

# THE STATE OF HEALTH CARE AND ADULT SOCIAL CARE IN ENGLAND

2013/14





Care Quality Commission

# The state of health care and adult social care in England 2013/14

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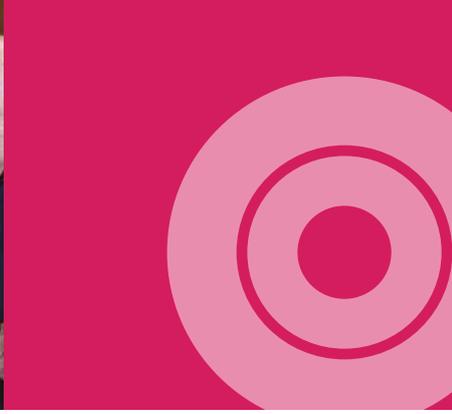
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# FOREWORD

We have found some outstanding care and rated many services as good. We have also found services that are inadequate or require improvement. This variation in the quality and safety of care in England is too wide and unacceptable. The public is being failed by the numerous hospitals, care homes and GP practices that are unable to meet the standards that their peers achieve and exceed.

It is no excuse that this problem has existed for years – quite the opposite. CQC is calling time on this unacceptable lottery, and challenging every health and care provider in England, and every commissioner and oversight body, to deliver the high standards of care that each person has a right to expect.

This report gives our perspective on the state of health care and adult social care in England in 2013/14 as we start to build a deeper and better understanding of the quality of care. It offers a unique perspective across more than 40,000 care services.

CQC's purpose is to ensure health and social care services provide people with safe, compassionate, high-quality care and to encourage services to improve. We provide robust, fair and consistent judgements of quality of care that expose poor care and variation in care, and make quality transparent in a way that it has never been before.

We have started to inspect and rate care services using a new more rigorous approach which has given us a deeper insight than we have ever had

before. Through this new approach and our new ratings, we are championing and celebrating the success of good and outstanding care. We are also improving our performance in taking serious action against inadequate providers – by stopping providers from operating or by requiring them to improve through our civil and criminal enforcement actions.

Understanding the quality of care is complex – it is about how people experience services, it is about the outcomes of the services (for example the clinical effectiveness of hospital care or the dignity of end of life care) and about how safe they are. These dimensions of quality are underpinned and influenced by the quality of the leadership and the culture that the leadership creates within a provider. Using the transparency of inspection helps to



recognise outstanding care, highlight areas of poor care and galvanise people to act to improve the quality of care.

CQC is an independent regulator, on the side of people who use services and acting to encourage all providers to improve the quality of services they provide. As we progress, we will uncover in greater detail the quality of care across health and care sectors than ever before. This job is not a simple one, and should not be underestimated. This is a huge responsibility and I am committed to meeting it. We will build a level of expertise such that our judgements are trusted and, importantly, used to drive improvement in the quality of services for the people who use them.

We acknowledge the rising pressure on care services, with people living longer with more complex and long-term conditions, and tight budgets across health and social care. Financial pressures are real but not unexpected, and they will continue into 2015/16 and beyond. And yet we have already seen many examples of good and outstanding care and we will champion these. There are examples for providers to learn from. Everyone deserves good care.

We are issuing a challenge to care providers and the system at large – to have the courage to use our judgements to have the greatest impact on improving care quality. Use our assessments of

where care is outstanding to learn from what others are doing. Use our assessments to invest energy in driving improvement rather than defending the indefensible. Care failure is unacceptable. For improvement to take place there needs to be an acceptance that there is a problem to be solved.

We are also issuing an invitation to the public – to use the information provided by CQC or by professionals who help you, to make decisions about your care and the care of your loved ones. Where you don't have a choice of care, then become more demanding of those who should be acting in your interests. They should be putting you at the heart of good quality care. It is your right.



**David Behan**  
Chief Executive  
Care Quality Commission

# SUMMARY

- CQC's more rigorous, people-centred and expert-led inspections are seeing some outstanding care; we have already rated many good services. We are also finding care that is inadequate or requires improvement.
- This variation in the quality of health and adult social care is too wide, and unacceptable.
- It is no excuse that this problem has existed for years. CQC is calling time on this unacceptable lottery.
- Too many providers have not got to grips with the basics of safety.
- Strong, effective leadership at all levels is vital. We have found in our more rigorous inspections that 'well-led' drives up quality and safety.
- There is a mounting financial challenge across the sectors, but this should not excuse inadequate care. Providers must learn from the outstanding examples of others with the same resources.

## **We are issuing a challenge to care providers and the care system:**

- Don't wait for a CQC inspection to get to grips with what 'good' care looks like.
- Accept where there are problems and use our inspections to drive up care quality.
- Where CQC identifies failing services, the provider and the supportive system around them should act.

## **We are issuing an invitation to the public:**

- Become empowered consumers. Use the information provided by CQC or by professionals who help you, to make decisions about your care and the care of those close to you.

**GO TO PART 1 ►**



## **Adult social care**

- We have seen many examples of excellent care. Providers need to learn from those who are doing it well.
- There is significant variation in quality. In particular, people living in nursing homes receive poorer care than those in care homes without nursing.
- Working in adult social care is a tough job, but very rewarding. It is important that staff are supported, valued and trained well. Encouraging more nurses to work in the care home sector should be a higher priority.
- Good leadership is vital. The care provided by care homes with a registered manager was substantially better than by homes without a manager.
- We have concerns about whether 15-minute home visits can truly deliver care and support that is safe, caring, effective and responsive to people's needs.

## **Our challenge to providers...**

- Maintain a focus on recruiting for values and building the professionalism of staff.
- Leaders at all levels should develop a culture of support, openness and learning.

## **...and the system**

- Recognise and value excellence in all staff, especially those in professional or leadership positions.
- Have the courage to tackle failure in the interests of people who use services.

**GO TO PART 2 ►**



## Hospitals, mental health care and community health services

- By the end of August 2014, CQC had inspected 62 NHS acute trusts and published ratings for 38 trusts under our new approach: almost a quarter of NHS acute trusts in England. We also inspected 12 mental health trusts and eight community health providers.
- We found wide variation in care between trusts, between hospital sites, between hospital services and within each service.
- In September 2014, we awarded the first outstanding rating, to Frimley Park Hospital.
- The first trusts to be inspected tended to be higher risk. Of the 38 acute trusts, nine were rated good, 24 required improvement and five were inadequate.
- Safety was our biggest concern: four out of five ratings were inadequate or requires improvement.
- 49 of the 82 acute hospitals covered were requires improvement or inadequate in terms of well-led. Again, these inspections were of higher risk trusts.
- Our new tougher mental health inspections found problems with poor physical environments and a lack of admission beds.
- Most community healthcare staff were compassionate and caring, and patients were very positive about the care they received.
- Providers have limited ability to assess the effectiveness of their own services. We also need to do more work to assess the effectiveness of acute services more reliably.

### Our challenge to providers and the system...

- Be open and use CQC's assessment as a stepping stone to improving your services.
- Make safety a priority, and build a safety culture.
- Recognise and invest in your leadership from the board right through to the ward.
- Listen and act on feedback from staff and patients.
- System leaders should understand and discharge their own responsibilities for improving quality.

**GO TO PART 3 ►**

## Primary medical services and integrated care

- We inspected GP practices for the first time this year, and found variations in the quality of care.
- We inspected 30 NHS GP out-of-hours services under our new approach, serving more than a third of England's population. Most services were safe, effective, caring, responsive and well-led.
- We found that, on average, larger GP practices delivered better quality of care than smaller practices.
- The quality of dental care was generally good, and continued to be lower risk than most other sectors.
- We published thematic reviews into diabetes care, dementia care and the transition to adult services by children and young people with complex physical health needs.
- Our work with the sector has highlighted the importance of a clear quality assessment framework, alongside better data through Intelligent Monitoring. Until now, the sector has had no robust way of assessing the overall quality of care.

### Our challenge to providers...

- There needs to be innovation to meet increasing demand, but don't wait to innovate.
- Make the basics of safe care and effective practice a priority.
- Be responsive to local needs and the latest issues or clinical developments.
- Empower patients in their own care and help them to make informed decisions.

### ...and the system

- Encourage feedback within and across providers on the performance of services, and encourage and enable co-ordination between providers.
- Tackle failure with courage and in the interest of patients.

**GO TO PART 4 ►**



# PART 1

## THE STATE OF CARE IN ENGLAND

### Key points

- CQC's tougher, people-centred, expert-led and more rigorous inspections are seeing some outstanding care and we have already rated many good services.
- We are also finding care that is inadequate or requires improvement: care that no one would want themselves or those close to them to experience. The variation in the quality of health and adult social care is too wide, and it is unacceptable.
- The principle of keeping people safe from harm is fundamental. Too many providers have not got to grips with the basics of safety. Of the first NHS acute hospitals we have rated, eight out of 82 were rated inadequate for safety, and 57 were rated as requires improvement for safety. (It is important to bear in mind, though, that our early inspections of acute hospitals under our new approach mostly focused on those that were deemed higher risk. This picture is not representative of acute hospitals across England.)
- Strong, effective leadership at all levels within an organisation is vital. We have found in our new, more rigorous inspections that being well-led drives up quality and safety overall.
- There is a mounting financial challenge in health and adult social care. But this should not excuse inadequate care. Providers must learn from the outstanding examples of others who have the same resources.
- We are challenging providers and the care system to accept where there are problems and to use our inspections to drive up care quality.
- We are issuing an invitation to the public to become empowered consumers, and to use information from CQC and others to insist on the best possible care for themselves and their loved ones.



## A period of hard realities and rapid change

CQC's assessment of the quality of care in England in 2013/14 is set within a rapidly changing and increasingly challenging economic and social environment. There are rising expectations of care services, and increasing demand. The impact of longer life expectancy, the prevalence of long-term and multiple conditions, and the increasing demands from consumers to have access to the latest treatments are well documented.

Many providers, local commissioners and national bodies are responding to new expectations and requirements. They are honestly facing up to care failures instead of hoping that things will just get better by themselves. Drivers for change are different across health and social care, but there are common themes across them – caring for people with dignity and compassion, good engagement of staff and people who use services, strong and open leadership, meeting the challenges of tighter funding and responding to failures in care quality. The pace and scale of change over the last year have been unprecedented and there are further changes already on the horizon.

- **In health care**, the Francis Report into the catastrophic failings at Mid Staffordshire, published in February 2013, had a profound effect on the health sector throughout 2013/14. Most providers have taken the time to consider what the report means for them, and taken action to improve the care they provide. This is particularly shown by the increase in nurse numbers seen from autumn 2013.

The Government published its response to the Mid Staffordshire public inquiry, *Hard Truths*, in November 2013. While there were recommendations for commissioners, providers and professionals, it outlined the whole healthcare system response to tackle the issues identified by Sir Robert Francis. This has been the driver behind many of the legislative and policy

changes, including the introduction (from April 2015) of fundamental standards for the quality of health and adult social care, radical reform to CQC's regulatory approach, and the appointment of Chief Inspectors of Hospitals, Adult Social Care and General Practice. For the first time, there will be a fit and proper person requirement for directors and an organisational duty of candour that will require providers to be open and candid when things go wrong (in addition to the professional duty of candour already in place for many clinical professions). Subject to Parliamentary approval, these two provisions will come into force in the NHS in autumn 2014 and in other sectors from April 2015.

The message of *Hard Truths* has come across loud and clear in the NHS's approach to care failures. The reviews into hospitals with high mortality rates, carried out by Professor Sir Bruce Keogh, for the first time put a number of hospitals into 'special measures'. This programme, run by Monitor and the NHS Trust Development Authority, aims to turn around failing hospitals. After a year in special measures, CQC assessed two out of the 11 hospitals (Basildon and Thurrock University Hospitals NHS Foundation Trust and George Eliot Hospital NHS Trust) as 'good' overall, and they were taken out of special measures. A further three trusts had made enough progress to exit special measures with ongoing support in place. The other six remained in special measures, continuing to receive intensive support. The programme shows that the NHS is willing to address the issue of failing care and work to improve services for their patients. It also raises the issue of the pace of improvement, and the variation seen in that improvement.

Implementation of the NHS reforms based on the Health and Social Care Act 2012 also saw big changes behind the scenes in 2013/14. These changes to the way primary care, NHS services and public health services are paid for

and commissioned, and the split of budgets between different commissioning organisations with different roles and geographies, have meant reforming professional relationships and organisational agreements at a local and national level and starting to redesign services. There are signs that the new clinical commissioning groups are starting to use the greater flexibility in how they choose to buy services to meet the needs of local people.

Primary care has always been at the front line of the UK healthcare system: its 'gatekeeper' role. However, general practice is now increasingly also seen as the coordinating interface between all the different types of care on offer. GPs are expected to help patients and their families negotiate their way between hospitals and care homes, and between local authority and NHS-provided care.

Against this background, there is an undeniable mounting financial challenge. Finances across the NHS are tight and likely to get tighter as rising activity and costs swallow the small real-term increases in NHS funding since 2010. So far, the NHS has been able to make efficiency savings while responding to the challenges of the Francis report within existing budgets. However, financial pressures are likely to increase into 2015/16 and beyond.

For example, the Nuffield Trust has reported that the financial robustness of NHS hospitals is weak and declining, the sector as a whole has moved from surplus to deficit and the number of organisations reporting a deficit has risen, and NHS trusts are increasingly dependent on one-off or short-term savings.<sup>1</sup>

NHS England and local bodies are working to meet the challenge of new standards, rising expectations, increased demand for services and tight budgets. With the new Chief Executive of NHS England, Simon Stevens, in post since April 2014, a wide ranging five-year forward

view is underway into the future opportunities for the NHS and the big questions it needs to answer. These discussions are likely to have a fundamental impact on the shape of care services.

In mental health care, the Health and Social Care Act 2012 introduced a parity of esteem between physical and mental health. The national campaign to reduce the stigma associated with mental ill-health is starting to change the public's attitudes to a problem that affects the lives of millions of people. CQC welcomes these important steps. However, while there has been some effort in working towards achieving parity of esteem (for example, the policy is now enshrined in the NHS Mandate, which sets the framework for all NHS commissioning), there is still a long way to go.

Too often people with mental health problems receive a second-class response when they seek urgent help. As a signatory to the Department of Health's Crisis Care Concordat<sup>2</sup>, CQC will use its regulatory powers to ensure that mental health services, acute hospitals and primary care services work together to deliver a coordinated, timely and effective response to mental health emergencies.

In acute hospitals, doctors and nurses too often fail to understand the interactions between physical health and mental health that can delay or prevent recovery. CQC recognises the importance of raising the awareness of this issue and of the value of comprehensive mental health liaison services in the general hospital setting.

Despite the commitment to parity of esteem within both commissioning and provision, specialist mental health services remain the Cinderella service. The Nuffield Trust found that, despite the government's work to promote parity of esteem to close the gap between the two sectors, funding for mental health providers increased more slowly than that for hospital



services in 2011/12 and 2012/13.<sup>1</sup> The Nuffield Trust found that, during this period, there had been a substantial increase in private sector mental health provision. An increasing number of people are being admitted to wards far from their homes in a way that would not be considered acceptable in physical healthcare.

The Minister of State for Care Services has called child and adolescent mental health services “the Cinderella service of a Cinderella service” and has established a taskforce to propose the actions needed to create a more effective and coordinated system for care.

- **In adult social care**, the introduction of the Care Act 2014 has significant implications for the sector and the role of local authorities. This impact will be felt through a new statutory requirement for safeguarding adult boards which will develop shared strategies for safeguarding and report to their local communities on their progress; statutory guidance on the provision of information and advice to all local people about care and support; options to have a direct payment for residential care; and new powers given to local authorities to shape the care market. From April 2015, CQC will be taking on a new role of providing market oversight in the adult social care market, with a duty to assess the financial sustainability of ‘difficult to replace’ providers.

The sector also continues to learn from high profile failures in care. The Serious Case Review and the CQC report into Orchid View is an example of poor care being exposed and lessons being learned so that failings do not happen again.

Finally, the financial squeeze in adult social care has been felt for a number of years, and longer and more deeply than in the healthcare sector. There was a real-term decrease in adult social care expenditure by local authorities of 8% between 2010/11 and 2012/13<sup>3</sup> and this

combines with the pressure on personal finances, given that a substantial proportion of adult social care is paid for privately. This financial pressure looks likely to continue, even with the advent of the new Better Care Fund (which is a local pooled budget to incentivise the NHS and local government to work more closely together in placing people’s wellbeing as the focus of health and care services). Overall, council-funded adult social care services are caring for fewer people, at a time when demand is increasing. This is putting extra pressure on families to find ways to care for their loved ones.

Across all sectors, the Supreme Court gave a judgement in March 2014 about the conditions under which a person, lacking capacity to consent to their care and treatment, may be deprived of their liberty under various provisions of the Mental Capacity Act and Mental Health Act.<sup>4</sup> The judgement set out more clearly the arrangements that may amount to a deprivation of liberty, and this will have a significant impact on the way mental health services, acute health services and adult social care services operate.

Also in March 2014, the House of Lords post-legislative scrutiny committee on the Mental Capacity Act reported. The committee found that the MCA is generally held in high regard (apart from the Deprivation of Liberty Safeguards). But it notes that implementation has not met the expectations that it rightly raised: the Act has suffered from a lack of awareness and a lack of understanding.

The committee commented:

“For many who are expected to comply with the Act it appears to be an optional add-on, far from being central to their working lives. The evidence presented to us concerns the health and social care sectors principally. In those sectors, the prevailing cultures of paternalism (in health) and risk aversion (in social care) have prevented the Act from being widely known or embedded. The empowering ethos has not been delivered. The rights conferred by the Act have not been widely realised. The duties imposed by the Act are not widely followed.”<sup>5</sup>

CQC is part of the national steering group dedicated to driving improvements in compliance with the Mental Capacity Act throughout health and social care.

Brought all together, the pressures on care are making themselves felt in a variety of ways. For example, there has been a 13% rise in emergency hospital admissions over the last six years. Performance against the 18-week standard from being referred to receiving treatment was on a downward trend in 2013/14 and went below the national standard for the last two months of the year, meaning more than 10% of people waited more than 18 weeks for treatment. The financial position is worsening with more organisations reporting deficits. Provider representatives, NHS

Confederation and Skills for Care are describing increasing challenges around recruiting and training our care workforce so that we have the right people with the right skills in the right place at the right time.

On the other hand, some indicators of quality are improving. For example, the last few years have seen substantial reductions in MRSA bacteraemia and *Clostridium difficile* infections, and there has been a dramatic reduction in hospital patients sharing mixed sex accommodation, from around 2,000 incidents a month in April 2011 to fewer than 200 in April 2014.

Until now, there has not been enough evidence to say whether quality of care is improving or getting worse overall, or by sector, because there has not been the framework in place to bring together all the different elements of a provider’s quality. With our new approach to regulation and the introduction of ratings, we are starting to understand much better the overall picture of the quality of care in England. We will be in a much stronger position this time next year, particularly in acute hospitals and mental health services, to describe this in detail.

What we do know is that there are big differences between the quality of care provided by similar organisations, and that this is unacceptable.

## **Variation in the quality of care is too wide and unacceptable**

The variation in the quality of health and adult social care is too wide. This unacceptable variation in quality needs to be widely acknowledged and addressed.

CQC’s much tougher, people-centred, more expert-led and more rigorous inspections have already seen some outstanding care where people are treated effectively, with dignity and compassion, in a safe



environment. But we have also found much care that is inadequate or requires improvement. This is care that no one would want themselves or someone close to them to experience. In all five of the NHS trusts we have rated inadequate so far, more than 40% of staff said in the 2013 staff survey that the standard of care provided by the organisation would not be good enough for a friend or relative.

