medical centre than they would have done in a hospital setting.

Although the vanguard scheme ended on 31 March 2018, the legacy organisation continues to maintain a number of the additional services, including the Rapid Paramedic Home Visiting Service and the community multidisciplinary teams, referred to as Community Hub Operating Centres (CHOCs).

Local services working together

Listening to groups that represent people who use services, we were told that people, their families and their carers were not always aware of what services were available to them. They lacked the support to navigate the health and social care 'system' when the different parts do not work together effectively. We have heard that people's health and social care needs were treated in isolation, without considering the whole picture. They can also feel that information was not effectively shared between services and that their care and treatment was not joined up.

These challenges can be felt hardest by those with multiple or complex health issues, and can be exacerbated at points of transition, such as being discharged from hospital and when moving between services. Representative groups have told us that carers and voluntary workers have had to fill in gaps in care, which is not sustainable as it has a physical and emotional effect on them.

Primary care services have been trying new, and sometimes innovative approaches to delivering care. Although it is still early days, we are beginning to see how working at a larger scale and in different ways can improve people's care and experiences.

For example, we have been seeing a growing number of primary care services working more collaboratively, in particular GP practices working more 'at scale' as part of a larger GP network or federation, as well as with community health and other services. Our early reflections from our work in this area are that there is great variation in how services are provided – in terms of organisational structure, maturity and objectives for working in this way. From working with a small number of GP providers in 2019, we saw there was the leadership capacity and capability to deliver high-quality care. One of the benefits of working at scale is the ability to learn in different environments and share this throughout the whole organisation to benefit patients.

In addition, primary care has continued to evolve through the development of primary care networks. As part of the NHS Long Term Plan, NHS England announced in July 2019 that around 7,000 GP practices across England – more than 99% – have come together to form more than 1,200 primary

care networks.⁷⁵ This involves practices working to support each other and deliver a wider range of specialist care services for patients from a range of skilled health professionals. Additional funding from the five-year GP Contract agreed at the end of January 2019 includes funding to recruit 20,000 more specialist healthcare staff to support general practices in multidisciplinary teams, including pharmacists, physiotherapists, paramedics, physician associates and social prescribing support workers.

While our staff have reported that this approach has potential for improved access by pooling resources, such as enabling patients to visit another practice in a GP network without having to re-register, or providing extended opening hours in a local area, they have cautioned that systems working is still an area of growth, and progress is not yet widespread across England. One important consideration will be how continuity of care may be affected by moving towards networks when people want to see their usual healthcare professional, and what providers need to do to ensure that they maintain the quality of care as services become more integrated.

In 2018/19, as in previous years, prescribing by non-medical prescribers increased, with prescribing by nurses increasing by 5% and pharmacist prescribing increasing by 55% over the previous year, although non-medical prescribing still only accounted for 4% of the 1.1 billion items prescribed in 2018/19.⁷⁶ We highlighted the value of involving pharmacists in our report *Medicines in health and adult social care*, as their contribution to medicines optimisation can improve both the quality and safety of people's care.⁷⁷ More involvement from community and clinical pharmacists across primary care networks can achieve better health outcomes for patients and the local population, and help to integrate primary care with the wider multidisciplinary healthcare team, particularly with clinical colleagues in community, mental health and hospital pharmacy.⁷⁸

The 2019 GP Patient Survey showed that 95% of respondents had "confidence and trust" in their family doctor as well as other general practice staff such as nurses and pharmacists.⁷⁹

More multidisciplinary working can also result in more flexible work arrangements for healthcare staff, which can help to address recruitment and retention problems.

For access to urgent care, there is a changing picture following the streamlining of urgent care services in line with the NHS Long Term Plan. The national mandate from NHS England called for integrated 24/7 urgent care access, combining three aspects of urgent care: call-handling, clinical assessment and treatment services. The resulting model of service delivery should shift from “access and refer” to “consult and complete”.

A key aspect of the new model is the development of integrated urgent care clinical assessment services

or integrated NHS 111 and out-of-hours services.⁸⁰ NHS 111 services employ clinicians, which enables people to receive clinical advice over the phone as well as options for where to get treatment. When asked about receiving care when their GP practice was closed, 91% of respondents in the 2019 GP Patient Survey said they had confidence and trust in the people they saw or spoke to.

Our inspectors are seeing examples of more efficient access to the right urgent care service where primary urgent care provides triaging services at the front door of an emergency department in an acute hospital. This can potentially reduce the waiting time for people, improve patient flow, and enable staff in emergency departments to focus on more urgent

Meeting local demand for urgent primary medical care

Medvivo is an independent provider of integrated urgent care rated as outstanding. Its services include NHS 111, GP out-of-hours and clinical assessment services, ‘Urgent Care @ Home’ health and social care crisis response service, and telecare monitoring.

To deliver a responsive integrated urgent care service, three CCGs in the Bath and North East Somerset, Swindon and Wiltshire Strategic Transformation Partnership (STP) combined and commissioned three core aspects of urgent care (NHS 111, clinical assessment and GP out-of-hours services) within a single contract, with Medvivo as the core contract holder.

Medvivo has developed several innovative ways to meet the rising demand for urgent primary medical care with limited clinical resources, and reduce pressure on hospital emergency departments. These include a rapid response service for health and social care crises, specific NHS 111 pathways for patients aged under five and over 80, trialling the use of different types of clinicians in the clinical assessment service (GP clinical navigators, prescribing pharmacists) and the use of the ‘Oysta’ device, which is a personal

alarm to support timely discharge of vulnerable patients.

The development of integrated urgent care has enabled more effective use of financial and workforce resource across the system due to an increased awareness of fluctuations in demand, and ability to share resources across organisations in the area.

Patient experiences of receiving urgent care have improved – particularly for the crisis response service, as the provider was able to provide an immediate response for health and social care crises without working out whose responsibility the patient was first. More information-sharing and awareness of local fluctuations in demand have also improved the flow of patients through the system.

Medvivo says of its approach, “As a provider... you need to work with other providers to make your systems more efficient and get the best out of that system, rather than effectively trying to protect your own boundaries and your own service... that can be very difficult; but actually, for the patient, that’s the best thing.”

cases. However, on occasions, inspectors have also seen professionals carry out tasks that are not within their competency, or without the appropriate training or support, putting patients at risk. For example, in a number of urgent care services (both those co-located with the emergency department and stand-alone services) severely unwell patients

were not being recognised and escalated for care soon enough. This happened because of a delay in the initial assessment of patients entering the department, or an incomplete initial assessment, by staff who did not have the appropriate competency, training or support to deal with these patients.

Harnessing developments in technology

The most significant change that we have seen through our regulatory work is the provision of online appointments alongside telephone appointments, as they can offer quick access to a consultation with a GP. This is not just limited to independent sector GPs: in May 2019, 0.5% of appointments with an NHS GP were delivered online nationally. At CCG level, this ranged from 0 to 5.9% (in Calderdale). Although this represents only a small proportion of all GP appointments, the fact that online appointments are starting to appear alongside traditional face-to-face appointments is a significant change and raises important considerations about how to make best use of them to benefit all patients.

Our staff have reported a growth in the use of digital health monitoring in GP practices, including using apps to measure blood pressure, blood sugar levels, weight, and heart rates. Technology such as health monitoring apps and online communities can help people to access health care and support, and make decisions about their own care. However, there are some challenges in understanding how this information should be used. Furthermore, technology isn't for everybody – individual patients have different needs and circumstances, particularly those with more complex needs who may need more personal interactions or people who prefer a more traditional service.

However, we know that adoption of technology is not consistent across primary care providers and improving information sharing is a recognised priority. For example, our staff had concerns that there is still a problem where clinicians are unable to access a person's medical records and history – with ineffective sharing between healthcare services in a local area, as well as between health and social care services.

There are also concerns in how independent sector providers are regulated where they are based outside of England. Where patients receive prescriptions through an online provider, we have some concerns around those that are not registered and regulated appropriately. We have responded to NHS England's Digital First Primary Care Policy consultation on patient registration, funding and contracting rules for GP appointments.⁸¹



Part 2: Equality in health and social care



In this chapter, we look at how the quality of care varies between people in different ‘equality groups’. By this, we mean people who have different characteristics protected by the Equality Act 2010, such as disability, sex, ethnicity, age,

religion or belief, sexual orientation, gender identity or pregnancy and maternity status. This chapter, alongside our Annual Report, enables us to fulfil our legal duties to report on equality issues.

Key equality issues in health and social care

- People in equality groups can face greater barriers to accessing good health and social care services. They can experience difficulties because the pathways and models of care for people in some equality groups, such as people with a learning disability or autism, are not working well.
- Geographical variation in the quality of care and overall pressure on services can also have a greater impact on people in some equality groups, such as older people.
- Through our inspections, we have observed little overall change in equality of experience in services. Although there is progress in implementing the Accessible Information Standard, sharing people’s information access requirements between services is a major challenge.
- Tech-enabled care has the potential to improve equality, for example by providing accessible communication for specific groups of people. However, it also has the potential to increase inequality, for example by replacing human contact with technology.
- While there is more attention to workforce inequality issues in health and social care, there has been little change yet in measures of equality for the workforce.

A personal experience of access to health and social care services

Aluna is from Tanzania but now lives in Sheffield. In the last year, she has accessed GP and hospital services for a number of health conditions.

Aluna initially saw male doctors and was not comfortable discussing her health problems with them, because of their “old school” approach. She did not feel that they listened to her. After a friend suggested that she could request to see a female doctor, Aluna now feels much more comfortable going to the doctor. She now feels listened to and understood. “The doctor is very good, she listens to me and even if I go over the time, she doesn’t rush me.”

Aluna feels lucky that she can speak and read English, is proficient in using a computer and has good “knowledge of the system”. However, she feels that language and culture can still be a barrier to accessing services for people in some communities. She would like to see more information about courses on how to navigate the system, as well as information on services in other languages to help the people in her community whose main languages are Arabic, Somali and Kurdish.

We have changed names to protect privacy.

Access to care

In last year's State of Care, we expressed concerns about how access to good quality care is not equal for all types of services, or all groups of people. This year, the national picture remains the same, as a lack of access to care is still a major barrier in achieving equality.

We know from our staff and organisations representing people who use services that some groups, especially those with disadvantages such as multiple care needs, can face greater challenges accessing the care and treatment they need. For example, recently published research and the GP patient survey shows that Gypsies, Roma and Travellers may still face barriers to registering with a GP practice or making an appointment^{82, 83}, and asylum seekers may also face barriers to registering, which has a particular impact on those who are pregnant or disabled.⁸⁴ This is despite NHS guidance for general practice that should enable both groups to register. GP practices are an important gateway into community-based healthcare services. In our local system reviews, we also found older people in some minority groups struggling to access community health and social care services.

Inequalities in access are caused by different factors:

Geographical variation in pressure on services.

This might affect some equality groups more than others depending on where they live, as well as the likelihood of them using services (for example, older people using NHS services). As shown in the chapter on primary medical services, based on the numbers of older people in clinical commissioning group areas, there appears to be a shortage of GPs in eastern parts of the country. In some of these areas, a higher than average proportion of appointments are with nurses or other practice staff, suggesting that where there are fewer GPs, some practices are addressing this by using efficient and innovative alternatives to ensure that people can still access care.

Geographical variation may also affect whether people in some groups can access good or outstanding services. For example, people in lower socio-economic groups are more likely to live in regions where a higher proportion of care homes are rated as inadequate or requires improvement.

The London region has the highest proportion of people from Black and minority ethnic (BME) groups in the country (40%), and also has the highest proportion of GP services and home care agencies rated as inadequate or requires improvement.

Some people in equality groups may have their needs overlooked or not met when they try to access health and social care services.

For example, our staff have observed that culture and language can become barriers to accessing care across all sectors. There are also recent concerns about specific access barriers for Gypsies, Roma and Travellers⁸⁵, refugees⁸⁶, asylum seekers⁸⁷, transgender people⁸⁸ and deaf people⁸⁹. For example, through our inspections we heard about the experience of a person who was profoundly deaf and needed nursing care. They had been placed in a care home based on their physical needs, but none of the staff was trained in British Sign Language. This meant that the person was unable to communicate, which left them feeling disempowered and extremely isolated. The feeling of isolation worked both ways, as the inability to communicate also affected staff.

Overall demand and pressure on services can have a negative impact on their ability to develop new ways to address barriers to access.

Our staff have observed that when demand is high, services may not be able to prioritise developing new ways to address the barriers to access. But GP and hospital services are working in a variety of ways to improve access for the different communities they serve. Having good leadership and culture, and reaching out to local communities, are key drivers of success.

Across England, the specialised health and social care pathways to support some groups of people are not working well.

This means that some equality groups cannot access good quality services that meet their needs. For example, the current 'system of care' for people with a learning disability and/or autism, which incorporates national bodies, providers and commissioners, has failed people whose care pathway has ended with them being segregated in a hospital. The system is not fit for purpose – as highlighted in our interim report on restraint, segregation and seclusion.⁹⁰

The role of the Accessible Information Standard in improving care

A consistent approach to meeting the information and communication support needs of people with a learning disability helps to ensure that they have improved outcomes and experiences, and receive safer and more personalised care and services.⁹³ The mandatory Accessible Information Standard (AIS) can help NHS trusts to meet the information and communication needs of disabled people.⁹⁴

We look at performance against the AIS on our inspections. To help us learn about both good practice and the challenges for trusts around implementing the AIS, we used our monitoring information and suggestions from NHS England to choose four non-specialist acute and mental health NHS trusts to interview: Dorset Healthcare University NHS Foundation Trust; Leeds and York Partnership NHS Foundation Trust; Salford Royal NHS Foundation Trust and The Pennine Acute Hospitals NHS Trust (these two trusts together forming the Northern Care Alliance NHS Group).

Adopting a trust-wide approach to the AIS.