There are big differences in the quality of care that people experience from different providers, in different places and sometimes at different times of the day or day of the week. Some variation may be inevitable and indeed desirable, for example when local care services reflect local needs. How services are delivered should be tailored to local needs, and enabling innovation in care means allowing some variation (within clear boundaries of safety) for new models of care to emerge. However, the scale of variation that exists cannot be explained by ‘warranted’ factors.

Variation in care is a challenge for all modern health and care systems (see box). It ranges from variation in the quality of care (where some people receive better quality care than others) to variation in the utilisation of care (where some people receive more treatment or care than others). It is not acceptable, however, when this variation cannot be justified on grounds of different needs or preferences of the people using services.

### VARIATION IN CARE – A GLOBAL PHENOMENON

The modern English health and social care systems are not unique in the significant variations that exist within them. A systematic review of the peer-reviewed literature found 826 studies documenting medical practice variations in OECD countries between 2000 and 2011. The review found “large variations across regions, hospitals and physician practices for almost every condition and procedure studied”.<sup>6</sup>

A recent OECD study documented geographic variations for high-cost and high-volume procedures in selected countries. It found that there are wide variations not only across countries, but within them as well.<sup>7</sup>

Many of the concepts and methods used in the study of variations have emanated from the research group at Dartmouth College, USA. First was Wennberg’s seminal 1973 article on variations in health care in Vermont<sup>8</sup>, and later the ongoing *Dartmouth Atlas of Health Care* series. Influenced by the Dartmouth methods, others in England, Wales, Spain, the Netherlands, and New Zealand have created atlases in order to scrutinise patterns of care in their countries.

Wennberg argued that unwarranted variations are those that cannot be explained on the basis of illness, medical evidence, or patient preference.<sup>9</sup> The Spanish Atlas recently reported “wide systematic and unwarranted variation in the Spanish National Health Service”.<sup>10</sup>

A recent study compared treatment of ambulatory care sensitive conditions in three French regions. The authors found significant disparities among geographic areas in access to primary care and revascularisation.<sup>11</sup>

In Sweden, regular regional comparisons on quality and efficiency in healthcare have been published, highlighting the many dimensions of variation. For example a 2012 study found poorer survival rates, higher rates of mortality and higher levels of avoidable hospital admissions among patients with the lowest levels of education.<sup>12</sup>

While variation in care is therefore a global phenomenon, the unique nature of the NHS in England as a national system suggests there may be greater opportunities for tackling unacceptable variation than in other, more fragmented systems.

The particular variation between good and poor care that CQC is still observing across England in all sectors is not acceptable. That care can be delivered in different ways does not justify poor quality for some people, settings or locations. Everyone should receive good quality care, no matter how or where it is being delivered. This means improving the care that is inadequate or requires improvement, while leaving others to flourish to develop their good and outstanding care.

Time and again we see differences in quality. In our new, more rigorous inspection of NHS trusts, which we rolled out from September 2013, we are seeing differences from one trust to another, from hospital to hospital within a trust, between different services within hospitals, and even between the different

quality attributes (are they safe, effective, caring etc) of each service (SEE FIGURE 1.1).

**WHAT IS QUALITY IN HEALTH AND CARE?**

We have five key questions that we ask of all the services to understand the quality of care they provide:

1. Are they safe?
2. Are they effective?
3. Are they caring?
4. Are they responsive to people's needs?
5. Are they well-led?

**FIGURE 1.1: EXAMPLE OF WIDE VARIATION WITHIN A SINGLE HOSPITAL SITE: RATINGS FOR THE SERVICES AT ROYAL BERKSHIRE HOSPITAL, JUNE 2014**

	Safe	Effective	Caring	Responsive	Well-led	Overall
Accident and emergency	Good	Inspected but not rated	Good	Requires improvement	Good	Good
Medical care	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Requires improvement	Good	Outstanding	Requires improvement	Requires improvement	Requires improvement
Maternity and family planning	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Children and young people	Good	Good	Good	Good	Good	Good
End of life care	Good	Good	Good	Outstanding	Good	Good
Outpatients	Requires improvement	Inspected but not rated	Good	Requires improvement	Requires improvement	Requires improvement
<b>Overall</b>	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement

Source: CQC Royal Berkshire Hospital inspection report, June 2014



There are examples of good care being delivered up and down the country and, despite the pressures facing the health and care sectors, we have identified examples of outstanding care. But equally we see many examples of unacceptable care. Of the 38 NHS acute trusts rated by the end of August 2014, nine were 'good' overall and 24 were 'requires improvement' (63%). Five trusts (13%) were rated 'inadequate'. It is important to note, however, that

our early inspections of NHS acute hospitals under our new approach mostly focused on those that were deemed higher risk, and so this early picture is not representative of acute hospitals across England.

It is unacceptable that not everyone receives at least good care. All parts of the system – providers, professionals, commissioners and regulators – need to step up to address this challenge.

### THE GOOD, THE POOR AND THE BAD: THE SPECTRUM OF CARE QUALITY



**VERY GOOD: "Since April 2013, the A&E at Homerton University Hospital had consistently met the government's 95% target for admitting, transferring or discharging patients within four hours of their arrival in A&E.**

A third of patients attending the A&E were treated in the primary urgent care centre. The trust introduced the role of a non-clinical navigator (NCN) to support patients to find and register with their local GP practice. This meant that patients were able to have their primary medical needs met in the local community.

The A&E team was aware that they had a high number of patients regularly re-attending A&E. To address this they established the first response duty team (FRDT). The FRDT worked with patients to identify their support needs and meet those needs in the community, reducing the number of patients needing to be admitted to hospital.

We saw that A&E staff took the time to listen to patients and explain to them what was wrong and any treatment needed. Patients told us they had all their questions answered and felt involved in making decisions about their care. The staff we talked to were proud to work for Homerton A&E and felt there was a 'can do' attitude within the team. Learning was shared among the staff team about incidents and complaints within the department and across the hospital."



**GOOD: "SELDOC, a GP out-of-hours service, kept up-to-date electronic information in their system for those patients from the GP practices they covered in the area who had long-term conditions, complex needs and those needing end of life care. This enabled the service to identify and quickly respond to these patients when needed. All calls from these patients or their carers are prioritised and they receive a call back from a duty doctor to assess their needs within 20 minutes. When required, a doctor will provide a home visit within two hours. The service also had close links with mental health teams who could provide additional specialist support as well as the emergency duty social work teams based at the same location.**

Information relating to vulnerable patients is stored electronically and is automatically highlighted if the person calls the service. The medical director told us that they did, on occasion, receive calls from hospital pathology teams when blood tests were grossly abnormal and we were provided with an example where it was necessary for SELDOC to respond and clinically assess the patient's medical condition."

 **GOOD:** “Staff from GoToDoc, a GP out-of-hours service, had attended community events to communicate with minority groups such as Eastern European and Somalian groups. They had also worked with faith groups and held workshops to raise awareness of the service. GoToDoc also works closely with local Healthwatch and voluntary providers to obtain public feedback and share service information. We saw that they had actively contributed to the Manchester homeless strategy and used social media to promote access to and awareness of the service.”

Our dementia thematic review found many examples of good and poor care:

 **GOOD:** “We saw how supporting dementia was built into each care plan. For example, the night time care plan for one person reminded staff that the person had little concept of night and day, and needed to be reminded it was night time. It showed that if the person said they were ‘hungry’ at night it usually meant they needed to use the commode. The manager told us ... staff might put dressing gowns on themselves to help people connect wearing a dressing gown with night time and going to bed.”

 **GOOD:** “...we observed large paper clocks in each area identifying the times that people had fallen. These were to remind staff to be vigilant at those times and monitor people to ensure they were safe.”

 **GOOD:** “We saw that a sweet shop had been created in one unit which opened for short periods each day staffed by people using the service ... The shop had been skilfully created as a reminiscence environment as well as providing an opportunity for people to interact. We saw staff working with one person in the shop and they told us that the individual had previously worked in a shop locally during their working life. A reminiscence lounge was being completed on another unit at the time of our inspection that was to be used for tea parties and activity sessions.”

 **POOR:** “Some rooms had little décor or pictures and no information to assist in getting to know the person. Other rooms, however, were warm and cosy and personalised. We found that the rooms with little or no personalised effects belonged to people in the later stages of dementia. This suggested that people with higher needs, or in the later stages of dementia, did not have their dignity maintained in the same way as people who were able to make choices and express their own needs.”

 **POOR:** “Mrs A was not prompted or helped to the loo at night and was left wet every night ... This resulted in two urinary tract infections which cause additional confusion. Indeed, she was so confused by them that she could not hold a conversation with anyone, including me. Staff actually thought it was just her level of dementia and were amazed at how different she was when she finally got over the infection.”

**✘ POOR: From our thematic review into the transition to adult services of children with complex physical health needs:**

“We spoke with a team responsible for a young person with profound disabilities who needed round-the-clock care. Although the young person was 20, their file was still held by the children’s community nursing team, who were unclear of any outcome of handover to adult services.

Any work the team had carried out for transition had revolved around arrangements for continuous provision of equipment needed for nutritional support (enteral feeding). Beyond this, there was no transition or health care planning, with no record of consent, capacity or individualised person-centred planning.

The last entry in the file was dated a year previously and suggested the team should be informed once handover had taken place. No subsequent action has been taken and the team were unclear as to the outcomes for this young person.”

**✘ POOR: “When we carried out our unannounced visit to Furness General Hospital, there were a high number of medical outliers (patients who have medical problems that are cared for in another speciality). Staff on the wards with medical outliers were doing their best to care for them. However, we found staff had not always received the relevant information in the form of a suitable handover when the patients had been transferred from other wards.**

Handover records were sometimes noted on pieces of paper, for example Mrs A refusing crucial medication, Mrs B had developed small blisters (the start of pressure sores) on her heels. This meant that critical information was not effectively shared at the point of handover and the receiving ward did not have all the relevant information for patients to receive good care. We saw a risk to a patient when we looked at their records and identified them as being allergic to latex gloves. When we asked the nurse caring for that patient they had not been made aware of this allergy at handover.”

**✘ ✘ VERY POOR: “Despite identifying pockets of very good clinical practice, we found surgical care at Medway Maritime Hospital did not sufficiently protect patients from risks of avoidable harm and abuse. We found patient flow within the surgical department was poorly managed, which often led to long delays in treatment and patients being cared for in inappropriate clinical areas.**

Data submitted to CQC suggested low rates of operation cancellations. However, seven days’ worth of handwritten emergency lists reviewed showed a high rate of procedure cancellation with an average of seven cases a day. Operating data was being collected in various forms of handwritten lists, diary notes, theatres lists and via an electronic system. There was no process to monitor the impact of frequent cancellations or delays on people’s clinical outcomes. It was also difficult to track the patient journey because emergency cases were moved to elective theatre lists and were not always easily identifiable as an emergency. Patients who had undergone surgery were being cared for in the recovery area for extended lengths of time due to a shortage of surgical beds on the wards. We were made aware of patients being returned to clinical areas that were inappropriate given the complexity of the patients’ needs.”

The variation cannot be explained by money alone. Money is likely to be a factor, and in a few cases a critical one. But there will be other drivers behind this level of variation, and these need to be fully explored and solutions implemented to ensure everyone gets the good quality care they deserve.

The early findings from our new tougher inspections, which we started to roll out in 2013/14, highlight two key aspects of the variation in quality that need to be addressed: safety and leadership.

### **“First do no harm”: basic safety is a concern across services and sectors**

We are concerned about the variation in basic safety, and particularly a lack of effective safety processes underpinned by a culture that truly learns from mistakes and near misses. These include safeguarding concerns, patient safety concerns in the NHS, slips, trips and falls in hospital wards and ‘never events’ – those incidents that should not happen at all but which do, at a rate of almost one a day across the NHS.

Providers must get the basics right. The principle of keeping people safe from harm is fundamental. In their independent reports both Sir Robert Francis and Professor Don Berwick highlighted poor safety and their recommendations to tackle it, and the profile of safety has been raised by a number of campaigners and the Secretary of State for Health. Yet safety still varies across all services and within all care settings. While the problems have been diagnosed, the impact of efforts to tackle them has yet to show through.

An outstanding safety culture is one that encourages reporting of all incidents, that reviews and investigates where there was significant harm or where a systemic failure might have occurred, is candid when things go wrong, and is transparent in how it handles mistakes and implements learning.

But there are a number of providers who have just not got to grips with the basics of safety. At the very least, we should expect every provider to offer a safe environment. No one should have to worry about being harmed while they are being cared for or having treatment.

We found in our ‘old-style’ inspections in 2013/14 across most of health and social care that a substantial number of providers failed to meet at least one of the quality standards relating to safeguarding and safety (**FIGURE 1.2**).

But also, in our new tougher and comprehensive inspections of acute hospitals that started in September 2013, we have found that far too many hospitals were inadequate on safety and the majority required improvement to be considered safe. Of the overall key question ratings for acute hospitals that CQC published up to the end of August 2014, eight out of 82 safety ratings were inadequate and 57 were requires improvement (**FIGURE 1.3**).<sup>\*</sup> Safety also had the most inadequate ratings overall. This level of poor performance is shocking.

The early findings from our new inspection approach have highlighted safety issues more clearly than before (even accounting for the fact that the first hospital inspections were focused on higher risk trusts), with a significant discrepancy between ‘compliance’ with standards under the old model and ratings of ‘good’ under the new.

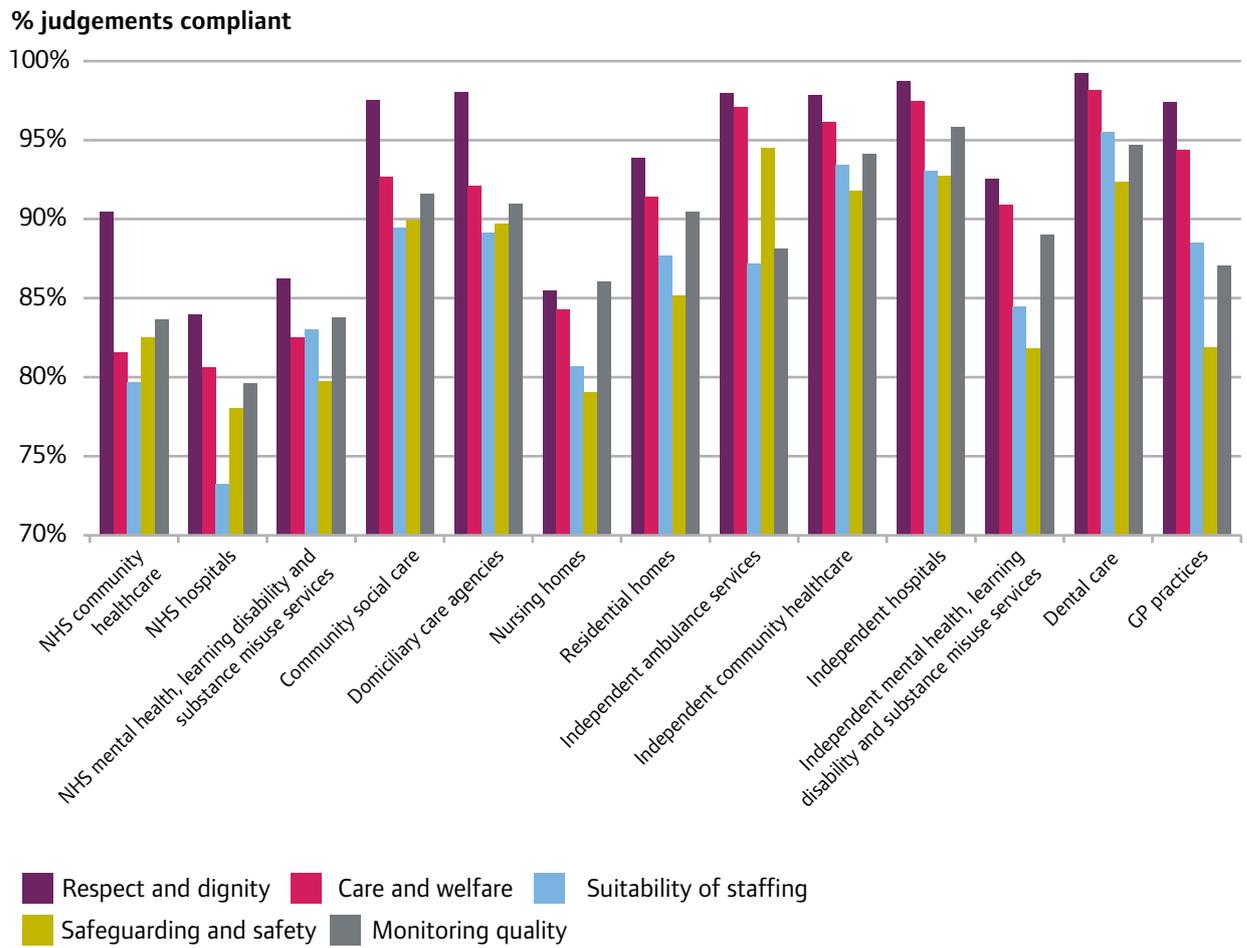
The new model gets under the skin of an organisation in a way that the old did not, and helps us to achieve a much better understanding of the quality of care being provided.

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<sup>\*</sup> Please note that the ratings included in this report were indicative ratings. CQC’s legal powers to rate came into force on 1 October 2014.

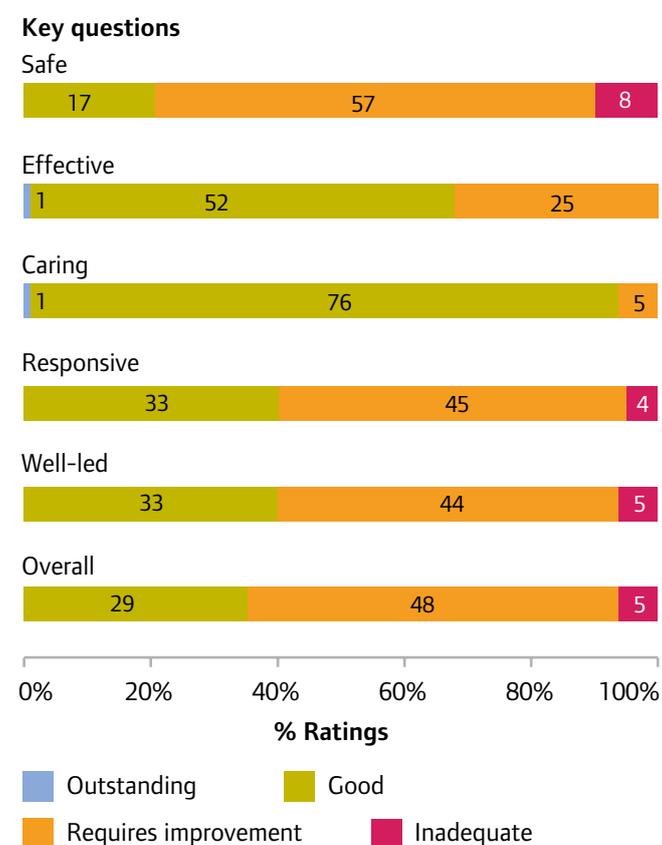


**FIGURE 1.2: PERFORMANCE AGAINST QUALITY STANDARDS, ALL SECTORS, 2013/14 ('OLD-STYLE' CQC INSPECTIONS)**



Source: CQC compliance data, 2013/14

**FIGURE 1.3: ACUTE HOSPITAL RATINGS BY KEY QUESTION, DECEMBER 2013 TO AUGUST 2014 (NEW APPROACH INSPECTIONS)**



Source: CQC NHS acute trust ratings data, December 2013 to August 2014, for 82 individual hospital locations. Note that only 78 hospitals received a rating for 'effective'. We were unable in that period to rate effectiveness in A&E and outpatients, and this will have meant that we were unable to give an overall effectiveness rating in some smaller locations.