Dorset Healthcare University NHS Foundation Trust took a trust-wide approach to the AIS by reviewing how it recorded, shared and highlighted people's information and communication needs. The ability to influence a new regional care record helped the trust to create a joined-up approach to accessible information and communication across services and with other providers, such as GPs.

With people in dedicated roles leading the work, the trust focused on culture change and learning about the AIS, engaging with staff about the benefits of the AIS to the quality of care. Staff received training to deliver the five steps of the standard, which included training delivered by a member of staff with autism. The trust also worked closely with people who use services and local organisations such as Healthwatch, People First Dorset and Bournemouth People First. It used feedback from staff and people who use services to continuously improve.

Leeds and York Partnership NHS Foundation Trust invested in a dedicated information design service for people with a learning disability. The service engaged extensively with people using its services to develop a free easy read image bank.⁹⁵ This aimed to improve people's access to care, and their experiences of it, by providing accessible information.

The trust's Health Facilitation Team works with primary care, social care and the acute trust, helping them to engage with people who have a learning disability. Part of this work has focused on supporting GPs to improve how they identify patients with a learning disability and flag this on their system. Another focus has been to improve the uptake of annual health checks and screening through the "Get checked out" website, which provides tools and resources in an accessible format for people with a learning disability and for professionals.⁹⁶

The Northern Care Alliance NHS Group developed a communication passport that patients and their carers could carry, which describes the most effective way to communicate with them. Bringing this information together in an easy-to-follow format helps health and social care organisations to record and meet a person's communication and information needs in the right way. People with a learning disability and/or autism have an additional passport that also specifies their reasonable adjustments around communication. The trusts regularly assess how people's information and communication needs are being met, and new staff are trained to use the passport and put the five steps of the Accessible Information Standard into action. The passport and related training have been rolled out to other organisations.

All trusts emphasised the need for a supportive and engaged leadership, working in partnership, and creating the positive culture in services that makes the AIS a part of a trust's day-to-day work.

Challenges. The trusts told us about the challenges they have faced in putting the AIS into practice. Although people with a learning disability use both health and social care services, information-sharing systems differ and do not ‘talk to each other’. This can mean that services rely on manual handovers when sharing information about people’s information and communication needs. The Northern Care Alliance Group developed shared codes for communication needs across areas and systems to help address this problem.

Embedding the five steps of the AIS into the routine work of all hospital departments, rather than purely the remit of learning disability services, remains a challenge. The trusts said they want to make sure that all staff take responsibility for recording and communicating people’s needs themselves, and not rely on others.

The Northern Care Alliance NHS Group also said that staff turnover is a challenge in maintaining momentum and knowledge of the AIS.

Learning Disability Improvement Standards for NHS trusts

In 2018, NHS Improvement asked all NHS trusts to share information about their compliance with the Learning Disability Improvement Standards.⁹⁷ Over 90% of England’s NHS acute, mental health and learning disability trusts took part (213 organisations), and the views of families and carers were included.⁹⁸

- 90% of trusts that answered the question said they offered accessible information about their services (166 of 184 trusts)
- 59% of trusts that answered the question said they offered accessible appointment letters (104 of 177 trusts)
- 33% of people who responded to the question said they were given easy to read information on how to make a complaint (207 of 634 people who used services from 119 trusts).⁹⁹

In *Beyond Barriers*, our 2018 report on our local system reviews for older people, we highlighted some examples of health and care organisations working well together – but there was still sometimes a disconnect between those plans and the funding to support them. There were also instances where information sharing needed to improve, which had an impact on older people.⁹¹

Overall experience of accessing care

Our analysis of people’s experiences of care has found that some people with mental health needs appeared to have difficulties when they needed to access acute hospital, primary medical or mental health services, because they did not feel that the appropriate services (such as crisis, community and child and adolescent mental health services) were available. Some people felt that services were not responding to their concerns and that staff lacked compassion and care. People with mental health needs and people with a learning disability are also the groups that most commonly report poorer experiences of care in patient surveys.

Without adequate access, it appears that some people had lost trust in these services and felt forced to turn elsewhere for support, such as emergency departments (A&E) and voluntary sector organisations. We have no evidence that there has been improved access or outcomes for children and young people since our 2018 report *Are we listening?*⁹²

Groups representing people who use services have told us that challenges in accessing services for those in specific equality groups, their families and their carers can lead to poorer outcomes. Delays in accessing services, or a lack of services, can mean that people’s conditions get worse, they reach crisis point before they get access, or they end up in inappropriate parts of the system. There can also be an impact on people’s emotional and social wellbeing, where people can become isolated, experience distress and loneliness, and develop mental health conditions.

Local services working together

Our inspection teams have observed little evidence of widespread change in meeting the needs of equality groups as a result of local services working together. Some areas need to pay more attention to equality and improving outcomes for groups who are less well-served, including what is needed to deliver more equal outcomes in line with the NHS Long Term Plan.¹⁰⁰

Nevertheless, we have seen some good examples where collaboration has helped to drive equality. LGBT Foundation offers a quality assurance and social prescribing programme called Pride in Practice. This service is designed to support primary care

services in meeting the needs of their lesbian, gay, bisexual and transgender (LGBT) patients. It includes access to training, assessment and an accreditation award (bronze, silver or gold) showing a service's commitment to providing inclusive, patient-centred care. The programme has received positive feedback from LGBT people and 100% of participating health professionals can show evidence of changes made within their practice to better support the needs of LGBT patients. Pride in Practice is funded for primary care services in Greater Manchester and has received funding from the Government Equalities Office to pilot the programme in selected clinical commissioning groups across England.

Equality of experience

Once people in equality groups have accessed care, we know that their experience of it may not always be inclusive and person-centred. We have found that people do not always feel services are for them, because they feel that their specific needs are not always suitably identified, understood, supported and valued.

In both the NHS acute inpatient survey and community mental health survey published this

year, younger people were again less likely to say that they had a good overall experience of care. As in previous years, people with a mental health condition or dementia were also less likely to say that acute inpatient services communicated well with them or had respect for their values, preferences and needs. However, there were very few statistically significant differences by ethnicity, gender or sexual orientation in these surveys, and in the maternity survey there were no differences on any equality

Providing person-centred and accessible care

Moston Grange care home in Manchester has completely transformed the culture and ethos of the service following initiatives introduced by its registered manager and appointing a resident involvement worker. An inspector told us, "They have embedded a human rights approach to how they deliver their services. The resident involvement worker's key priority is to meet with residents, find out about their life story, their background, their personal interests, who is important to them in their life, what things inspire and motivate them, and what they want to achieve in future. All of that is pulled together in one cohesive assessment tool. Their findings are shared with the wider team, so it becomes

everybody's business, not just the nurse or the support worker. It provides a foundation for them."

The resident involvement lead worked with the occupational therapist and activities coordinators to gain a deeper understanding of the people who used the service. This joined-up, holistic approach meant that staff considered the unique characteristics of all residents, including those people in specific equality groups. For example, through the home's links with Age UK, residents could get support to attend 'Out in the City', a social group for older lesbian, gay, bisexual and transgender people.

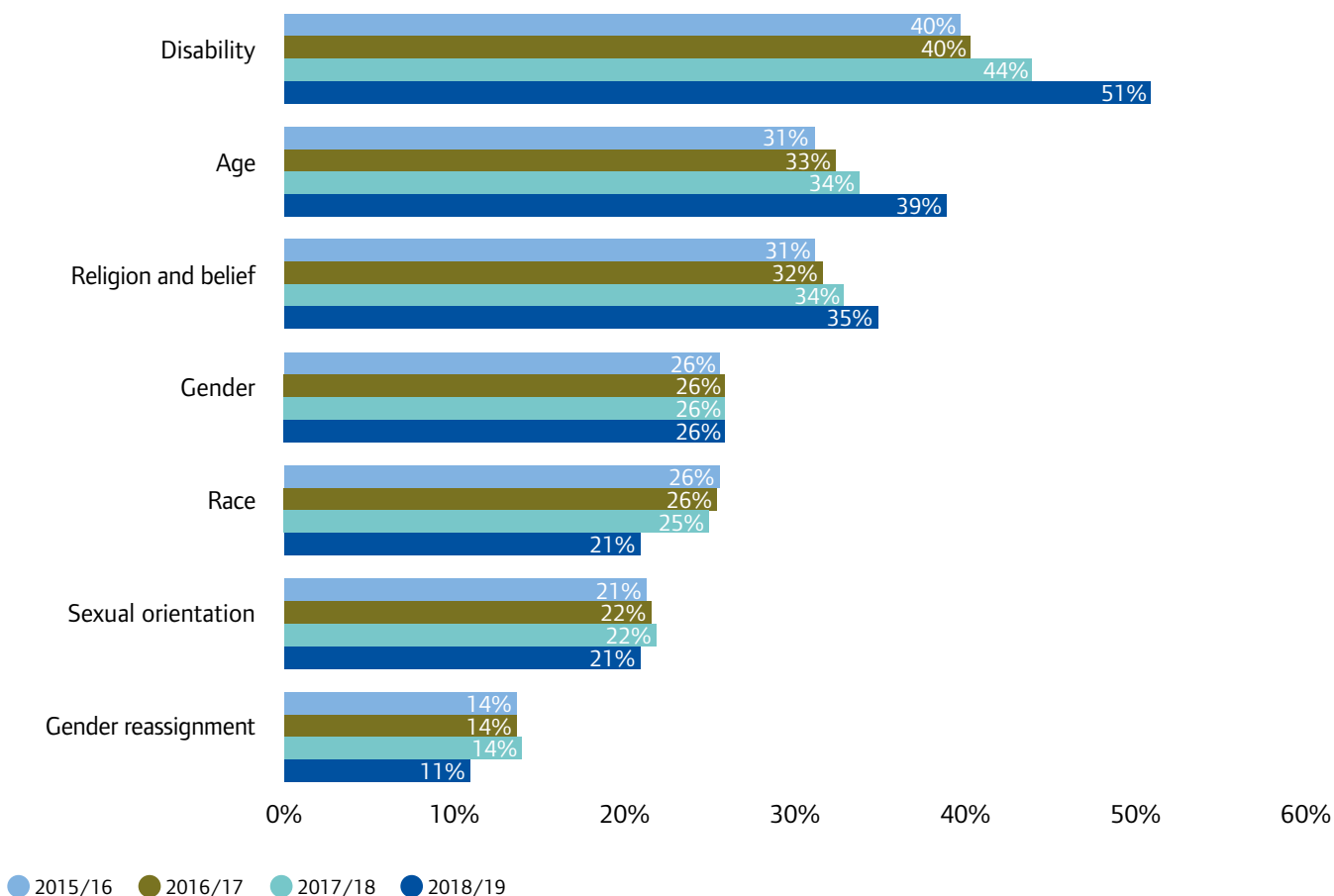
characteristic.¹⁰¹ The 2019 GP patient survey showed similar patterns to the previous year, except for an improvement in the overall experience of people with a developmental disability, such as autism or ADHD, and a deterioration in the experience of people who are blind or partially sighted.¹⁰²

Surveys only tell part of the story because people's individual experiences may still vary. For example, we have heard of examples of lesbian, gay, bisexual and transgender people not feeling listened to, and services making incorrect assumptions about a person's sexual orientation or gender. Through our analysis of people's experiences of care, we have also found that some people felt that their intrinsic knowledge of their health and quality of life was being dismissed. This sentiment was expressed differently across different types of health and care services, such as failures to provide good personal care in adult social care services, or for people's desires for occupational therapies in mental health services being ignored, despite this being of utmost importance for those receiving care in these environments.

Person-centred care is the basis of providing good care. But it can only be effective for some people if specific attention is paid to equality issues, so that staff in the service are "confident with difference" and so that any barriers to equality at a service level, rather than an individual level, can be addressed.¹⁰³

A smaller percentage of adult social care services this year told us that they have carried out work to address inequalities around sexual orientation, gender reassignment and race than in previous years. However, the percentage of services saying that they have worked to address disability equality has improved from 44% to 51% and the proportion of services addressing age equality and religion and belief has also improved (figure 2.28).

Figure 2.28 **Equalities work by adult social care providers to meet the needs of people with equality characteristics, 2015/16 to 2018/19**



Percentage of responding organisations who had done work in this area in the previous 12 months

Source: CQC provider information returns.

Using technology to reduce inequality and promote people’s rights

Our staff have observed that some providers are using tech-enabled care to help reduce inequality. In particular, we have seen technology used to make care more person-centred, for example to remove communication barriers for individual disabled people. However, wider communities – including people with English as an additional language – need to be better supported with tech-enabled care options, including supporting equipment that could increase access and engagement (for example, online translation tools that can help access online booking systems for GP services).

The potential for using technology to reduce healthcare inequalities is considerable. Organisations that represent people who use services have shared

with us examples of apps, tablets and online communities, and assistive technology having a positive impact on individual people and specific groups. For example, Carers UK highlighted the advantage of having digital resources for carers, which they could use to fit around their caring responsibilities.

Rethink Mental Illness also told us about how tech-enabled care has the potential to help people with mental health issues. For example, apps are currently being developed that look at physical and mental health issues simultaneously. They also told us about the benefits of online treatments in psychological therapies to support access to care and treatment in the home.

In Healthwatch Enfield's report, *Using technology to ease the burden on primary care*, research showed that 63% of patients would use video calling and/or email to contact their GP to seek medical help.¹⁰⁴ The report highlights how this kind of support is an opportunity to deliver primary care services in a new way to ease the burden on them. However, it also highlights the need to make sure that introducing new technological solutions does not widen the health inequality gap, by making access easier only for those who can afford the right equipment or who are computer literate. It is important to make sure that certain groups, such as older people or people

Workforce inequality

Inequality among the workforce can prevent providers from making the most of their staff. Our inspectors have reported that awareness of workforce equality issues seems to have increased among providers of health and care services. However, despite increased attention to this, there has been little change in outcome measures.