## ENSURING THE SAFETY OF PEOPLE EXPERIENCING A MENTAL HEALTH CRISIS – MORE VARIATION

Section 136 of the Mental Health Act 1983 allows for someone believed by the police to be experiencing a mental health crisis, and who may cause harm to themselves or another person, to be detained in a public place and taken to a place of safety where a mental health assessment can be carried out. This should usually be a 'health-based place of safety', generally in a mental health service or an emergency department at a general hospital. For too many people though, this is not the case: in 2012/13 more than 7,000 reported uses of section 136 of the Mental Health Act resulted in the person having to be taken to a police station.

We carried out a national survey of the availability and operation of health-based places of safety across England. While all but one upper tier local authority area is served by a designated health-based place of safety, there is variability across the country in how they operate. This can include how they are staffed, their capacity, their use of exclusion criteria (such as intoxication or disturbed behaviour), and how providers work with other agencies, including the police.

See some of the results of the survey in our online map: [www.cqc.org.uk/hbposmap](http://www.cqc.org.uk/hbposmap). This shows each location's opening hours, capacity, the age groups accepted, and the local areas they are intended to serve.



## The importance of leadership: being well-led drives up quality

Through its new tougher inspections, CQC is focusing more comprehensively than ever before on understanding the quality of the leadership at all levels of an organisation, and across all types of health and social care. Being well-led means having strong and effective leadership, a supportive and values-driven culture, and stable management. It means being open and collaborative, and encouraging teams to work together to solve problems. Good leadership, at all levels of the organisation, shapes its culture into one where people who use services and the quality of their care comes first.

“It’s the leaders in organisations who really make a difference to the cultures of organisations – by what they attend to; what they value; what they monitor; and what they model in their behaviours. The challenge for us is how can we ensure we have leadership, which ensures that there is a focus on the vision of providing high-quality, continually improving, and compassionate care at every level of the organisation? Not just in the vision or mission statements but in the behaviours throughout the organisation.”

**Michael West, The King’s Fund**

Through our more expert-led and rigorous inspections, we are seeing how leadership and culture have a significant impact on other areas of quality. Our early findings show that being well-led correlates well with our overall rating of quality and safety. In our new inspections of NHS trusts, we found that the well-led ratings at core service level were the same as the overall trust rating (‘aligned’) in 87% of cases, more than any of the other key questions (**FIGURE 1.4**).

**FIGURE 1.4: ALIGNMENT OF RATINGS AT CORE SERVICE LEVEL TO THE OVERALL PROVIDER RATING, DECEMBER 2013 TO AUGUST 2014**

### Key questions

Caring vs Overall



Effective vs Overall



Responsive vs Overall



Safe vs Overall



Well-led vs Overall

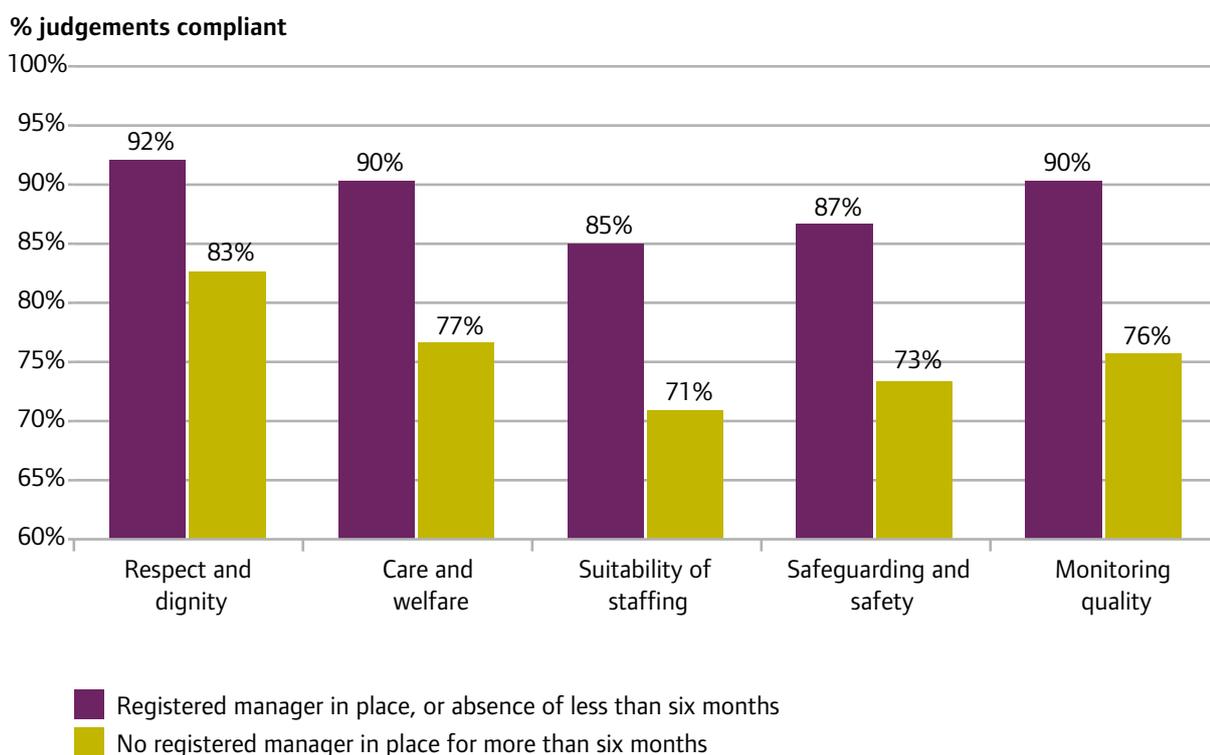


% Ratings

■ Aligned ■ Adjacent ■ Non-adjacent

Source: CQC NHS acute trust ratings data, December 2013 to August 2014

**FIGURE 1.5: PERFORMANCE OF RESIDENTIAL CARE HOME PROVIDERS AGAINST QUALITY STANDARDS, WITH AND WITHOUT A REGISTERED MANAGER, 2013/14**



Source: CQC compliance and registration data, 2013/14

We have also seen the influence of leadership in care homes. In 2013/14, we found that people received much better care in residential care homes where there was a registered manager in place, compared with those homes that had not had a manager in place for a long period of time (six months or more) **(FIGURE 1.5)**.

The importance of leadership is demonstrated in the focus on leadership, and the positive culture that strong leadership creates, in the new special measures programmes. These are tackling serious failings in the quality of care in NHS trusts, and they are to be extended to general practice and adult social care. The hospitals programme focuses on supporting and improving the leadership within trusts, and where necessary making changes to the leadership, to acknowledge issues and improve care.



## CQC's role in reducing variation and encouraging improvement

CQC now has a clear purpose: to make sure health and social care services provide people with safe, effective, compassionate, high-quality care, and to encourage services to improve. Everyone should receive good care and it is CQC's role to objectively establish the quality of care that is being delivered.

- **Developing our new methodology for inspecting and regulating services across health and adult social care**

A central role of CQC is to provide transparency on the quality of care in England, so as to eliminate poor quality care and encourage continuous improvement. With a new and more transparent approach to regulation, CQC will shine a light on poor quality care wherever we find it and also highlight good and outstanding care. Where care is inadequate to meet the needs of people using them, we will continue to use our enforcement powers to protect people from harm or to require improvement.

This work is being led by CQC's three Chief Inspectors, appointed in 2013 to lead expert and specialist inspection teams in: adult social care; hospitals, mental health care and community health; and primary medical services and integrated care. The Chief Inspectors and their teams began co-producing the new inspection approach for each sector in 2013/14, and testing it and learning through a series of pilot inspections. The new approach for NHS acute hospitals began formally in April 2014 and the other main sectors started their full roll-out in October 2014. We have now published our provider handbooks in these sectors, and our regulatory framework will be locked down until we have rated all providers at least once.<sup>13</sup>

Through our inspections and assessments, we aim to provide rigorous and robust assessments of quality so that providers, commissioners and people who use services can make effective choices – choices about what services to use or to buy on behalf of others, and choices about where to focus resources on improvement efforts.

Through the transparent and intelligent use of information and by promoting a positive learning culture, CQC will encourage improvement in care services.

- **Increasing intelligent transparency**

CQC will contribute to a culture of openness and transparency. We will be clear with the public about what we find through our assessments and inspections, and present the information to different audiences so that it can be used for different purposes.

Our new approach will help improve quality across the care system. In particular, having consistent lines of questioning for our inspectors in each sector, and providing clear characteristics of what good care looks like, will help providers to see where improvement is needed and help people who use services to recognise when they are receiving sub-standard care.

Ratings in particular will help to make variations in care clearer. We will highlight where care is good or outstanding, as well as where it is inadequate or requires improvement. In this way, ratings will be a spur to improvement and help empower choice.

Our new 'Intelligent Monitoring' tool is helping us prioritise our resources in high-risk areas. The Intelligent Monitoring tool is built on a set of indicators that relate to the five key questions we ask of all services – are they safe, effective, caring, responsive and well-led? For example, in NHS acute hospitals, more than 150 indicators – including patient experience, staff experience and patient outcome measures – are used to

create priority bands for where and when to target inspections. Trusts in 'Band 1' are our highest priority for inspection, with those in 'Band 6' the lowest. Many of the high risk trusts have already been inspected using our new approach.

We are publishing the Intelligent Monitoring indicators and information on our website so that we are held to account for how we are prioritising our work. The indicators raise questions about the quality and safety of care, but they are not used on their own to make final judgements. These judgements will always be based on a combination of what we find at inspection, what people who use services tell us, Intelligent Monitoring data and local information from the provider and other organisations.

By using data in an intelligent way, we will also present more 'thematic' findings. These will comment not just on how individual services are performing, but also how people who use services are having their particular care needs met by a range of services.

Over the next 30 years, health and social care faces the challenge of a rise in long-term conditions and the associated challenges with care. From 2012 to 2042, the number of people aged over 65 in England with care needs is expected to increase by 75%. CQC will increasingly be looking at how people experience the joined-up care needed for their long-term, complex conditions, and whether it is safely coordinated around them. We will be looking along care pathways to improve our understanding of the quality of care as experienced by people who use services.

This report is partly based on our thematic work into dementia care, children's transitions to adult services, diabetes, and mental health. Snapshots of two of these are shown in the boxes on these pages, and more details are set out in part 4. Some of our findings are reported here at an

early stage, but they are sufficiently important and illustrative that they are shared ahead of full reports to follow.

### **THEMATIC SNAPSHOT 1: CHILDREN AND YOUNG PEOPLE WITH COMPLEX PHYSICAL HEALTH NEEDS – TRANSITION TO ADULT SERVICES**

In England, there are 40,000 children and young people with complex physical health needs. We found that the transition from children's to adult services is variable, and that previous good practice guidance has not always been implemented. We described a system that is "fragmented, confusing, sometimes frightening and desperately difficult to navigate".

Among the unacceptable things we found were parents and young people caught up in arguments between children's and adult health services as to where care should be provided, care services ceasing when children's services end and adult services have not yet begun, and where transition only works where parents proactively push to make it happen.

An urgent review is needed into how services for young people are commissioned, and for commissioners to listen more effectively to young people and their families and deliver better, more effective, joined-up services. Existing good practice guidance must be followed to ensure young people are properly supported through transition.

We also said that GPs should be more involved, at an earlier stage, in planning for transition. General practice has a crucial role as the single service that does not change as a result of reaching adulthood.



## THEMATIC SNAPSHOT 2: DIABETES CARE

There are more than 3.2 million adults in England currently diagnosed with diabetes. Diabetes accounts for about 10% of the NHS budget and 80% of these costs are due to complications. Given current demographic trends, the treatment of complications associated with diabetes will become a growing burden on the NHS unless solutions can be found to improve management within the community and better empower people to take control of their condition.

Our review found that large numbers of people continue to experience potentially preventable hospital admissions related to their diabetes. Significant geographical variations occur in both emergency hospital admissions for diabetes and other measures of primary care performance regarding diabetes management in the community.

People with diabetes are more likely to experience an emergency admission to hospital than people without diabetes. They are also likely to stay longer in hospital, have a greater chance of emergency readmission and are more likely to die in hospital.

- **Encouraging a learning culture in health and social care**

CQC aims to develop a positive learning culture and demonstrate, through what we do and how we do it, an open style of leadership and learning. We will listen harder to, and act on, complaints and concerns raised about us and about the providers we regulate. Complaints and concerns – from both people who use services and care staff – are opportunities to improve. We will take these opportunities. We will also look for this responsiveness in the providers we regulate.

Concerns raised by people using services, their families and friends, and staff working in services provide vital information that helps us to understand the quality of care. In our new approach, we will gather this information directly from people who use services and staff (through our website and phone line, and providing opportunities to share concerns with inspectors when they visit a service), from national and local partners (such as the Local Government Ombudsman and the Parliamentary and Health Services Ombudsman, local authorities and Healthwatch) and by requesting information about concerns, complaints and whistleblowing from providers themselves.

We will also look at how providers handle concerns, complaints and whistleblowing in every inspection. A service that is safe, responsive and well-led will treat every concern as an opportunity to improve, will encourage its staff to raise concerns without fear of reprisal, and will respond to complaints openly and honestly. Through our new approach we will assess the leadership and culture of the organisation in more depth than previously attempted. And through the implementation of the new duty of candour, which (subject to Parliamentary approval) will come into force this autumn in the NHS and everywhere else in April 2015, we will reinforce and help to embed these principles of openness.

We will draw on different sources of evidence to understand how well providers encourage, listen to, respond to and learn from concerns. Evidence sources may include complaints and whistleblowing policies, indicators such as a complaints backlog and staff survey results, speaking with people who use services, families and staff and reviewing case notes from investigations.

We have been developing this approach over recent months, including carrying out a pilot

with the Patients Association in 11 acute trusts. In these pilots we found a high level of board involvement and interest in complaints, with all trusts having an identified complaints lead. However, few had an identified non-executive lead. Complaints governance structures were in many cases emerging but generally good, and most trusts had recently updated or were in the process of updating their complaints policy. Many of the trusts inspected needed to improve the information for patients and carers about how to complain and provide better access to information and patient advice services.

Most of the trusts involved in the pilot showed an increased awareness of the importance of good complaints handling systems and governance. But we also found that, too often, people’s experience of raising complaints remained poor. For example, only around half of those surveyed (at a sub-set of four trusts in the pilot) felt that they had received a fully honest response to the issues they raised.

Sir Robert Francis QC is currently leading an independent review into creating an open and honest reporting culture in the NHS. He is looking at how staff on the frontline can be supported to raise concerns and ensure safe care for patients, and wants to hear from as many people as possible who have experiences, both good and bad, of raising concerns in the NHS. We encourage people to post their comments in confidence on the ‘Freedom to speak up’ website at [www.freedomtospeakup.org.uk](http://www.freedomtospeakup.org.uk).

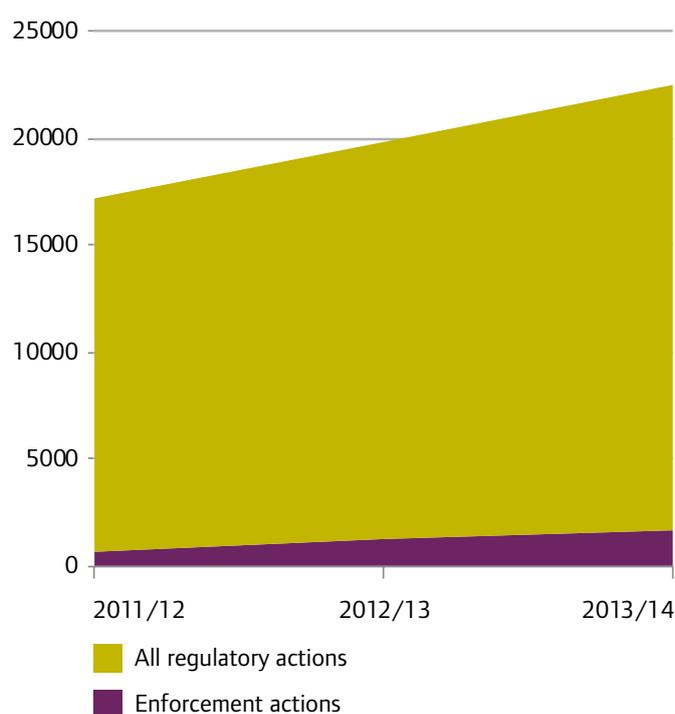
- **Requiring and encouraging improvement on behalf of people who use services**

Our ambition is to see the quality of all services improve. This is what the people who use services expect from the regulator. CQC will act to encourage improvement, although we are not an improvement agency. By providing comprehensive and impartial assessments of quality and ratings across all providers of health

and social care, CQC will help to identify where care needs to be improved, and where care has improved over time.

We will work closely with stakeholders and partners to drive improvement. Where there is no improvement, we will become more effective at using the full range of our enforcement powers, including the power to prosecute providers where serious breaches of fundamental standards have occurred. In the last two years we have increased the amount of regulatory action we have taken across all sectors (FIGURE 1.6). We have already started to increase our enforcement activity (from 1,200 warning notices issued in 2012/13 to 1,588 in 2013/14) and with new fundamental standards coming into force by April 2015, CQC will have strengthened powers to act swiftly where there is a risk to people’s safety. We will use these powers to hold poor providers to account through criminal or civil action, or even by stopping them from operating.

**FIGURE 1.6: TREND IN REGULATORY ACTIONS AND ENFORCEMENT ACTIONS, ALL SECTORS, 2011/12 TO 2013/14**





Where there is serious and persistent inadequate quality of care, providers will be put into a special measures programme. CQC's role in special measures is to provide a rigorous and independent judgement of where care is failing, and whether care has improved. In the NHS, where needed, we can recommend that providers are put into special measures, and when it is suitable to take them out. Over the coming year we will further develop special measures to target inadequate providers in adult social care and primary medical services.

Through our registration of all providers of health and adult social care services, we will be firm on which models of care are inappropriate and which will not be allowed to operate. We will stop providers at significant risk of providing poor care from entering the market, through strengthened registration against the new fundamental standards, and through the introduction of the legal fit and proper person requirement for directors.

We will also challenge the system and sectors to make tough choices in the interests of people who use services – to ask whether existing providers can improve or whether, in some cases, an alternative provider could offer better services at the same location or nearby. If providers cannot improve then we will stop them from providing services in the interests of people who use their services. In doing so, we will call time on poor care.

While CQC will strive to ensure we can give robust and transparent assessments of quality across health and adult social care, the responsibility for maintaining and improving quality sits with the provider. As the independent regulator with a whole sector overview, we challenge the providers we regulate, their commissioners and other organisations that play a role, to do whatever they can to drive up improvements in quality and to reduce variation.

## Our challenge to providers and the system

CQC is calling time on the unacceptable lottery of poor care. We are challenging every health and social care provider, and every commissioner and oversight body, to deliver the high standards of care that each person in England has a right to expect.

Tackling failure wherever it is found should be a priority for the managers and leaders of care providers, the people who commission services, and the system leaders. By targeting efforts to improve care that is inadequate or requires improvement, unacceptable variation will be reduced.

We should all celebrate the success of those services delivering outstanding care and recognise the dedication and skill of those on the frontline in these services, and also the leadership standing behind them.

Over the course of 2013/14 and into 2014/15, CQC has and will continue to uncover poor quality care through its tougher, people-centred and expert-led inspections. We challenge the system to respond in two ways.