We have analysed data on ethnicity, gender and pay published by NHS Digital (figure 2.29). This shows that women across all ethnic groups except 'other' are earning less in total each month than the national monthly average for NHS staff of £2,610.

The gap for women in the 'mixed/multiple ethnic' group is 8% or £201, followed by 5% (or £141) for women in the 'Black/African/Caribbean/Black British' group. Reflecting the gender pay gap, men in the categories of 'other ethnic group', 'unknown' and 'White' earn more in total than the average (10% or £252 for 'unknown'). Male Black/African/Caribbean/Black British employees earn 5% (£127) less.

The Workforce Race Equality Standard (WRES) was created to reduce inequality between staff from BME groups and white staff working in the NHS and NHS-funded independent health care. In NHS trusts, having a set of standards to follow seems to have raised awareness of workforce equality. However, change is slow. Staff from BME groups are still very under-represented in senior or executive roles. In 2018, 19.1% of the workforce in NHS trusts were from a BME background, yet only 6.9% of very senior managers were from a

with a learning disability, are not excluded from the roll-out of digital solutions and tech-enabled care. It is important for providers to take individual differences into account and involve the people who use their services in designing any systems.

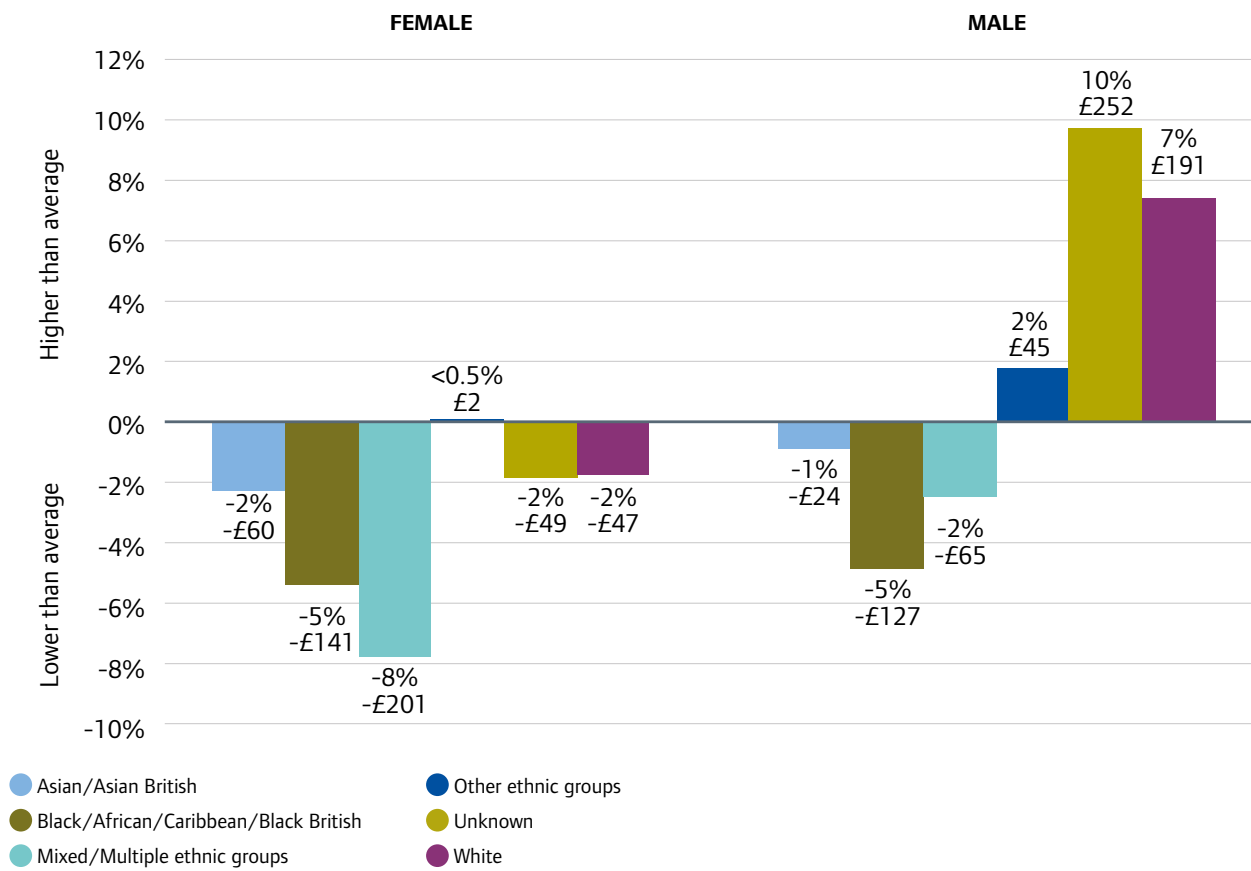
Our staff have shared concerns around issues of confidentiality, governance, and enabling access, as well as being mindful about losing the human element of care. Organisations representing people who use services have also expressed caution about the potential risks of technology, and stressed that it should not be a replacement for human support.

BME background, though this rose from 5.7% the previous year. Percentages of staff from BME groups who experience bullying, harassment or discrimination have changed little in three years and the percentage of staff from BME groups who believe that there are equal opportunities for career progression was slightly lower in 2018 than in 2017 or 2016.¹⁰⁵

We have found a mixed picture of progress with WRES in the NHS trusts that we inspected in 2018/19 – in trusts of all ratings, there is both emerging good practice and areas that still need to improve.

While we are seeing increasing awareness of workforce equality issues, on inspection, our staff have seen that some providers need to do more. Where we see examples of good and outstanding practice, it is often down to individual managers and providers who promote inclusion and workforce equality as part of the working culture.

Figure 2.29 Percentage pay gap in mean total monthly earnings compared with national average (£2,610), by gender and ethnic group, January 2018



Source: NHS Digital, NHS staff earnings estimates, January 2018

Effective implementation of WRES

Northamptonshire Healthcare NHS Foundation Trust provides services to people of all ages, including mental health, learning disability, community health and prison health services. The trust serves a population of 733,000 and employs more than 5,000 staff to deliver care and treatment.

When we inspected in June 2018, we found that the trust had improved on several WRES indicators, compared with previous years. There was an established, accessible BME network that supported both staff and patients. As part of the action plan, the trust had implemented a reverse mentoring scheme, involving junior members of staff exchanging their skills, knowledge and understanding with more senior staff, as well as staff focus groups.

Three key areas were important to the effective implementation of WRES:

- Co-production allowed the provider to understand and address the real issues, as well as improve trust between staff and the senior leadership.
- Leadership from the chief executive officer enabled the initial change with the equality steering group, but ongoing scrutiny of future action plans from senior leaders was also important.
- The right culture provided the 'building blocks' to improve the workforce experience which, in turn, improves experience and outcomes for patients.