- **Firstly, don't wait for a CQC inspection to get to grips with what 'good' care looks like.** CQC is publishing through 'provider handbooks' what good looks like so that everyone – providers, care staff, public, and the wider system – can understand what good care is and what they should expect. Take the time now to understand what good care is for people who use your services, and ask yourselves whether the services you provide are meeting this expectation. If you are not confident or satisfied that you are meeting expectations, then act now to improve them. This may mean small changes; it may mean more fundamental change to how the service is led and managed.

Having the courage to act when you see something that is not right is a sign of good leadership. So is promoting and celebrating the

willingness of staff to speak up when they see poor care.

- **Secondly, where CQC identifies failing services, the provider and the supportive system around them should act.** Whether the system includes the local authority, NHS England, the local clinical commissioning group, Monitor, the NHS Trust Development Authority, the industry body or a professional body, having recognised there is a problem with the quality of care there is a collective duty to act. We urge the system to respond swiftly in the interests of the safety and wellbeing of people who use the service.

This may require in some cases a dedicated programme of support (including through a special measures programme, where relevant) or specialist expert advice, or peer to peer support. Although there have been some good and effective initiatives put in place, to date the response to failure has been patchy. In some cases there has been denial of an uncomfortable truth, and in others there has been a lack of clarity over which organisation is taking responsibility to act swiftly in the interests of people who use services.

CQC's challenge to the extended web of organisations that make up 'the system' is to turn around this patchy track record, to appraise what works and to focus resources where they are needed most and in a way that will have greatest impact. And, where necessary, to take tough decisions about changing ownership, changing board members, or decommissioning services where the quality of care is not good enough.

Good leadership, and the buy-in of staff to the values and goals of improving care for the people who use their services, is of primary importance in effecting change. More and continued attention should be placed on supporting failing providers to upskill or bring in strong, effective leaders.



Successful improvement also means using all levers that drive improvement. Greater transparency and candour, humility to copy what works rather than create from new, and action in response to complaints, concerns and public feedback will all be important.

Renewing the collective efforts to act where we find failure will have a significant and lasting impact on the quality of services for people who use them. Where there is little improvement or co-ordinated support to help a failing provider, CQC will increasingly raise questions relating to the role that other statutory and professional bodies could or should play.

## Our invitation to people who use services, their families and their carers

With all the complexity and challenge in the health and care system, the focus should always be on people who use services. CQC is putting people at the heart of how care is regulated so that we act on their behalf and give them a greater voice. We have a role to play in increasing the availability and usefulness of information on quality. People who use services can help us with this, telling us what information they find most useful.

We also help to highlight the variations in care so that people can make informed decisions. As more information becomes available on the quality of care, we invite people to use it. Whether that is the results of patient and staff surveys including the Friends and Family Test, or our CQC inspection reports, the more information is used to inform decisions the better care will become.

The role of people who use health and social care services is central to making improvement happen. CQC invites you, as people who use health and care services, to:

- Become ever more empowered consumers; through making informed choices about your care you can drive change. Where there is no or little choice, then ask those care workers and professionals who are there to support you to ensure your interests are represented fairly.
- Give feedback on both the good and the bad care you receive, and look at feedback from others before making decisions about the care services you need. Fill in the Friends and Family Test when you are offered it and tell CQC about your care (call us on 03000 616161, email [enquiries@cqc.org.uk](mailto:enquiries@cqc.org.uk), or use **our online form**).
- If the care you receive is unsafe or doesn't meet your expectations, then raise your concern with those who are meant to be caring for you, or with the management of that service. Raising a concern or complaint is a way to learn for the future and good providers will always listen to and respond with the intention to learn and improve.

CQC will work hard to help protect you, inform you and amplify your voice – to give everyone the opportunity to access good and outstanding care.



## PART 2

# ADULT SOCIAL CARE

### Key points

- There is significant variation in the quality of adult social care. In particular, people in nursing homes tend to receive much poorer care than those living in residential (non-nursing) care homes.
- We see many examples of excellent care being delivered up and down the country. Providers need to look at those who are doing it well and learn from them.
- Working in adult social care is a tough job, but a very rewarding one. To ensure high-quality care, it is important that staff are supported, valued and trained well.
- Encouraging more nurses to work in the care home sector should be a higher priority. We are concerned about the current shortage of nurses in adult social care. In 2013/14, one in five nursing homes did not have enough staff on duty to ensure residents received good, safe care.
- Good leadership is central to people receiving high-quality care. We found that the care provided by care homes with a registered manager in place was substantially better than by those homes that had not had a registered manager in place for six months or more.
- We have concerns about 15-minute home care appointments, and whether they can truly deliver care and support that is safe, caring, effective and responsive to people's needs.



## Introduction and context

Our Chief Inspector of Adult Social Care, Andrea Sutcliffe, leads our adult social care inspection directorate. Her staff regulate and inspect residential care homes and nursing homes, home care services, hospices, Extra Care housing, Shared Lives and supported living services.

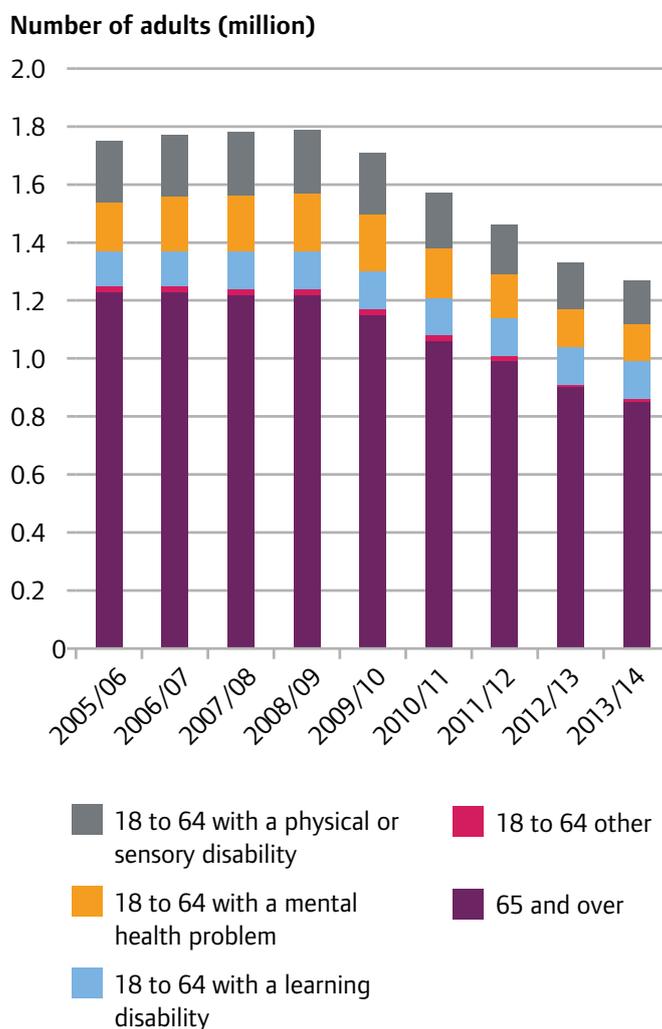
People using social care services often have complex and varied needs which can be life-long. Social care is generally provided in people's own homes, either because domiciliary care is provided at home or because their home is now a nursing home or a residential care home. High-quality social care can make a huge, positive difference to people's lives.

This ambition to have high-quality care available for everyone is set within a challenging context. This has been difficult for several years, with declining public sector budgets, increasing demand for services from an ageing population and pressure on people's ability to pay towards their own care. Commissioners and providers will need to consider how care is organised and provided within their budget constraints to meet the changing and growing needs of people. The number of people receiving state-funded care has decreased (**FIGURE 2.1**), despite the growing needs of an ageing population living with more long-term conditions.

### The Care Act 2014

While the adult social care system continues to face financial pressure, it will also see a significant period of reform in the next few years, as the requirements of the Care Act 2014 become law. The new statutory requirements for safeguarding adult boards, which will develop shared strategies for safeguarding and report to their local communities on their progress, will be an important way to ensure that system partners identify issues and learn lessons.

**FIGURE 2.1: NUMBER OF ADULTS RECEIVING LOCAL AUTHORITY FUNDED SOCIAL CARE SERVICES, 2005/06 TO 2013/14**



Source: National Audit Office analysis of referrals, assessments and packages of care (RAP) data, 2005/06 to 2012/13; Health and Social Care Information Centre analysis of RAP data, 2013/14

A number of elements of the Care Act will impact on the social care market, such as direct payments in residential care, universal access to information, advice and prevention services, and the financial reforms of deferred payments and capped care costs.

CQC's role in providing accurate and impartial information about quality in adult social care will be critical in helping people who use services, their carers and their families to make informed choices

about their care. The cumulative impact of all these changes on the quality and stability of the social care market is difficult to accurately predict and is something we will keep under close review.

## Stability of the market

Most care providers are relatively small. Should they fail, local authorities are able to ensure that people's care needs are still met with minimum disruption to them, their carers and their families. Providers join and leave the adult social care market frequently, and local authorities manage the vast majority of these well.

However, corporate ownership (by which we mean ownership by an overarching 'brand') is increasing. There were 182,000 available residential and nursing home beds in corporate owned care homes (39% of the total of around 465,000 beds) at the end of 2013/14, compared with 172,000 (37%) at the end of 2012/13. Where care providers operate in several local authority areas, are particularly dominant in some, or provide highly specialised services, their sudden or unplanned exit from the market could present a very real challenge to authorities needing to ensure people's continuity of care. We saw this in the collapse of Southern Cross in 2011. We estimate that there are around 50 to 60 such 'difficult to replace' providers.

We asked the Institute of Public Care to analyse the main factors that affect stability in the adult care market. Their report was produced in relation to our new market oversight responsibilities, but it was also a useful indicator of some of the challenges facing providers. They told us that:

- Recruiting a trained and well paid workforce is a major issue for the future, and the older people's care market continues to be fragile.
- A rise in property values, alongside the demands of regulation and lower levels of local authority funding, may persuade providers to cash in their assets and leave the market.

- The greatest risk is likely to be the failure of a large care home provider that does not own the properties in which it operates, and where it has a concentration of homes in a limited number of authorities in less affluent areas.

In response to the issue of 'difficult to replace' providers, from April 2015 CQC will have the duty to assess their financial sustainability. The intention of the scheme is not to prevent provider failure, but to ensure there is an early warning so local authorities can ensure continuity of care for people if a large business fails. With new powers through the Care Act 2014, CQC will be taking on a new role of providing market oversight in the adult social care market for the providers identified. We are working with our partners across the sector for the remainder of the year to develop the detail underpinning how these new powers should be delivered.

## Setting a higher bar for entry into the adult social care market

To provide health and care services in England, services must register with CQC. In doing so they must give an undertaking that they will provide safe, high-quality care.

In July 2013, we introduced more rigorous checks of new providers applying to register learning disability services in line with the commitment we made in the Winterbourne View Concordat. This included not only asking more questions in the application form about the premises, environment and quality assurance processes but also asking how the applicant would meet the individual needs of people who use services, focused on the five questions about safe, caring, effective, responsive and well-led services.

We will be rolling out this approach to all new providers in the coming year. Registration will assess whether they have the capability, capacity, resources and leadership skills to meet relevant legal requirements. We will make judgements about, for example, the fitness and suitability of

applicants; the skills, qualifications, experience and numbers of key individuals and other staff; the size, layout and design of premises; the quality and likely effectiveness of key policies, systems and procedures; governance and decision-making arrangements; and the extent to which providers and managers understand them and will use them in practice.

In making these changes, we intend to focus on the robustness and effectiveness of the registration system in a way that does not stifle innovation or discourage good providers of care services, but does ensure that those most likely to provide poor quality services are discouraged from doing so.

## Good care is achievable by all

There are significant differences in the quality of adult social care that people receive in England. We see many examples of excellent care being delivered up and down the country. We also see care that is nowhere near good enough. This variation is unacceptable. We see time and time again that good and outstanding care can be delivered. Providers need to look at those who are doing it well and learn from them.

Our new tougher, more rigorous and more expert-led inspection – launching formally in October 2014 – aims to get under the skin of the services provided in adult social care. By focusing on the same five questions – are services safe, effective, caring, responsive to people’s needs and well-led – CQC will highlight where we find good and outstanding care and expose where care requires improvement or is inadequate.

Over the coming years we will develop a much more detailed and comparable understanding of quality in adult social care, from the very best to the very worst.

## CASE STUDY: EXCELLENT CARE AT HOPE HOUSE CHILDREN’S HOSPICE

Hope House Children’s Hospice provides specialist nursing care for up to 10 children and young people with life limiting conditions from Shropshire, Cheshire and north and mid-Wales. The hospice also supports the families of the children and young people who use the service.

The staff understood the children and young people’s needs. Children, young people and their families told us they were happy with the care. We clearly saw that care was provided with kindness and compassion.

The care was provided in a safe environment by staff who were appropriately trained and skilled. They had a robust induction and training system to ensure this. Throughout our inspection we saw examples of innovative care that promoted an inclusive culture.

The hospice appointed a transition nurse to support young people as they moved to adult services. The culture was one of promoting independence, for example enabling people to administer their own medicine. The children and young people and their families were involved in risk assessments and care planning. A diversity group has led to improvements in the service. We received highly positive views from staff about working at the hospice and from relatives about the attitude and approach of staff.

Individual staff had become care champions to ensure that best practice guidance was implemented and followed by all staff. The registered manager consistently assessed and monitored the quality of care.

## CASE STUDY: TACKLING APPALLING CARE AT A CARE HOME IN EAST ANGLIA SPECIALISING IN DEMENTIA

We received a report from a whistleblower alleging abuse by other members of staff. The allegations had been investigated locally, but the police, the safeguarding vulnerable adults team at the local authority and previous CQC inspections could not find clear evidence of the problem. However, the local council told CQC that they felt there was a poor culture among staff at the home that they couldn't pin down.

We inspected the care home as part of our tougher, person-centred and more expert-led inspections. While the environment of the reception area was immaculate, the residential areas beyond it smelled of urine. We found residents still in bed at 10.30am, with many not getting the help they needed to eat breakfast.

One person who was still in bed at noon told us, "I have been waiting for hours for staff to come and help me get up."

Some people were lying in wet beds. Staff were not responding to people who were calling out for help and inspectors had to intervene to tell staff to deliver care to people. There was a lack of direction and leadership in the home, with a blasé attitude towards the allegations of abuse.

We took decisive action, issuing four warning notices. We worked closely with the local council and local NHS organisations. We raised the issues with the corporate owner, and they removed the registered manager in the interests of the 80 residents, so that immediate improvements could be made while ensuring the continuity of care for people who were in vulnerable circumstances.

We've been back to see that improvements are being made, and will continue to actively monitor this provider to ensure this momentum is maintained.

In 2013/14 we found that the general overall improvements in the quality of social care that we started to see in 2012/13 were for the most part sustained (**SEE FIGURE 2.2**). However, figure 2.2 also shows the wide differences in how people were cared for by adult social care services over the last three years. For example, people were more likely to be treated with dignity and respect than have their safety ensured. In our inspections, we see this variation in most types of social care setting and it has not narrowed over the last three years.

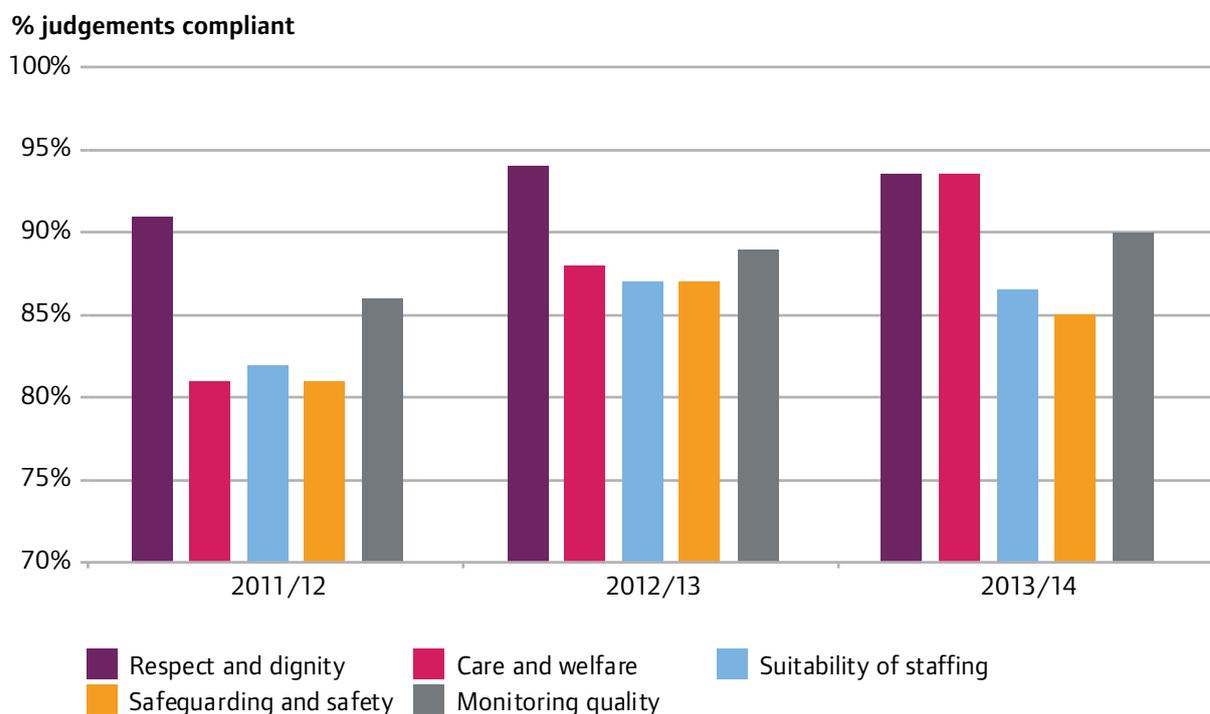
### Nursing and residential care homes

Once again we found that people living in nursing homes experienced poorer care than those living in residential care homes with no nursing provision (**FIGURES 2.3 AND 2.4**). These differences have not changed over the last three years and are a continuing concern.

We have also seen significant local differences in the quality of care that people received. We looked at the quality of care homes by the local authority in which they are located (**FIGURE 2.5**). In some areas, almost 100% of care homes met the expected standards of quality; in others it was less than 70%. This shows that good care is being delivered up and down the country. We would encourage providers to look at those who are doing it well and learn from them.

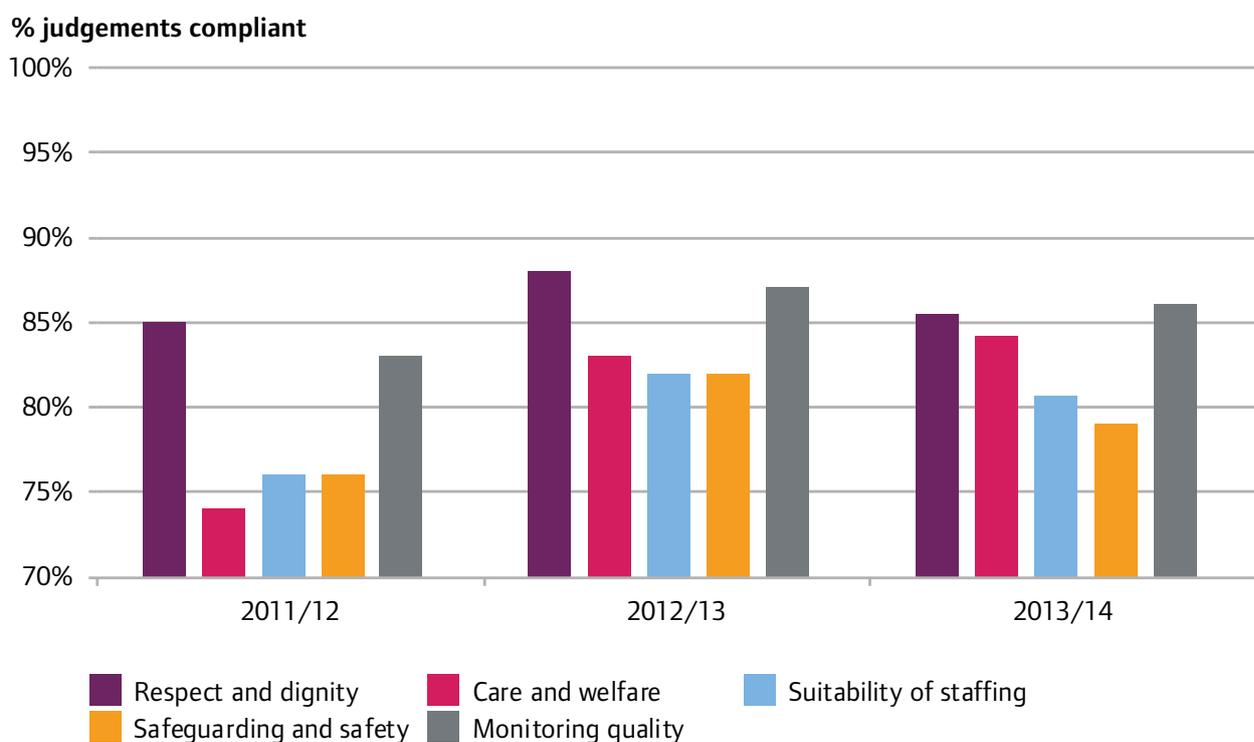
In 2013/14, we also saw a difference in the quality of care according to the size of the service. Among residential care homes, we found that there was some association between the size of the home (by number of beds) and the quality of the care provided, with smaller homes tending to perform better (**FIGURE 2.6**).

**FIGURE 2.2: TRENDS IN PERFORMANCE AGAINST QUALITY STANDARDS IN ADULT SOCIAL CARE, ALL TYPES, 2011/12 TO 2013/14**



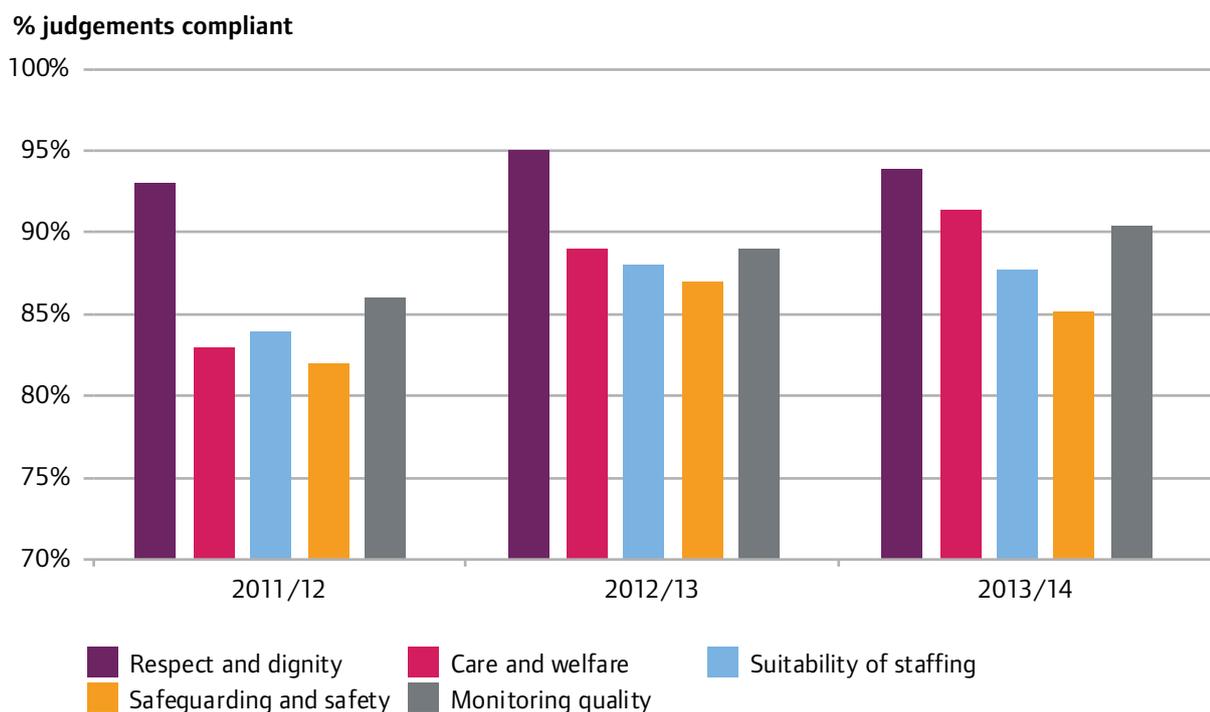
Source: CQC compliance data, 2011/12 to 2013/14

**FIGURE 2.3: TRENDS IN PERFORMANCE AGAINST QUALITY STANDARDS, NURSING HOMES, 2011/12 TO 2013/14**



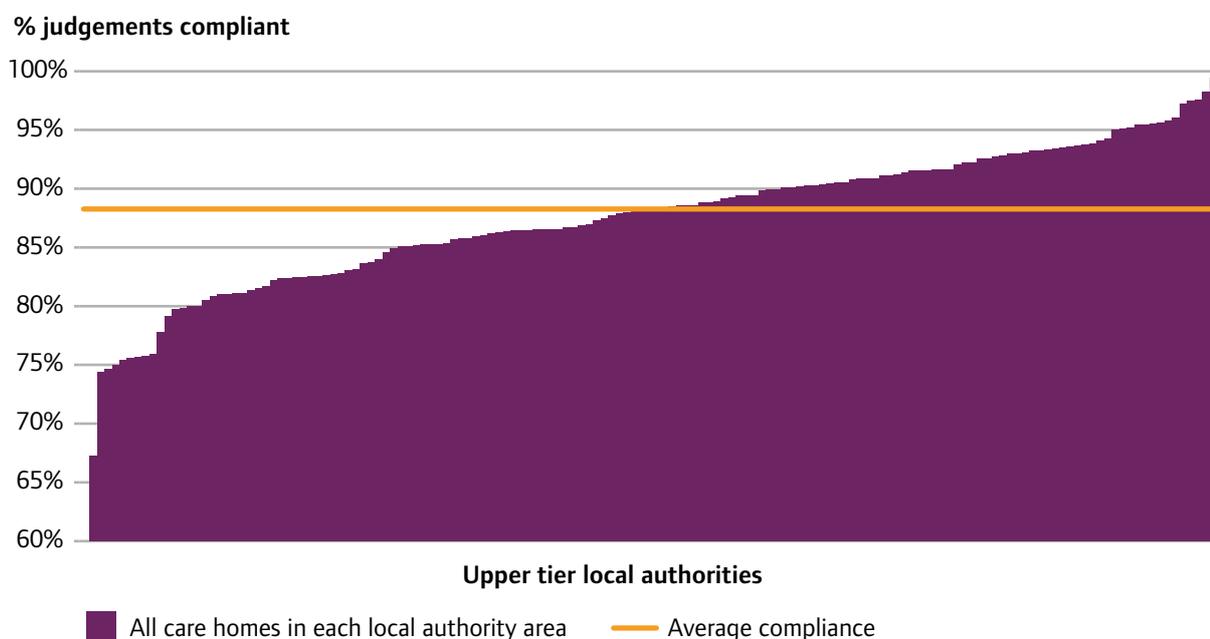
Source: CQC compliance data, 2011/12 to 2013/14

**FIGURE 2.4: TRENDS IN PERFORMANCE AGAINST QUALITY STANDARDS, RESIDENTIAL HOMES, 2011/12 TO 2013/14**



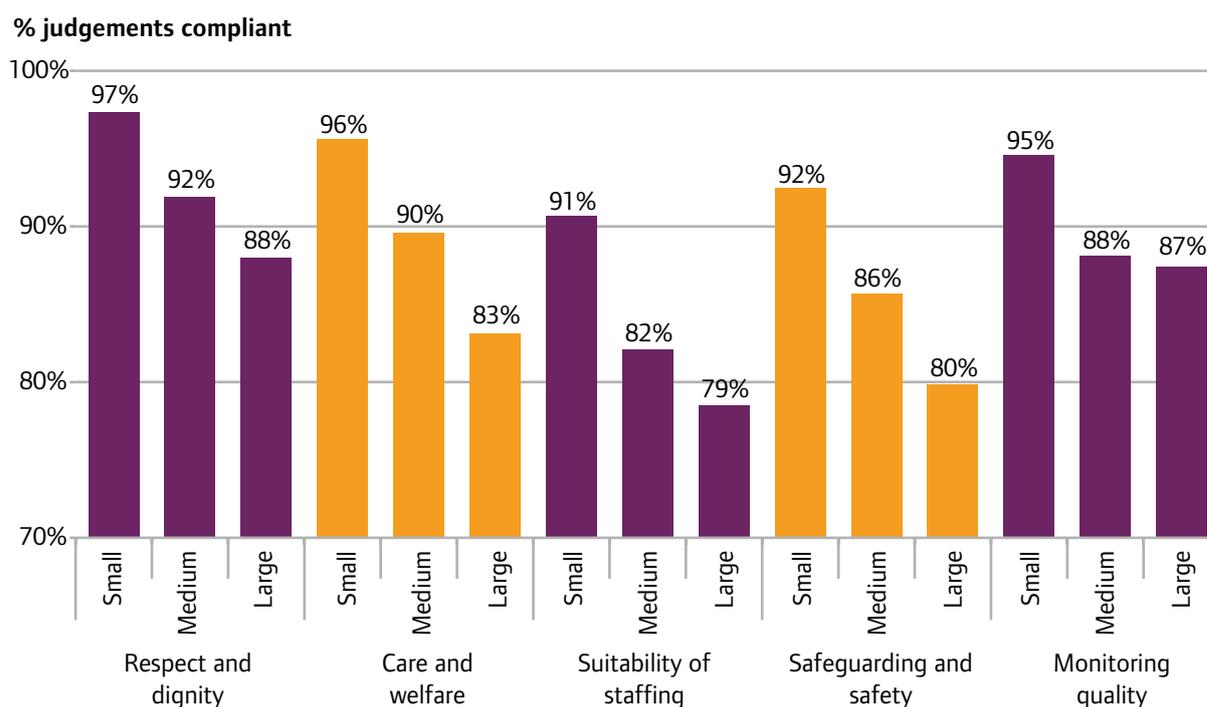
Source: CQC compliance data, 2011/12 to 2013/14

**FIGURE 2.5: PERFORMANCE AGAINST QUALITY STANDARDS WITHIN UPPER TIER LOCAL AUTHORITIES, 2013/14**



Source: CQC compliance data, 2013/14. Isles of Scilly omitted due to low number of inspections

**FIGURE 2.6: PERFORMANCE AGAINST QUALITY STANDARDS FOR RESIDENTIAL CARE HOMES, BY SIZE, 2013/14**



Source: CQC compliance and registration data, 2013/14. Note: Small 1-10 beds, Medium 11-50 beds, Large >50 beds

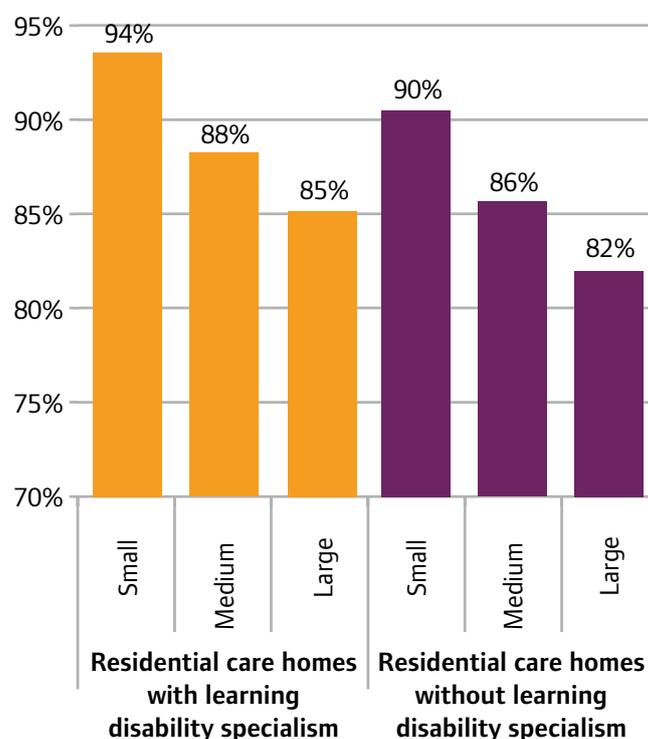
Locations with a learning disability specialism are far more likely to be small than other residential care homes. Smaller learning disability services perform better than medium and large services (FIGURE 2.7). However it is interesting to note that learning disability services do better than non-learning disability services regardless of size.

### Home care

The quality of home care services improved slightly in 2013/14 (FIGURE 2.8).

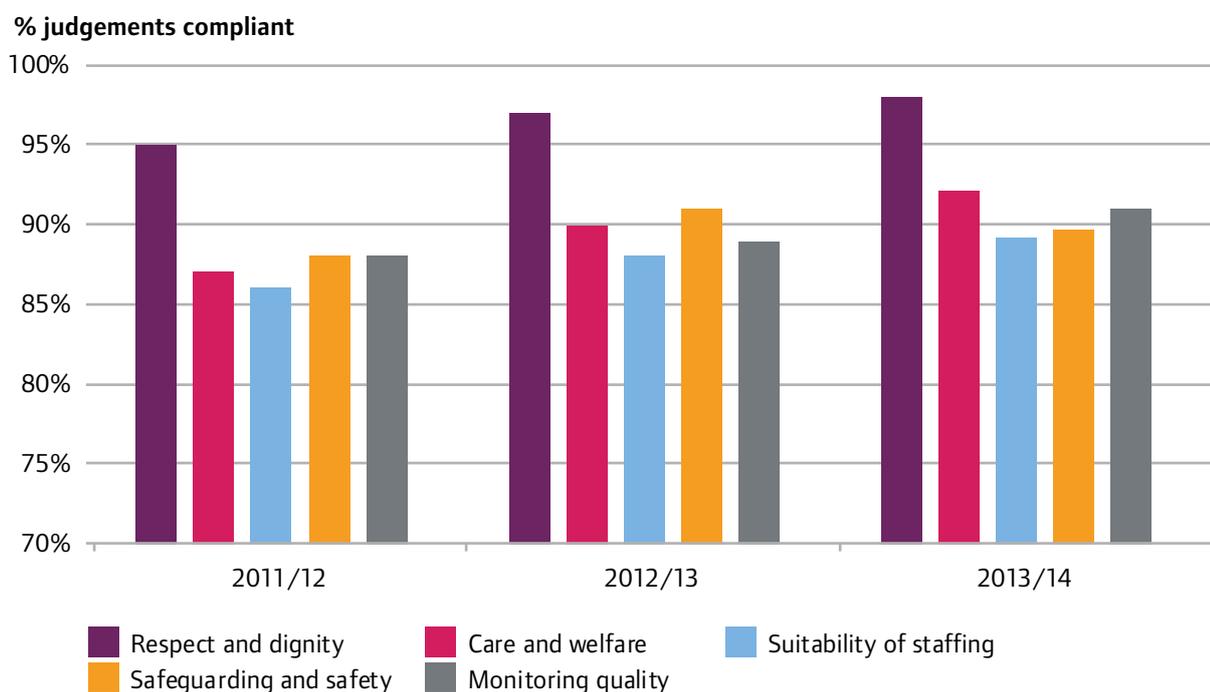
From October 2014, when we start our new tougher approach to inspections of adult social care services, we will be assessing a service using our five key questions – is it safe, effective, caring, responsive to people’s needs and well-led?

**FIGURE 2.7: PERFORMANCE AGAINST QUALITY STANDARDS BY RESIDENTIAL CARE HOMES, WITH AND WITHOUT A LEARNING DISABILITY SPECIALISM, 2013/14**



Source: CQC compliance and registration data, 2013/14

**FIGURE 2.8: TRENDS IN PERFORMANCE AGAINST QUALITY STANDARDS, DOMICILIARY CARE AGENCIES, 2011/12 TO 2013/14**



Source: CQC compliance data, 2011/12 to 2013/14

One example of looking at the quality of care in this way is the issue of 15-minute home care appointments. We are clear that the experiences of people using services should be taken into account and that a service should be measured by what it achieves, rather than the time it takes.

Sometimes providers may feel forced to deliver care in this way because that is what has been commissioned. But it can also be due to poor organisation of rotas and timetables, cutting corners to reduce costs, inadequate assessments of people’s needs and a lack of flexibility on the part of the provider.

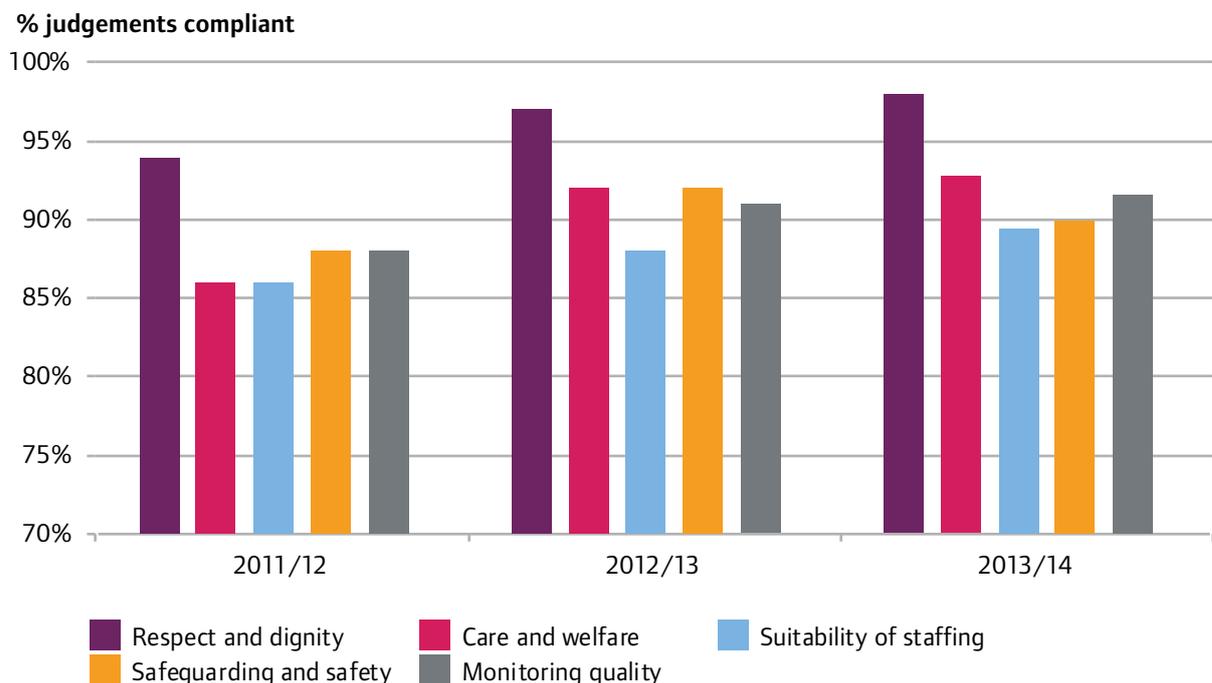
Our focus is the quality of the service and how it impacts on the people using that service. If we rate services as inadequate or requiring improvement, we expect providers to use our reports and rating judgements to reflect on the reasons for poor services – and if it is within their own responsibility to sort out, then to do just that. But if it is an issue

they need to raise with commissioners, they should use our reports to explain why.