The trust's approach to improving the working experience for all staff, including people from BME groups, led to many positive outcomes:

- An improved recruitment process and feedback system was supported by career development workshops to equip staff with the skills to plan their career.
- Staff were supported to work on national programmes, such as the WRES experts programme, to gain new perspectives on improvements.
- The trust used the WRES approach as a template to support staff with other protected equality characteristics, and planned to work with external partners to further improve workforce experience.
- Patients benefited from the 'moving ahead' project, which aimed to understand challenges faced by the local community and how to collaboratively address them.
- Experiences and outcomes for patients improved through a more engaged workforce.

Staff at the trust recognise that their journey to improvement is an ongoing one. One member of staff said, "What's really important for us is that we're not comfortable with where we are... Yes, we have made improvements, yes, we have started to improve the experience; but we're not finished yet; there's still a lot of work to do to get some equality coming through to the experiences of all colleagues with protected characteristics."



Part 2: The Deprivation of Liberty Safeguards



Use of the Deprivation of Liberty Safeguards in 2018/19

- Local authorities continue to deal with high volumes of applications under the Deprivation of Liberty Safeguards (DoLS), often with limited resources. This can lead to people waiting too long, and risks infringing their human rights.
- The gap between the number of applications received and those completed narrowed between 2014/15 and 2017/18. We have seen that good communication and partnership working between local authorities and providers can support the implementation of the DoLS process.
- Lack of understanding and confusion around the DoLS legislation remains one of the primary reasons for poor practice among providers. While we have seen some evidence of increasing awareness through our inspections, progress has not been good enough.
- Involving a Relevant Person's Representative and consulting friends, families and carers in the DoLS process can be key to making sure the person's human rights and needs are kept at the forefront. However, we have heard that the process can be confusing and families can experience a lack of information. Involving these groups will be even more important as the Liberty Protection Safeguards come into force in October 2020 and care provided in people's own homes comes into scope.
- Clear and committed leadership and culture around DoLS and the Mental Capacity Act, alongside in-depth and practical training, can help staff to engage better with the legislation. Training and culture will play an important part in providers preparing their staff for the new Liberty Protection Safeguards legislation.

Introduction and context

The Deprivation of Liberty Safeguards (DoLS) legislation is in place to protect people in care homes and hospitals (including hospices) who may need to be deprived of their liberty. The safeguards help to ensure that the correct process is used to protect their human rights and provide necessary care and treatment.

Together with the Mental Capacity Act 2005 (MCA), the safeguards help to ensure that people are protected while being supported to make decisions for themselves where they have the capacity to do so. Decisions made for a person should always use the best interests decision-making processes, considering the least restrictive option, and carefully balance respect for the person's wishes and feelings with the need to keep them safe. The process also gives the person or their family the right to challenge a DoLS authorisation in the Court of Protection.

Since being introduced in 2009, the safeguards have received criticism, with care providers experiencing

challenges around understanding the legislation, its scope and exactly how to apply it.

The large number of DoLS applications remains a continued pressure on local authorities. In 2017/18, more DoLS applications were received (227,400) than completed (181,175). Figures for 2018/19 will be available in November 2019. At 31 March 2018, of the applications that were not completed, 39% had been waiting for more than a year. This is higher than 2017, when 28% of incomplete applications were more than a year old, so it will be important to monitor whether this has improved in 2018/19.¹⁰⁶ The delays mean that providers are not always in a position to use all the legislation, which risks people being restricted without lawful authority or left without the protection of the safeguards.

However, a desire to improve the situation has resulted in legal reform. The Liberty Protection Safeguards (LPS) were brought into law through the Mental Capacity Amendment Act 2019, and will replace DoLS from October 2020.¹⁰⁷ The LPS are

The Liberty Protection Safeguards: What are the key changes?

The Liberty Protection Safeguards (LPS) will bring in several changes for the health and care system. They will:

- apply to people aged 16 and 17 for the first time
- extend to services not currently covered by DoLS, such as domiciliary care and supported living services
- enable the first authorisation to last up to a year, be renewed for up to a year after that, and then up to three years after that
- introduce the new role of Approved Mental Capacity Professional (AMCP)
- make clinical commissioning groups (CCGs) and NHS hospital trusts responsible bodies as well as local authorities, which will also enable NHS hospitals to authorise an LPS for their patients (independent hospitals will still need to apply to a local authority)
- enable care home managers to have a role in coordinating the assessment process if agreed by the local authority or CCG, although they will not be able to authorise an LPS, as this remains with the responsible body
- halve the number of assessments that are currently required under the DoLS system and introduce a new role called the 'appropriate person'.

intended to provide a simpler process that will better support the safeguards that people need.

Until the new legislation comes into force, it is important that health and care providers continue to focus on protecting people within the current DoLS

framework and learn from best practice. The LPS will not change the fundamental principle of keeping people's needs and their human rights at the heart of each decision to deprive them of their liberty, and the importance of involving family and carers in the process.

Key issues

In 2018/19, as in previous years, we have continued to find that DoLS practice is varied across different types of health and care services. Practice can also vary within services, such as hospital trusts.

The main factors that can affect the implementation of DoLS have also remained similar to the previous year:

- level of understanding of the DoLS legislation and how it affects people
- availability and effectiveness of staff training
- numbers of staff, pressures and time available
- involvement of family and carers in the DoLS process
- partnership working between local authorities and providers.

Understanding of the legislation

We know that there can be confusion over the DoLS legislation and a lack of understanding about how to implement it. Although our inspectors have reported seeing evidence on inspection that awareness may have improved, the level of understanding has remained concerning and we have found that it can result in poor practice.

We have continued to see providers that do not understand the wider legal principles of the MCA, those who submit DoLS applications without first carrying out the appropriate assessments, and a lack of understanding around presumed capacity. We have also seen providers that are not always focused on what they could do differently to support a person, understand their capacity, and potentially prevent the need to apply in the first place.

We have also found confusion around which piece of legislation to use, such as when the Mental Health Act should be applied and when it should be the MCA and DoLS.

Our inspection staff have reported that the quality of leadership around DoLS and the MCA, and the organisational culture, can set the tone for how frontline staff approach the safeguards. We have encountered senior managers who do not understand the legislation and providers who see DoLS as procedural or 'box-ticking', with little thought given to how the legislation could be used to properly protect people. We have sometimes found care plans that lack any reference to a DoLS application, with relevant information kept separately – further separating the process from the person, and contributing to a lack of understanding.

Staff training

Although our staff have reported seeing evidence on inspections of providers training their staff on DoLS, actually embedding training into practice can be a sticking point. We have found that, in some cases, training is not equipping staff with the practical skills they need to properly apply the legislation. We have particular concerns about the quality of training completed online.

On inspection, we have seen examples of providers making assumptions about the level of understanding of DoLS among their staff, and failing to support them to embed their learning.

However, while we continue to have concerns about the general quality and effectiveness of training, we have seen examples of providers prioritising face-to-face, in-depth learning.

Workforce capacity

Staffing levels, and therefore having enough time, can have an impact on DoLS and MCA practice.

In both hospital and adult social care services, where frontline staff have busy workloads and face pressure to get things done, our inspection staff have reported that this can affect the time they have to fully consider or prioritise DoLS. A high staff turnover and regular use of agency staff can also affect practice, as awareness of who has a DoLS authorisation in place, and what that means for them individually, may not be as strong.

Positive Behaviour Support

We inspected a care home run by a large corporate provider. The home had improved its practice in the MCA and DoLS by employing fully trained PBS practitioners. Positive Behaviour Support (PBS) is a person-centred approach that looks at the whole person to support those who have behaviours that lead to staff using restraint. It considers ways to meet people's needs through teaching new skills, creating supportive environments, and trying to reduce

restriction where possible. It can help reduce the need to deprive a person of their liberty in the first place. Because of the PBS training, staff at the care home had a much better understanding of applying the safeguards (or not needing to apply them in practice), they could understand how and when to reduce restriction, and were better able to see each person as an individual and consider if an application for a DoLS was even necessary.

Family and carer involvement in the DoLS process

Involving a Relevant Person's Representative and consulting families, friends and carers in the DoLS process can be central to making sure that decisions made about a person are timely, supportive and meet their individual needs and preferences. We have seen some good practice, such as providers supporting family members by linking them with advocacy services and others liaising with them about their relative's care.

We spoke to three people who had experienced a relative being deprived of their liberty and who were also the Relevant Person's Representative (RPR). An RPR can be a family member, friend or carer, and every person with a DoLS in place must have one.

They all agreed that communication with families and carers could and should be improved so that they can be fully involved, understand their rights and know how they can provide support and challenge.

All three spoke of the initial confusion around the DoLS application and assessment process, and a lack of clear, advance communication. However, they explained that once they understood their role as an RPR, they felt supported and had gained the confidence to speak up for the rights of their relative. They all also spoke positively about the safeguards and how they had helped their family member to still have freedom, while being kept safe.

Rachel's story: DoLS protection after moving from child to adult services

Rachel's daughter, Caroline, has profound multiple learning disabilities and lives with a life-threatening medical condition. As a result of this, Caroline lacks capacity and is unable to make her own decisions. When Caroline turned 15, she left home and transitioned to a full-time residential school.

Caroline has been subject to several DoLS authorisations in the last three years. The first application was made when she was 18 years old, and at the point of transition from children's to adult services.

Because of issues with the transition process and the quality of care that her daughter was receiving at that time, Rachel sought legal support. The lawyer explained the DoLS process to her and identified that a DoLS application had not been made for Caroline.

Once the application was made, the assessment process was completed quickly. Rachel was very positive about how thorough the DoLS assessments have been and she has been able to contribute her views.

Rachel is happy to be Caroline's RPR. She feels confident to raise concerns and, if necessary, challenge Caroline's care and safety, as part of the role.

"The DoLS protects her, it's a legislation, a law. And actually, what it does, once you really get to know it a bit, is it gives me, as her representative, quite a bit of authority to keep checking on her, keep making sure that standards are high, that she's being well looked after, you know, to request reviews, to let them know that I know about DoLS and how it works. So there's quite a bit of clout behind having a DoLS and the best interest decisions must always include me."

Rachel feels that more needs to be done to ensure that families know their rights when their child is moving into adult services.

We have changed names to protect privacy.

Harry's story: Improved communication leading to better involvement

Harry cared for his wife at home for many years after she developed vascular dementia. Her condition worsened over time and she eventually went to live in a nursing home in 2016.

"I got a letter out of the blue, to say that the staff had applied [for a DoLS authorisation] without my knowledge ... although they said in the letter, 'As you are aware' ... I wasn't aware at all; I was quite taken aback."

Harry was upset that he was not involved in the decision-making process. "I assumed that other

people were taking over... which I was quite perturbed about really, although I must admit, I agreed with everything that had been said."

He went to speak to the nursing home manager to get a better understanding of DoLS and agreed that it was appropriate. After that, things got much better. He became fully involved in the assessment process and became his wife's RPR.

"I was happy to realise that I was able to influence the staff, but I didn't need to influence them very much because I thought they were quite good."

Eleanor's story: Standing up for the right to quality of life

Eleanor's mother moved to a care home after suffering a stroke, which then led to dementia. She was subject to four DoLS authorisations while living at the care home.

The first time the home applied for a DoLS authorisation, Eleanor met with an assessor who explained the conditions of the DoLS authorisation. Eleanor was happy to hear that these would make a positive difference to her mum's life.

"The assessor suggested that mum might be less challenging if she could go out and be more stimulated to do activities. This is right; it's what I always wanted for mum... She is a very sociable person."

Eleanor felt that the conditions in the DoLS authorisation made a "tremendous difference" to her mum's wellbeing and quality of life.

"...When I came to take her out – which I did two to three times a week – her face would light up, and she related very well to the activity organiser who did lots of activities with her."

However, Eleanor always needed to take the initiative and stand up for her mother's rights. After several years, she received the support of an advocate who helped Eleanor to understand the RPR role better and how to communicate with the care home on her mother's behalf.

Eleanor felt strongly that relatives and carers should be involved at all stages of the DoLS process and that communications could be improved to enable this.

We have changed names to protect privacy.

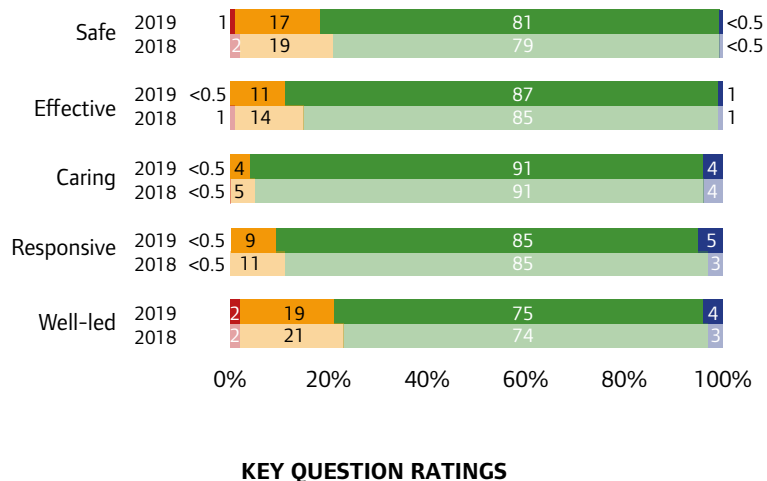
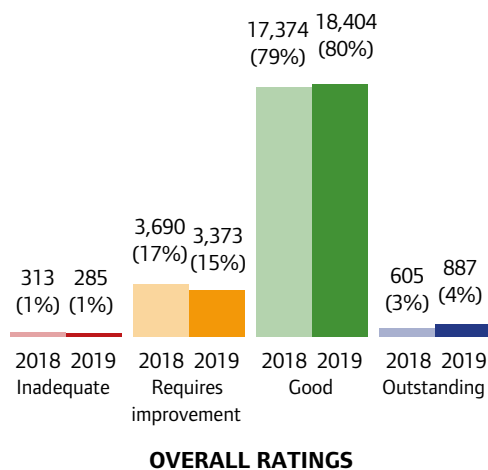
Partnership working with local authorities

We have seen that good partnership working between local authorities and providers can support the implementation of the DoLS process. However, our inspection staff have reported that good practice is not widespread, with barriers including stretched resources at local authority level, and limited capacity and/or understanding within providers to follow up on the progress of an application. Where we have found examples of good practice, there has been a tendency for this approach to be driven by individual leadership within services or local authorities.