### Other providers of social care

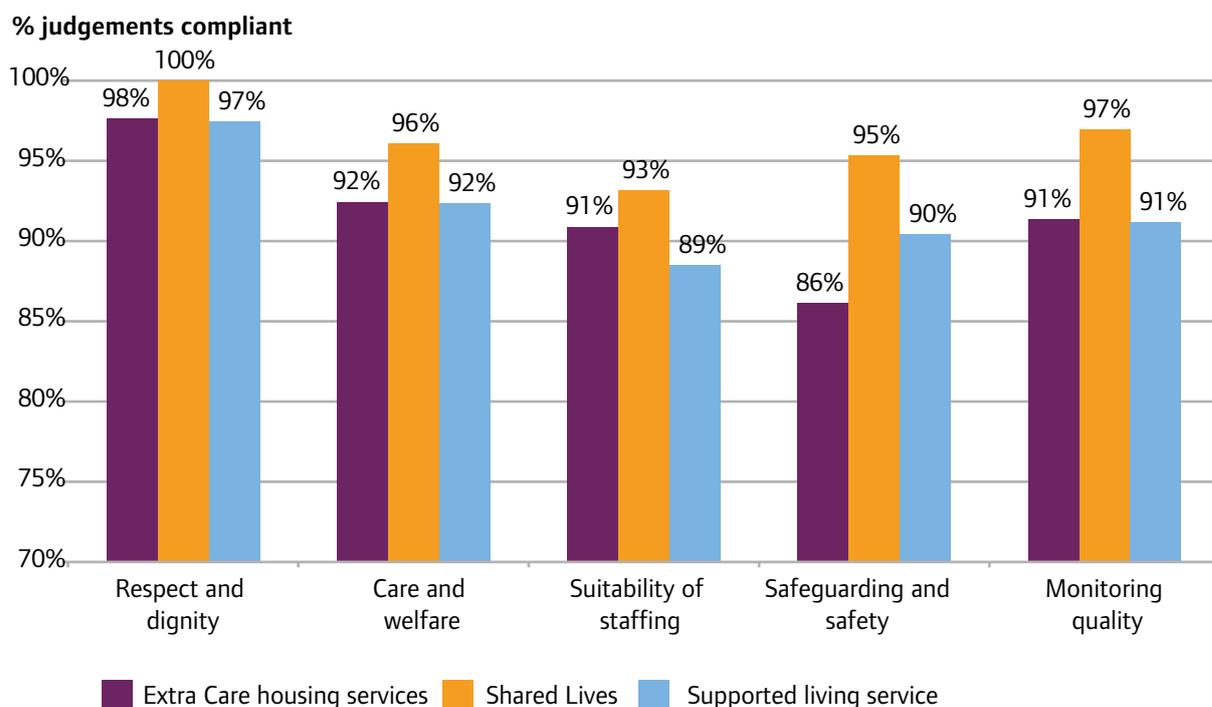
The quality of other social care services, such as supported living, Shared Lives and Extra Care housing services, also improved slightly in 2013/14 (FIGURE 2.9). Figure 2.10 shows a further breakdown of the care provided by the community social care group, where there were some notable differences in performance.

**FIGURE 2.9: TRENDS IN PERFORMANCE AGAINST QUALITY STANDARDS, 'COMMUNITY' SOCIAL CARE SERVICES, 2011/12 TO 2013/14**



Source: CQC compliance data, 2011/12 to 2013/14

**FIGURE 2.10: PERFORMANCE AGAINST QUALITY STANDARDS FOR DIFFERENT SERVICES WITHIN COMMUNITY SOCIAL CARE 2013/14**



Source: CQC compliance data, 2013/14

## What impacts on quality?

### The care workforce

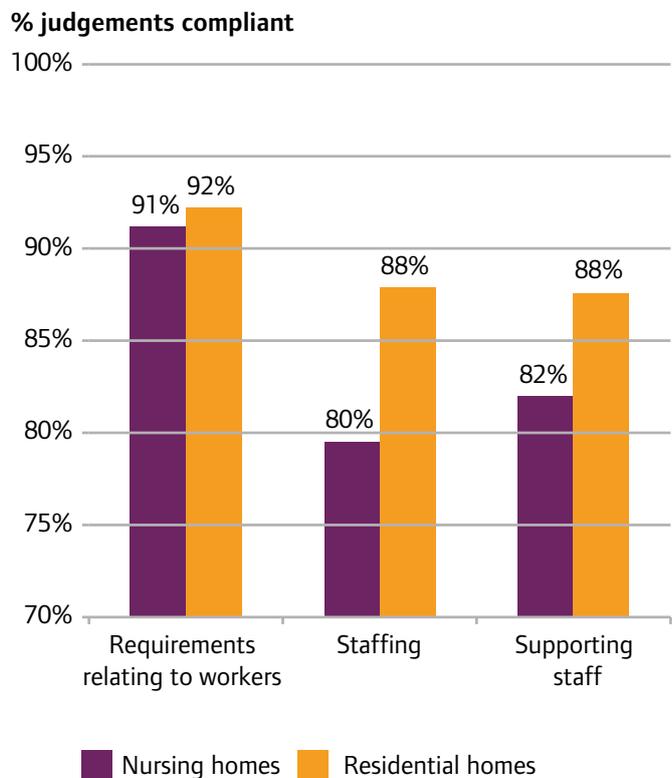
A caring and committed workforce, appropriately skilled and supported through good training and supervision, is central to providing high-quality social care. Good care workers enhance the independence and quality of life of the people they care for. It is a hard role to do well and it can put a strain on the capacity and capabilities of the care staff. Many care settings experience high turnover of staff, who are often on low wages.

We are particularly concerned about the current shortage of nurses within social care services. In 2013/14 we found that many nursing homes did not have sufficient staff on duty to ensure residents receive good, safe care (**FIGURE 2.11**).

When we split nursing homes into corporate providers (that is, those that are operated under an overarching 'brand') and non-corporate providers, corporates in 2013/14 had better processes for recruiting and training staff, but had more problems with overall staffing levels.

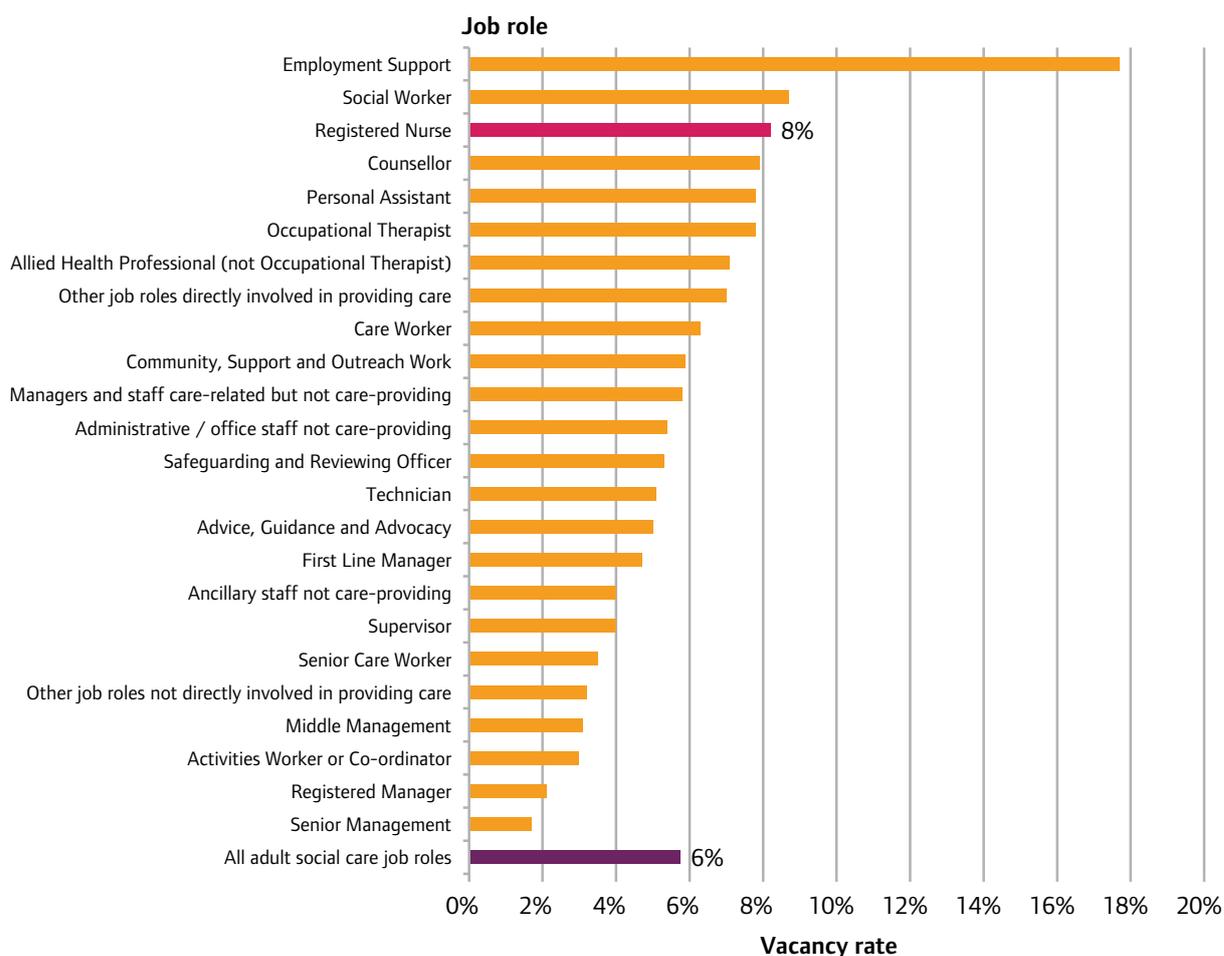
“The care staff are aptly named; they really do care”

**FIGURE 2.11: PERFORMANCE AGAINST STAFFING STANDARDS FOR NURSING AND RESIDENTIAL HOMES, 2013/14**



Source: CQC compliance data, 2013/14

**FIGURE 2.12: SOCIAL CARE VACANCY RATES BY JOB ROLE, JULY 2014**

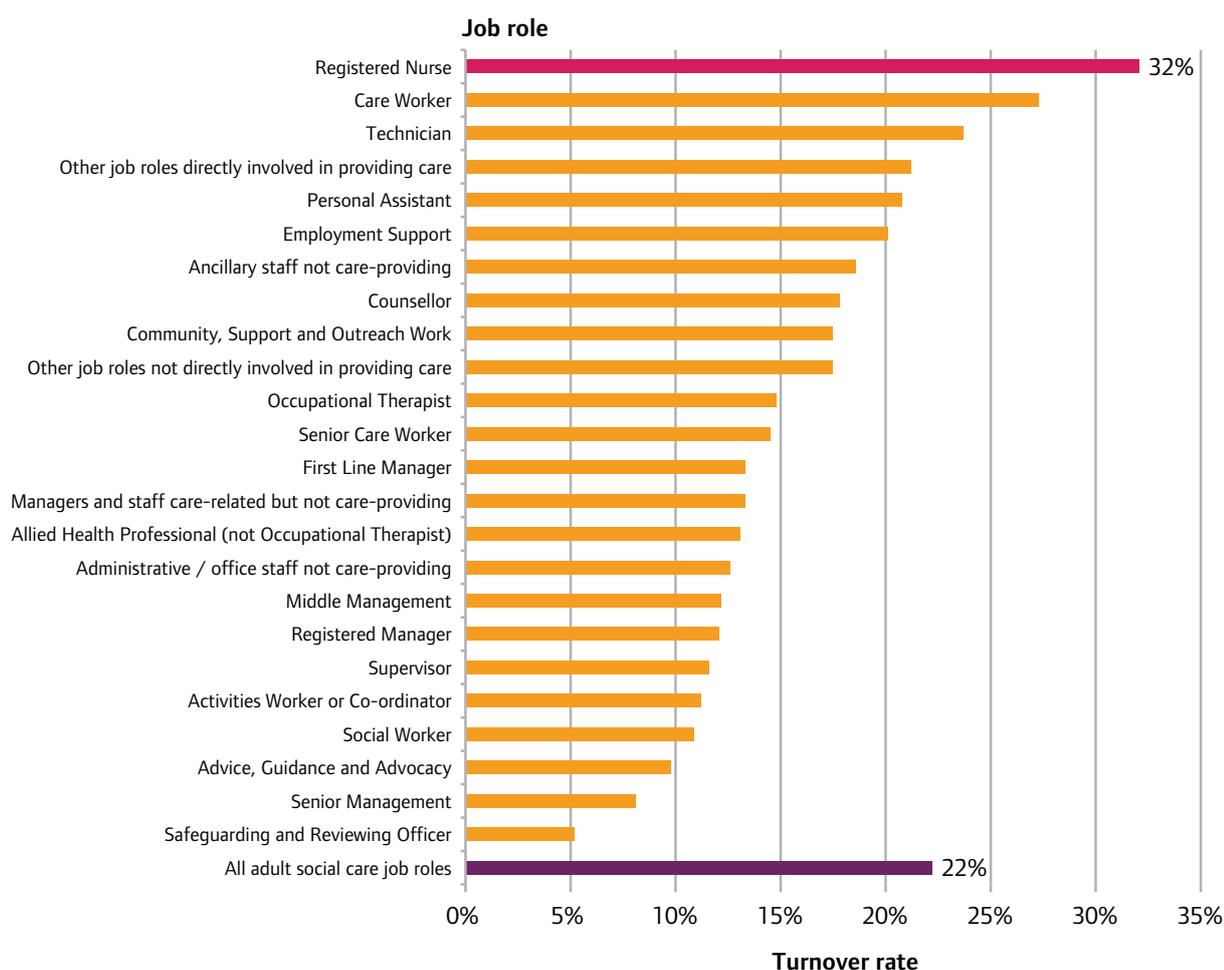


Source: Skills for Care data, July 2014

Data provided by Skills for Care shows that nursing vacancies and turnover within social care are a particular problem. Registered nurses experience the third highest vacancy rate of all care roles (8.2% on average across the country in July 2014) (FIGURE 2.12). This is exacerbated by wide regional differences. At local authority level vacancy rates ranged from 0% to over 36%.

Skills for Care data also shows that registered nurses within social care settings have the highest turnover of any job role at 32% (FIGURE 2.13). Again, this is exacerbated by regional differences. In some local authorities in July 2014, turnover rates were approaching 100%.

**FIGURE 2.13: SOCIAL CARE TURNOVER RATES BY JOB ROLE, JULY 2014**



Source: Skills for Care data, July 2014

Although there is no clear evidence of what is causing this shortage of nurses, plausible explanations include providers reporting that they find nurse recruitment harder in areas where there has been a push from the NHS to recruit additional healthcare-based nurses. The recent increase in nurses in the NHS following the Francis Report may have exacerbated this. There may also be challenges about the perception of how well non-health care nursing roles are seen to fit into long term career paths for nurses.

This issue is now impacting on the quality of care, and is a pressure that is likely to increase as many of the current registered nurses working in social care are approaching retirement age. Around 29% of

these registered nurses are likely to retire in the next 10 years according to Skills for Care.

“The staff really understand who my family member is, their history, their likes and dislikes.”

“I have quite complicated needs – and a lot of medication – the care workers have the right skills and I believe the provider monitors their suitability to do difficult tasks.”

In domiciliary care, some care workers are paid at or even below the National Minimum Wage. In 2013 the Low Pay Commission reported that, between October 2008 and April 2012, 1.1% of domiciliary care workers were paid below the minimum wage. This rose in the period October 2011 to April 2012 to 2.5%<sup>14</sup>. In each case a larger proportion were paid at the minimum wage, indicating that even where the law is not broken there are providers who do not or cannot pay rates that might be expected to compete with other employment options in or beyond health and social care.

We are encouraged to see the development, jointly by Health Education England, Skills for Care and Skills for Health, of a Care Certificate for healthcare assistants and social care support workers. This was one of the key recommendations of the review by Camilla Cavendish, in the wake of the Francis Inquiry, into their recruitment, learning and development. The review found that the preparation of healthcare assistants and social care support workers for their roles was inconsistent.

Establishing the Care Certificate should ensure that support workers have the required values, behaviours, competences and skills to provide high quality, compassionate care. It is planned to be introduced in March 2015.

## Leadership

“This is a really happy home. I think that comes from the top.”

We are clear that providing good quality care requires good leadership. This is why in our new approach to regulation and inspection, we will ask as one of our five key questions: are services well-led?

The leadership role of the registered manager is important in making a difference to people’s experiences of care. A registered manager is a person who has registered with CQC to manage the service and has specific legal responsibilities for the service.

### CASE STUDY: FOCUSING ON LEADERSHIP IN OUR INSPECTIONS, MERLEWOOD HOUSE

All the care staff at Merlewood House told us about the strong commitment they had to providing a good quality service for people living in the home. They said they were well supported by their managers and enjoyed their role. One member of staff told us, “We have excellent staff and management team. The managers are very supportive and approachable”.

Staff were invited to house meetings and attended handover meetings at the end of every shift. The manager and deputy manager had an ‘open door’ policy and staff were encouraged to talk to them about any aspect of practice. Staff were well supervised and had an annual appraisal of their work, which meant they could express any views about the service in private. Staff were aware of the whistleblowing procedures if they needed to raise any concerns about the managers or organisation. There was a culture of openness in the home, allowing staff to question aspects of the care delivery and suggest new ideas.

The manager and deputy manager used a number of ways of gathering and recording information about the quality and safety of the care provided. The deputy manager carried out audits of the service which included checks on care plans, activity evaluations, risk assessments, finances, records and health and safety. We saw copies of the completed audits during the visit and saw that action plans had been drawn up to address and resolve any concerns.

In January 2014 the registered manager was awarded an “Outstanding Leadership” award for the north region by the provider, the National Autistic Society.

Our inspection data from 2013/14 confirms that having a registered manager is correlated with better care. We identified care homes where there had been no registered manager in place for at least six months, and the differences were stark. Care homes with a manager in place were much better at meeting quality standards than those homes without a manager in place for more than six months (FIGURE 2.14).