But there are some examples of good communication about the status of applications between providers and local authority DoLS teams, and support for providers once an application has been authorised, for example checking that conditions are being met. We have also seen a local authority and clinical commissioning group hold quarterly meetings with providers to support understanding of DoLS and to share good practice.

Appendix: Overall sector ratings

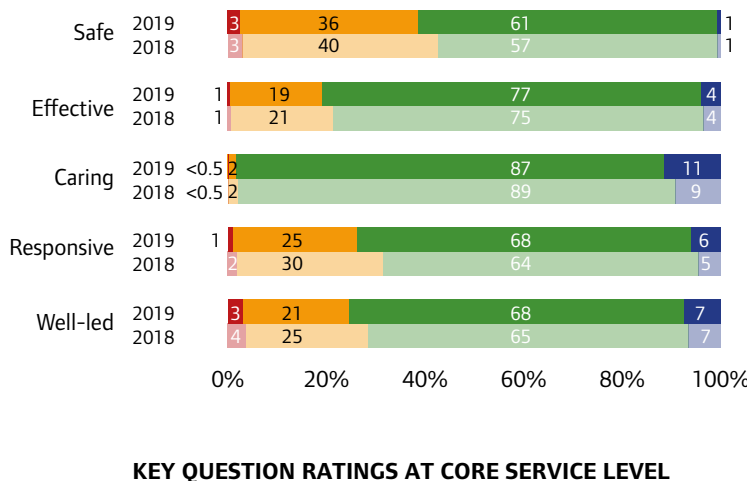
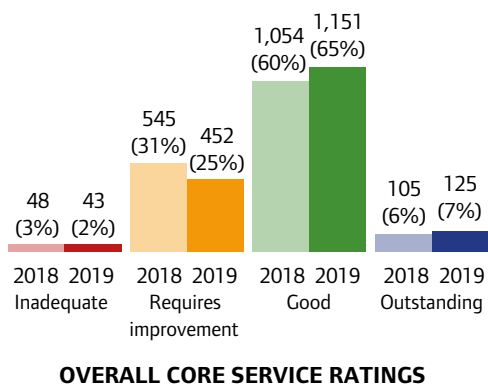
Adult social care overall and key question ratings, 2018 and 2019



● Inadequate ● Requires improvement ● Good ● Outstanding

Source: CQC ratings data, 31 July 2018 and 2019

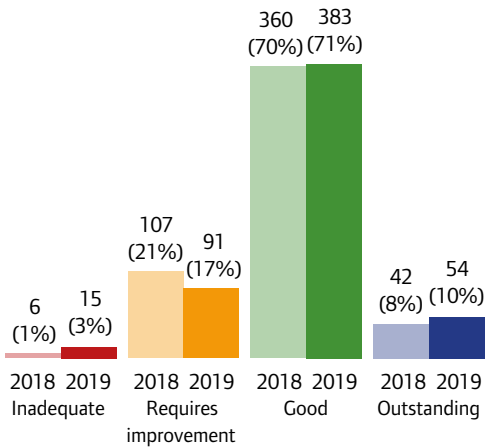
NHS acute hospitals, overall core service and key question ratings, 2018 and 2019



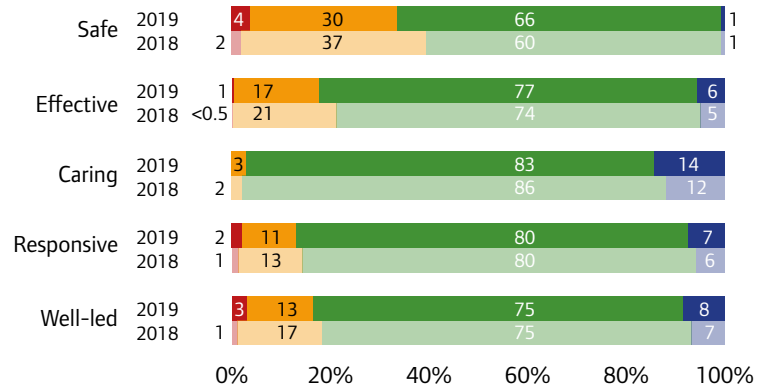
● Inadequate ● Requires improvement ● Good ● Outstanding

Source: CQC ratings data, 31 July 2018 and 2019

NHS mental health trusts, overall core service and key question ratings, 2018 and 2019



OVERALL CORE SERVICE RATINGS

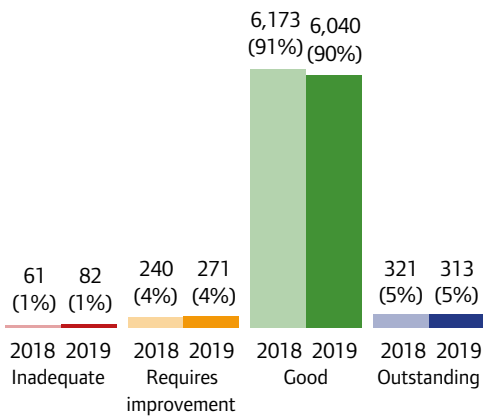


KEY QUESTION RATINGS AT CORE SERVICE LEVEL

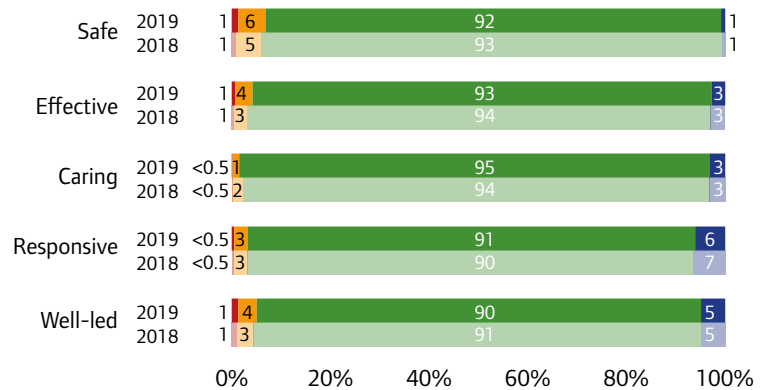
● Inadequate ● Requires improvement ● Good ● Outstanding

Source: CQC ratings data, 31 July 2018 and 2019

GP practices, overall and key question ratings, 2018 and 2019



OVERALL RATINGS



KEY QUESTION RATINGS

● Inadequate ● Requires improvement ● Good ● Outstanding

Source: CQC ratings data, 31 July 2018 and 2019

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