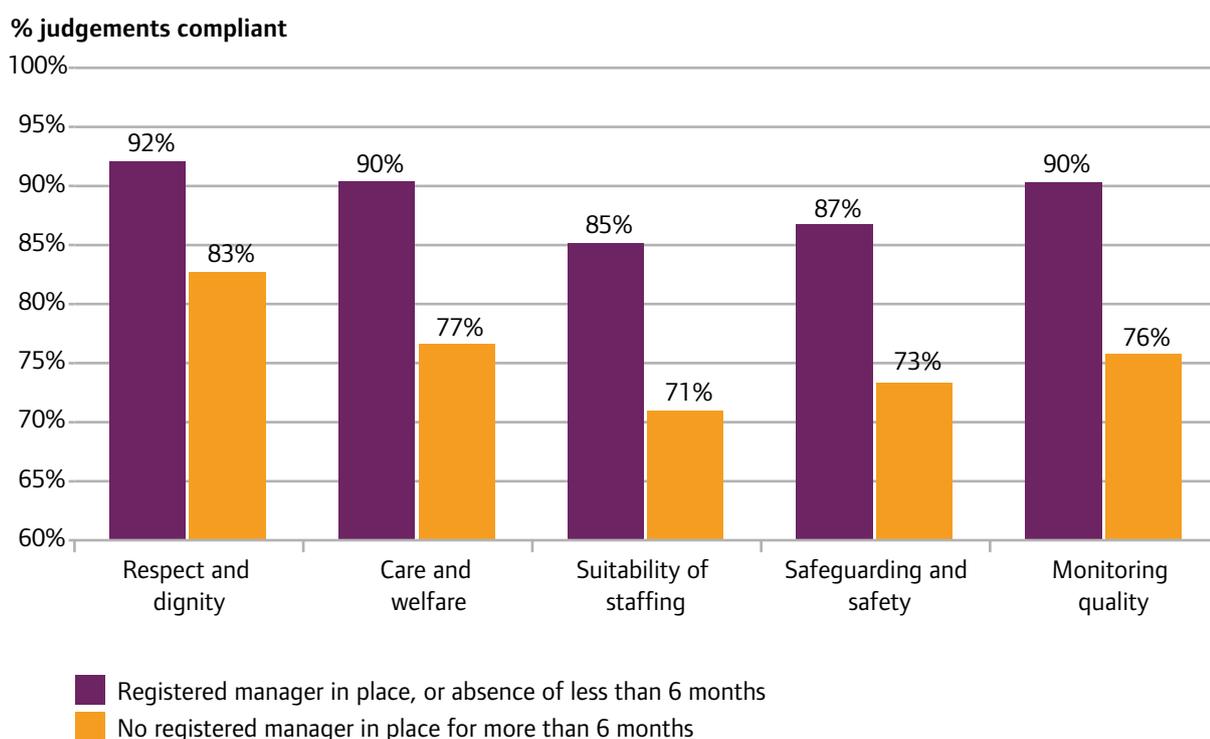
The lack of a registered manager is unacceptable. We ran a project from November 2013 to April 2014 aimed at significantly reducing the number of locations operating without a registered manager. We focused on 2,439 locations that had not had a registered manager for more than six months. The majority of providers responded positively to our challenge and ensured that registered managers were in post. By April 2014, 1,395 of those locations had put a registered manager in place. A further 470 (20%) manager applications had been submitted for approval.

We used our enforcement powers in relation to 590 locations that failed to appoint or submit an application for a registered manager, and we have continued to take action against those that have not.

Going forward we have made changes to our methodology to always highlight and routinely monitor if a registered manager is in place or not where one is required. In adult social care, a service will not normally be eligible for a rating higher than 'requires improvement' if it has been without a registered manager for more than six months without a good reason.

“All the staff are discreet and handle personal things so well. I never feel uncomfortable, the staff are so respectful.”

**FIGURE 2.14: PERFORMANCE AGAINST QUALITY STANDARDS, RESIDENTIAL CARE HOME PROVIDERS WITH AND WITHOUT A REGISTERED MANAGER, 2013/14**



Source: CQC compliance and registration data, 2013/14

## **CASE STUDY: A RELENTLESS FOCUS ON ENDING THE POOR CARE GIVEN TO RESIDENTS OF A CARE HOME IN NOTTINGHAM**

Our inspector raised concerns, in successive inspections, about the lack of dignity and respect shown for people living in a care home in Nottingham. At the same time, one of the nurses had raised concerns by whistleblowing, and there had also been a number of safeguarding alerts.

We carried out an inspection and found that people were not always helped to eat their meals at lunchtime, which often meant they did not get the nutrition they needed. Sometimes people were put too far away from the table, which meant they spilled their food down their clothes before they could eat it.

Several people in one unit were distressed and shouting out for help, but staff were ignoring them. Some did not have their dressings on pressure sores changed often enough. Shockingly, in one unit, people were not given any stimulation at all for the entire two days we were there. Some felt that activities were only for “more able people”.

CQC worked closely with the local council and clinical commissioning group (CCG) and acted quickly after the inspection. We met with the provider and the threat of urgent cancellation of registration was the impetus for action by the provider to bring in highly regarded care staff and managers from other locations in the company.

We did see some initial improvements. But we later received more safeguarding alerts and whistleblowing concerns. The concerns began to mount up, including that staff brought in from other locations had been replaced with agency staff. Finally we received notifications of two unauthorised restraints, one of which had injured a resident.

CQC served the provider with a warning notice. The manager of the home was dismissed and replaced. Two months later we re-inspected and we found such high levels of concern about the immediate safety of residents that we made an immediate decision to stop the provider being able to care for people at that home. The local authority and the CCG served a 30-day closure notice on the provider.

Even though the care in the home was so terribly poor, some residents and their families were concerned at the prospect of having to move home. The local authority made sure that they were able to settle people into new homes, and we subsequently learned that the residents were happy with the outcome.

“I never knew care could be like this” – resident of care home when describing their new home

## CQC's role in reducing variation and encouraging improvement

From October 2014 we will be rolling out the new regulatory approach to the adult social care sector. Similar to other sectors, this will involve a more thorough inspection focused on understanding quality across the five key questions (are services safe, effective, caring, responsive and well-led), and resulting in a rating (outstanding, good, requires improvement or inadequate). We expect the impact of ratings to be a driver for change in the social care market. We have developed the new approach through extensive co-production with the sector – people who use services, carers, providers, commissioners and national organisations.

These new ratings will help people and families make more informed decisions about their care. Choosing a care service, which will either become your home or which will determine who comes into your own home and deliver often intimate care, is a difficult and sometimes stressful decision, often taken at a point of crisis in people's lives. Through greater awareness of what good care looks like, and where it can be found, CQC ratings will help reduce the stress and uncertainty for people making decisions and will help to raise the quality of services to reach and then exceed the level described as 'good'.

We will also increase our responsiveness to complaints and concerns raised about the safety and quality of care – we want to hear from staff, from people who use services and from their carers and families. As there is less data in social care than in healthcare, we will rely much more on other sources of intelligence and information to help us understand the risks associated with a provider's service. Where we listen to complaints we also expect the providers we regulate to be listening too. How complaints and concerns are handled will be an important part of our new regulatory assessment.

## Our challenge to providers and the system

To providers of adult social care services:

- **Maintain a focus on recruiting for values and building the professionalism of staff.**  
Work in adult social care can be a tough job, but it can also be very rewarding for those who have the right values and are able to live up to those values. Providers should ensure that their staff have the skills to do the job they are being asked to do. They should work with organisations such as Skills for Care to ensure recruiting, training and education processes are robust, and skills and values-driven to develop the professionalism of this vitally important workforce. The introduction of the new Care Certificate in 2015 is a welcome development.
- **Leaders at all levels should develop a culture of support, openness and learning.**  
Welcome feedback on the service you provide and treat it as a free source of intelligence that can help you improve. Respond to complaints and concerns openly and without becoming defensive. Investigate cases with a view to zero tolerance of wilful or professional neglect, yet be open and learn from mistakes so that they can be put right before they happen again. Offer support to staff who are trying to do the right thing in often difficult and stressful environments, and enable them with the skills and the emotional support to do the job with compassion.



To the adult social care system:

- **Recognise and value excellence in all staff, especially those in professional or leadership positions.** By recognising the contribution of, for example, registered nurses in nursing homes and excellent registered managers in any service, supportive systems can start to attract, and critically retain, excellent staff in these positions. Stability and professionalism will help to improve care.
- **Have the courage to tackle failure in the interests of people who use services.** Do not accept excuses for inadequate care, but work in the interests of people who use services to strive towards everyone having access to care that is good or better. Help providers share learnings through their networks, corporate structures and trade bodies. For those making funding decisions always ask yourself – would I be happy for my mum or anyone I love to be cared for like this?



## PART 3

# HOSPITALS, MENTAL HEALTH CARE & COMMUNITY HEALTH SERVICES

### Key points

- By the end of August 2014, CQC had inspected 62 NHS acute trusts (of which we had issued formal ratings to 38 trusts, covering 82 hospital-level ratings) under our new approach. We had also inspected 12 mental health trusts and eight community health providers.
- CQC had issued ratings to almost a quarter of NHS acute trusts in England by the end of August 2014. We found wide variation in care between trusts, between hospital sites, between hospital services and within each service – from outstanding to inadequate.
- In September 2014, we awarded the first outstanding rating to an NHS hospital: Frimley Park in Surrey.
- The first acute trusts to be inspected under our new tougher approach tended to be higher risk. Of the 38 acute trusts, nine were rated good, 24 required improvement and five were inadequate.
- Safety was the biggest concern: four out of every five safety ratings were inadequate or requires improvement
- 49 of the 82 acute hospitals were rated as requires improvement or inadequate in terms of being well-led. Again, it should be noted that our early inspections were of higher risk trusts.
- Our new tougher inspections of mental health care found problems with poor physical environments and a lack of admission beds. Also we found that too many people were taken to police cells when experiencing a crisis in a public place, because of problems accessing a place of safety in a mental health service or an emergency department in a general hospital.
- In our initial community healthcare inspections, we found that most staff were compassionate and caring and patients were very positive about the quality of care they received.
- It is very concerning that providers have limited ability to assess the effectiveness of their own services.
- We also need to do more detailed work if we are to assess the effectiveness of acute services more reliably, especially in A&E and outpatients. We are working closely on this with Royal Colleges, professional societies and with organisations responsible for national clinical audits.

## Introduction and context

Our Chief Inspector of Hospitals, Professor Sir Mike Richards, leads national teams of expert inspectors to carry out in-depth and comprehensive inspections of acute hospitals, community health services, specialist mental health services, independent hospitals and ambulance services.

During the year we began the process of developing a radical new approach to inspection in three distinct areas: NHS acute hospital trusts, NHS mental health trusts, and NHS community health services. This new approach is a totally new way of inspecting acute hospitals:

- Gathering and analysing a large amount of hard data and soft intelligence held by many different parts of the system.
- Large multidisciplinary inspection teams consisting of senior clinicians, junior doctors, student nurses, senior health managers, Experts by Experience and patient representatives, and CQC inspectors. The inspection team leaders are senior CQC staff experienced in hospital inspection. They led the process and the relationship with the trust's CEO. A team chair, who is usually a very senior clinician or manager, assured hospitals that leadership of the process was driven by frontline understanding of quality and of how hospitals work.
- Asking the same five questions – are services safe, effective, caring, responsive to people's needs and well-led – and asking them of eight core services in every hospital: A&E, medical care (including older people's care), surgery, critical care, maternity and family planning, services for children and young people, end of life care, and outpatients.
- Placing huge value on the insight from talking and listening to staff and patients.

- Testing for the first time an approach to ratings for hospitals, so that the public can clearly understand the quality of different services on offer and so that there is a clear driver for improvement.
- Looking for care that is good and outstanding – not just what requires improvement or is inadequate.
- Convening a meeting of all local health economy parties at a quality summit to agree with each trust a coordinated plan of action and support needed.

## Understanding the wider context and pressures on the sector

We have seen some excellent examples of care in England's hospitals, mental health service and community health. There are a number of internationally renowned hospitals within the NHS and ours is one of the most progressive healthcare systems when it comes to undertaking clinical trials and developing new treatment and technological innovations. There are many elements of the hospital sector in England of which we should be proud.

However, the context of care in the hospital sector is that of change and seemingly inevitable squeeze, as demand rises and funding is flat in real terms. With major changes to the behind-the-scenes operations of the NHS (in terms of who contracts, commissions and pays for care) and a review of how to commission specialist services, there has been considerable change and uncertainty across the NHS acute system.

Some policy ambitions are yet to be realised. For example, we have not yet seen a significant shift of services into the community, emergency admissions are still rising, and we are a long way off parity of esteem between mental and physical health, despite the clearest of signals that this should be a priority.

Where we have found poor care, there have been a number of themes emerging. We have typically found problems with staffing (e.g. shortages, workforce planning, mandatory training, knowledge of guidelines), culture (e.g. fear of reporting concerns or incidents, bullying, poor leadership, resistance to adopting practices such as the WHO surgical checklist) and poor management of access (waiting times and appointments), both in advance and on the day.

Underpinning this may well be a lack of effective leadership. It is reassuring that the special measures programme is starting to become a mechanism for improvement. CQC has and will continue to play a role in these programmes to aim to get 'good' care delivered to patients within a reasonable timeframe.

Responding to a critical CQC report presents a challenge to the leadership of hospitals. Some have been ill-prepared for this. Where rapid improvements have been made, hospitals have taken responsibility for their problems early, within an open and honest culture. They have used CQC findings to communicate the need for change and focus efforts to have greatest effect. Those hospitals, by contrast, that have rejected or sought to undermine the findings have generally made little progress, and seem to have misdirected their efforts away from driving improvement.

## What we have found

Our new more rigorous and expert-led approach to inspecting NHS acute trusts began in September 2013 when we started our Wave 1 pilot inspections. These were followed by further development and testing of the new approach. This included developing our approach to rating trusts, hospitals and the core services they deliver.

By the end of August 2014 we had inspected 62 acute NHS trusts under the new approach. Of these, by the end of August 2014, we had issued formal ratings to 38 trusts. This means that CQC has now rated almost a quarter of all the acute hospital

trusts in England. We will have rated them all by the end of December 2015. We also carried out pilot inspections of a smaller number of mental health services and community health services. These began in January 2014 and have continued through to August 2014.

It is important to note that the acute hospitals we have inspected so far were not a representative sample of all acute hospitals in England. For the most part, we planned our inspection schedule to include hospitals that we considered to be higher risk. In some cases the inspections were carried out in response to existing concerns that had placed the hospitals into special measures. However, we also inspected some trusts that we thought were likely to be good in order to assess the range of quality. We also inspected some trusts that were aspiring to become foundation trusts. These early findings, therefore, are not a fair representation of the quality of hospital care across England.

However, what we can already see from our tougher, in-depth approach to inspection is that there is unacceptable variation in the quality of care among hospitals in England.

## Variations in care quality in NHS acute hospitals

Variation in quality is already clear from the ratings applied to the first NHS acute hospital trusts. There is variation between hospitals, within hospitals, and even within the core services provided by each hospital. We found:

- A wide range of quality between hospitals: some were good or outstanding, others had a number of poor quality services.
- In several hospitals, marked variations between services – for example high quality maternity care but poor A&E services, and vice versa.

- In some hospitals, variation within a service. This was particularly noticeable where one or two of the medical wards (especially in care of the elderly wards and on ‘escalation’ wards) were poor – what we call ‘worry wards’ – while others were good. Some hospitals are providing good or outstanding care for patients, but access to the higher standards of care should be available to everyone. Hospitals must address these variations in quality: they must learn from what others are doing.

### COMMITMENT TO CONTINUOUS IMPROVEMENT: SALFORD ROYAL NHS FOUNDATION TRUST, INSPECTED OCTOBER 2013

We found that Salford Royal NHS Foundation Trust was an extremely well-run trust. Strong, clear leadership was embedded at all levels within the trust, across all wards, consistently and without fail. Staff were encouraged to be innovative in improving the quality of care. They were able to tell us how quality was given a high priority and that patient care was personalised. For example, individual nurses are supported to make contact with relatives following a bereavement, to offer them further support.

The trust showed an openness and commitment to continuous improvement. It put patient safety at the top of its priorities. Staff were focused on safety and what it meant in their own particular role.

The trust strives to be the best in the country and to deliver care that is “safe, clean and personal every time” (which they call SCAPE). All staff regardless of their role work to this ethos. Every member of staff we spoke to could tell us what this meant to them and all took pride in wanting to achieve the status for their ward or their area of work.

The vast majority of people we spoke with were very positive about the care and treatment they received at the hospital. Staff worked hard to involve patients in their own care.

The trust works hard to be transparent with staffing levels. Each ward we visited identified (at the entrance to the ward) the planned staffing numbers for each shift and the actual staffing levels provided. This clearly shows any patient or visitor if the ward is sufficiently staffed. Staff told us that they had regular updates on the numbers of staff and, if necessary, staff were moved to accommodate any shortages. The trust made use of bank and agency staff as appropriate. We did not identify any concerns about staffing levels.

The trust had a ‘fair blame’ culture which empowered staff to be fully involved in the way the trust was run. It encouraged all staff to learn from each other and share ideas. For example, we saw evidence of a housekeeper being fully involved in the quality improvement agenda and identifying ways of improving the service and producing savings in the equipment budget.

**Note:** Salford Royal was part of our first wave of test inspections. It was not given a rating, as we did not start publishing indicative ratings until the second wave of test inspections.

## LEADERSHIP IS THE KEY: BASILDON AND THURROCK UNIVERSITY HOSPITALS NHS FOUNDATION TRUST, INSPECTED MARCH 2014

Basildon and Thurrock University Hospitals NHS Foundation Trust was one of the 11 trusts put into special measures as part of the 2013 Keogh review of a number of trusts with high mortality rates. Before the Keogh Review, Monitor had overseen appointments to new leadership roles at the trust. An improvement director was appointed, who supported the trust's own leadership to make progress towards securing good quality care. A partnership with the Royal Free London NHS Foundation Trust was put in place to support the trust; this partnership worked so well that it has extended beyond the period of special measures.

When we inspected the trust in March 2014, we rated the trust overall as good, and maternity services as outstanding. We were impressed by the clear vision and strategy shown by its leadership and management to deliver high quality care to patients. All the staff we spoke with on the wards or in our focus groups understood the trust's vision. Many of the staff spoke about the executive team with enthusiasm and respect. Staff told us they were highly visible and they knew the staff on the wards.

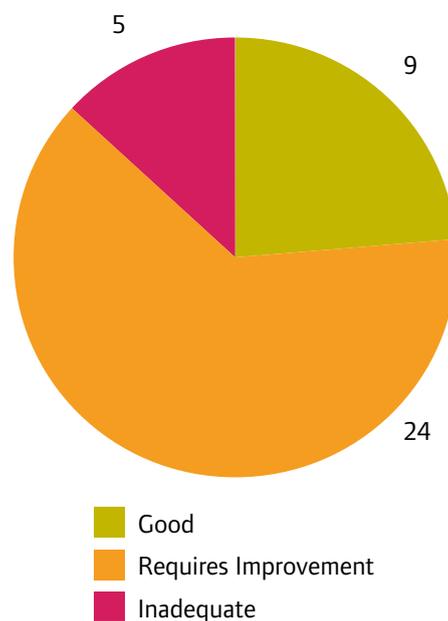
The change in leadership in the trust had been significant. Staff felt encouraged to speak up, raise concerns and be involved in the trust. Communication from the board to the ward had changed significantly, with staff feeling they could contact any member of the senior management team at any time.

Staff were supported by their peers and managers to deliver good care and to support each other. Staff said they felt proud to work at the trust, and were included and consulted about plans and strategies. The trust identified areas where improvements could be made, and organised work groups to address them.

Variation can be wide in a single hospital. Our inspection of Royal Berkshire Hospital is an excellent example of the services on one site incorporating all four rating levels (**FIGURE 3.1**). In the inspections up to the end of August 2014, across each trust's entire ratings 'grid': all trusts covered more than one of our four rating bands; nine spanned two bands; 24 spanned three bands; and five spanned all four bands.

Of the 38 NHS acute trusts rated by the end of August 2014, nine were 'good' overall and 24 were 'requires improvement' (63%). Five trusts (13%) were rated 'inadequate' (**FIGURE 3.2**). As mentioned above, it is important to note that these first inspections are not representative of all hospitals in England, as they included a disproportionately larger number of trusts considered to be higher risk.

**FIGURE 3.2: OVERALL NHS ACUTE TRUST RATINGS AWARDED BY CQC, DECEMBER 2013 TO AUGUST 2014**



Source: CQC NHS acute trust ratings data, December 2013 to August 2014

**FIGURE 3.1: RATINGS FOR THE SERVICES AT ROYAL BERKSHIRE HOSPITAL, JUNE 2014**

	Safe	Effective	Caring	Responsive	Well-led	Overall
Accident and emergency	Good	Inspected but not rated	Good	Requires improvement	Good	Good
Medical care	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Requires improvement	Good	Outstanding	Requires improvement	Requires improvement	Requires improvement
Maternity and family planning	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Children and young people	Good	Good	Good	Good	Good	Good
End of life care	Good	Good	Good	Outstanding	Good	Good
Outpatients	Requires improvement	Inspected but not rated	Good	Requires improvement	Requires improvement	Requires improvement
<b>Overall</b>	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement

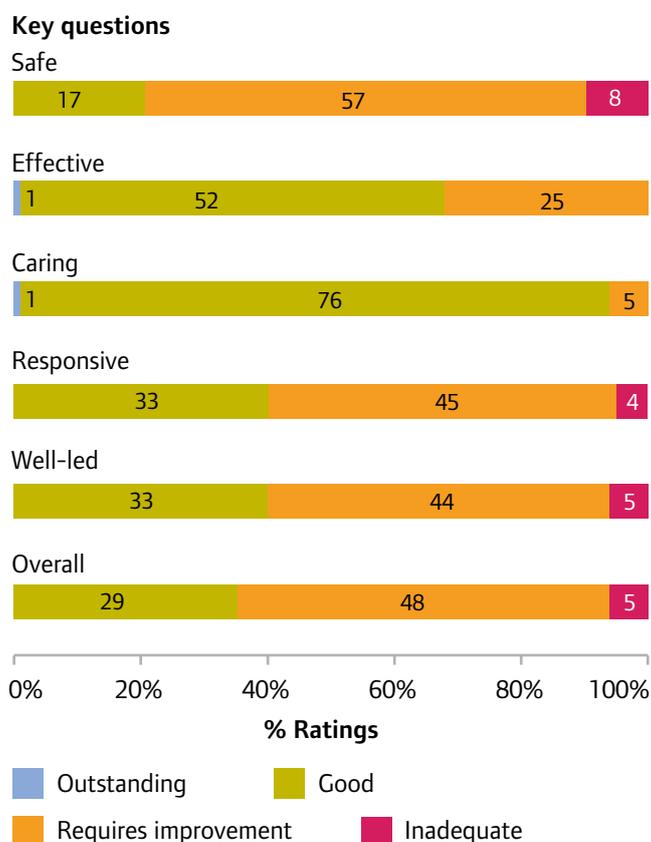
Source: CQC Royal Berkshire Hospital inspection report, June 2014

In September 2014, we awarded the first outstanding rating to an NHS acute trust: Frimley Park Hospital NHS Foundation Trust. One of the most striking things about Frimley Park was the way that teams worked together across the hospital, and with other providers, to make sure that people get the best possible treatment and care. Staff engagement and culture at this trust was impressive, and it had a clear vision and set of values which had been developed with staff. These are things that other trusts could learn from.

### Our five key questions

We ask the same five questions through our inspections – are services safe, effective, caring, responsive to people’s needs and well-led? We have already found strong differences across these questions. Trusts have shown that they have caring staff – this was the only key question with no ratings of inadequate so far at hospital level. Safety is the main area where we have found greatest variation and the most worrying findings **(FIGURE 3.3)**.

**FIGURE 3.3: OVERALL NHS ACUTE TRUST RATINGS AWARDED BY CQC, BY KEY QUESTION, DECEMBER 2013 TO AUGUST 2014**



Source: CQC NHS acute trust ratings data, December 2013 to August 2014, for 82 individual hospital locations. Note that only 78 hospitals received a rating for 'effective'. We were unable in that period to rate effectiveness in A&E and outpatients, and this will have meant that we were unable to give an overall effectiveness rating in some smaller locations.

## Safety

Safety has the highest proportion of any key question at hospital level rated inadequate, the highest proportion rated requires improvement and the lowest rated good. Seventy-nine per cent of safety ratings at key question level were 'requires improvement' or 'inadequate', higher than for any other key question.

Far too many hospitals were inadequate on safety and the majority required improvement on safety.

We found widespread evidence of the impact of staffing issues on patients. Staff were often aware of the impact of shortages on the quality of patient care; this could include patients waiting longer for appointments, or call bells not being answered promptly (which presents a safety issue as staff do not know the reason for the call until they respond). A particular issue found in a number of hospitals was the shortage of staff at night. For example, we found one ward where the number of falls among older patients had increased when staffing levels were low.

However, we have also found examples of staff working particularly hard to maintain patient care while under pressure from shortages of staff. In at least two hospital trusts we found good systems in place to alert senior management when staffing levels were not safe, so that nurses could be reallocated to wards that were under staffed.

Across the core services, there were instances where patients were at risk through the failure to provide sufficient numbers of suitably qualified, skilled and experienced staff. The impact on safety in A&E was prominent. We observed shortages of A&E nurses, including hospitals where the availability of a registered sick children's nurse could not be guaranteed, and shortages of A&E consultants. This included a lack of continuity of consultant cover, and reliance on non-permanent staff, which in turn affected the quality of handover between shifts. For patients the impacts have included long waits, sometimes on trolleys in corridors, and children sometimes being cared for in an adult environment.

Similarly we found concerns with safe staffing affecting medical care, including poor night-time cover, and in some cases staffing issues cutting across all disciplines. We were told at one trust that staff were not always able to update bedside documentation to reflect patients' current care needs.

In maternity we found shortages of midwives and consultant obstetricians was a frequent issue,

including cases where the ratio of midwives to mothers was below recommended safe levels. In other hospitals however we found good levels of staffing, including excellent access to specialist midwives.

We also found examples where progress had been made addressing staffing shortages, including a reduction in medical vacancies from 30% to 5% as a result of a recruitment drive, and nurses in trusts being recruited from Ireland, Spain and Portugal.

In some of the hospitals we inspected we found that planning to ensure adequate staffing and skill mix was not good enough. However, we also found many examples of a good use of plans and accredited safe staffing tools, which were being shown to have alleviated some problems with staffing.

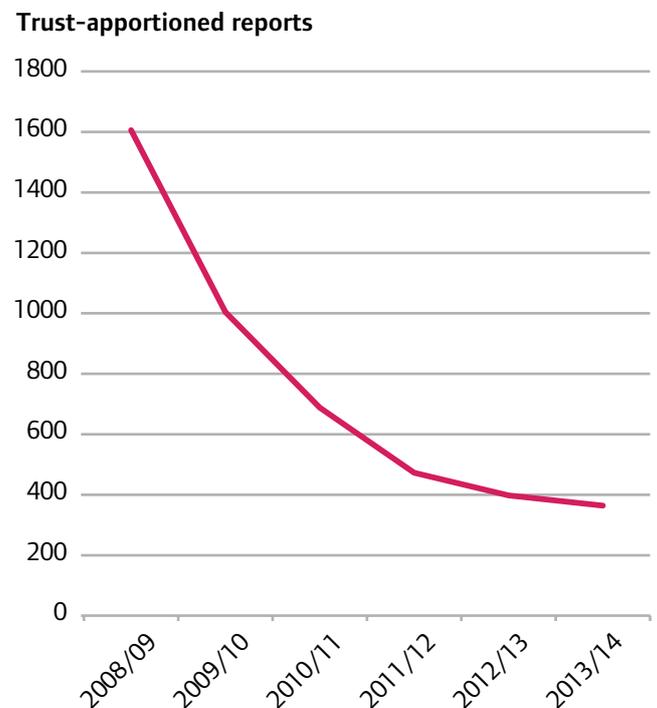
Other safety issues included:

- The World Health Organization surgical checklist was being used in the large majority of operating theatres – but not for all patients in all theatres. Auditing the use of the checklist was variable and needs to be standardised as a matter of urgency.
- Staff often told us that mandatory training was put on a back burner when there were staff shortages. In particular, safeguarding training tended to be incomplete.
- We saw a range of other problems with environments or facilities in individual hospitals (for example, on some wards, theatres and outpatient clinics).
- Some services need to make improvements in relation to reporting and learning from incidents, accurate documentation of medical records, and safer management of medicines.

We know that with focused attention on a particular safety problem, rapid improvement is possible. One notable example is reports of MRSA bacteraemia and of *Clostridium difficile* infections, where concerted leadership, clinical engagement and a

high profile campaign at national and local level led to a significant drop in these rates since 2008/09 (MRSA by 77%, *C. difficile* by 75%) (FIGURE 3.4).

**FIGURE 3.4: ANNUAL TRUST-APPORTIONED REPORTS OF MRSA BACTERAEMIA, 2008/09 TO 2013/14**



Source: Public Health England, 2014

## Effectiveness

To assess effectiveness of treatment and care, we looked for example for evidence of:

- The extent to which trusts were implementing and following guidelines (whether from NICE or elsewhere).
- Whether trusts were making use of national comparative audits.
- The prevalence of dashboards to monitor key performance indicators and other data.

More than half of the hospitals we inspected were rated 'good' for their effectiveness. However, there is much for hospitals to do in assuring themselves of how effective their care is. With the notable

exception of critical care units and maternity, a number of hospitals do not appear to be aware of, or able to demonstrate, their comparative effectiveness on national clinical audits. We also saw variable progress towards the implementation of seven-day services.

The inspections have shown that CQC needs to carry out more detailed work if we are to assess the question of effectiveness more reliably, especially in A&E services and outpatients where we decided we could not yet award ratings for effectiveness. We are working closely on this with Royal Colleges and professional societies, and with those responsible for national clinical audits, in order to build a robust understanding of the standards and metrics that indicate effectiveness at the specialty level.

We will particularly fill gaps where there are no widely recognised industry standards or there is no measurement of the standards undertaken in a comparable way. For example, the NHS has honed the use of clinical audit and it has many effective uses at a specialty and local level. However, often it is not consistent, comparable or repeated over time. In other areas there are no audits or measurement at all. In developing our new regulatory approach through extensive consultation with providers, professionals, industry bodies, expert observers and people who use services, it is particularly concerning that there is limited knowledge of or ability to measure the effectiveness of many health and care services.

## Caring

Our inspection teams saw high levels of compassionate care. Patients were generally treated with dignity and respect and they were positive about their care and treatment. Patients told us across many hospitals that staff were caring, compassionate, polite and helpful.

It is encouraging to report that most hospitals have caring staff. That does not mean that the degree of caring is not variable between or within providers, or

that we have ways to completely capture the totality of what it means to be caring. This is something we will be exploring as we refine our new approach to inspection.

### BEING CARING: GLENFIELD GENERAL HOSPITAL, INSPECTED MARCH 2014

We found that all staff were caring. Patients commented that they felt positive about their admission to this hospital. The NHS Friends and Family Test showed that patients would recommend all of the wards to their family, which implied that they received caring treatment. We saw a number of staff going the extra mile to ensure that patients' needs were met and we saw some outstanding care in specialised areas.

We saw and heard that the trust had implemented the Listening into Action approach to engage the right people in quality outcomes, which enabled staff and patients to feed ideas and suggestions into the management team. We saw a number of areas where action had been taken to improve care as a result of patients' feedback.

The services for children and young people at Glenfield received a high level of positive support from parents for being caring and compassionate. Play therapists provided activities for children in a group and one-to-one, while each child had an age-appropriate plan aimed at normalising their time in hospital. Play was used to support the physical, social, emotional and sensory requirements of each child but also to help prepare children for investigations and surgery, and for painful procedures and blood tests.

## Responsiveness

Responsiveness has multiple facets, including access to services, how long people must wait to be diagnosed and treated, and how local people are served by the provider. The NHS has been very

responsive to targets. However, high profile waiting times are increasing, and the number of patients still waiting for treatment who had already waited longer than 18 weeks rose steadily during 2013/14 after a long period of improvement. Hospitals have a challenge to maintain or improve responsiveness in the face of financial challenges.

The way that patients experience their journey through the hospital is a major problem in some trusts. We found:

- Long A&E waits (partly because of a failure to admit patients to acute medical units in a timely way).
- High numbers of patients who needed medical care being put on surgical wards (or on 'escalation wards') instead of on medical care wards.
- Cancelled operations.
- Difficulties discharging patients from critical care units to the wards.
- Delays in discharging patients to the community – in some cases due to late discharge planning.

Some hospitals have, however, been able to largely overcome these challenges – with processes to avoid admissions and to improve discharge planning.

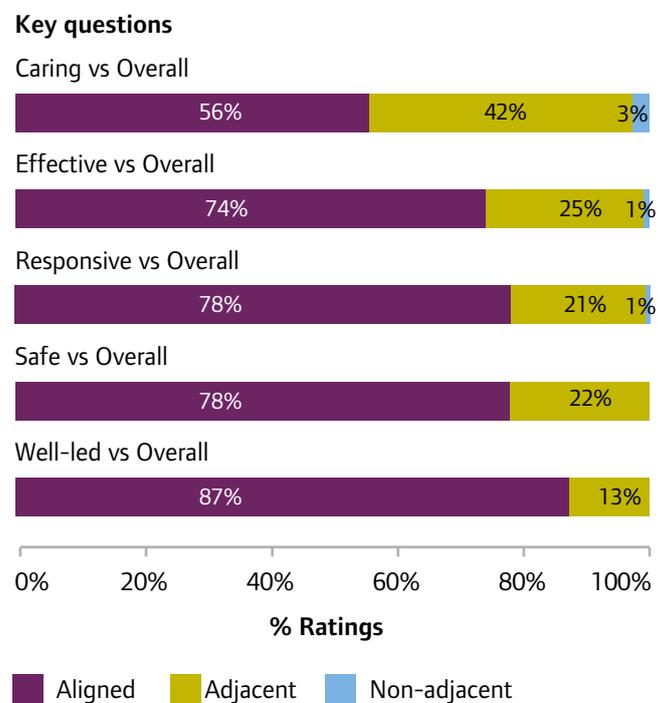
## Well-led

Our new approach to inspection has helped us understand the impact of good leadership on quality. We have developed our key lines of enquiry to explore in more detail how well-led each organisation is, both at corporate and at service level. We look at the quality of board/executive level leadership, the vision and strategy for the trust, the governance of quality and safety, and the culture of the trust. We examine the leadership of individual services, and the leadership on the wards. We look at whether the organisation's leaders are open in discussing the problems they face, and whether they are keen to learn from staff and

patient feedback, from audits and research, and from good practice shown by others.

Leadership and culture have a significant impact on other areas of quality. Among the 504 core service ratings across NHS hospitals from December 2013 to August 2014, we found that of all the key questions the well-led rating was most closely aligned to the overall core service rating. In 87% of cases, the rating for well-led matched the rating for the trust overall (**FIGURE 3.5**).

**FIGURE 3.5: ALIGNMENT OF RATINGS AT CORE SERVICE LEVEL TO THE OVERALL PROVIDER RATING, DECEMBER 2013 TO AUGUST 2014**



Source: CQC NHS acute trust ratings data, December 2013 to August 2014

Around 40% of all the hospital ratings for well-led were good; 60% were requires improvement or inadequate. In some hospitals the staff were very well engaged. In others there was a 'them and us' culture – especially between senior doctors and managers.

Some hospitals appeared to lack a clear vision or strategy. Staff engagement programmes seemed to be more effective in some hospitals than others.

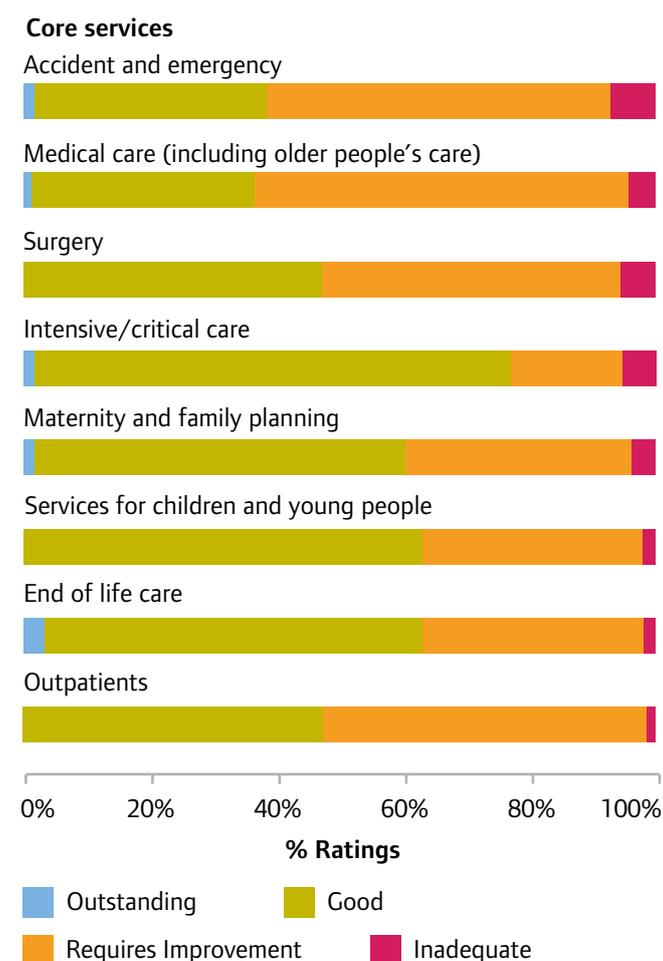
Boards and wards were disconnected in several hospitals, and information on quality and safety was sometimes insufficient to give boards the assurance they need about the quality of care.

We found that the staff survey results and staff sickness rates frequently gave a good general indication of the overall culture and leadership of a hospital.

### Core services

Figure 3.6 shows the ratings we have given to hospitals in our inspections up to the end of August 2014, according to the eight core services we inspect in all hospitals (where provided).

**FIGURE 3.6: NHS ACUTE RATINGS AWARDED BY CQC, BY CORE SERVICE, DECEMBER 2013 TO AUGUST 2014**



Source: CQC NHS acute trust ratings data, December 2013 to August 2014

This highlights the variation across services. We gave some outstanding ratings to hospitals in five of the core services, but all of these core services also saw some inadequate ratings.

A&E has the highest proportion of inadequate ratings and the second lowest proportion of good or outstanding ratings of the core services. Overcrowding, long waiting times and insufficient staffing levels were the commonest problems. We saw high levels of agency staff and locum use in A&E departments, particularly among doctors. Problems in A&E departments are often partly due to staff in other departments not actively facilitating the transfer of patients out of A&E.

Some hospitals, especially those serving smaller populations, did not have adequate staff trained in providing care to children in the A&E department. This could impact on safety. Some did not have separate areas in A&E for children.

We also had concerns about medical care, which had the highest proportion of requires improvement and inadequate ratings among all the core services. In several hospitals, we saw good care on the large majority of medical wards but with unacceptable levels of care on one or two wards (what we think of as 'worry wards'). These were almost exclusively either wards designated for the care of older people or so called 'escalation' wards (wards that are kept ready to be opened and staffed as necessary in times of increased demand).

Maternity and family planning services were again typical of the picture of variation. We were pleased to see that almost all maternity units were using dashboards and were able to assess their own performance against a set of quality indicators.

But maternity services also saw some inadequate ratings. We found problems with staffing in some hospitals, either in relation to midwife to birth ratios or consultant hours. Both these could impact on the safety of maternity services.



The best performing services were critical care services. Almost 80% of services were good or outstanding, and in general we found that critical care services were delivering high quality, compassionate care.

Services for children and young people were also generally of a high quality, with the highest proportion of good ratings after critical care. We have taken a 'child-centred' approach to assessing these services, looking across inpatient wards, outpatient services and end of life care.

Outpatients is an area that is frequently poorly organised and managed, with lengthy waits and over-booking of clinics. Outpatients represents a significant proportion of activity by patient numbers and so ought to have a high priority. The lack of effective management often translates not only into inconveniences such as long waits, but also into potentially significant risks such as reliance on temporary medical records because a patient's full file is not available on the day.

### Equality in using acute hospital services

People will only receive safe, effective, caring and responsive services if providers address issues of equality and human rights. We have developed a human rights approach to regulation which uses human rights principles to help us look at care from the perspective of people using the service.

Recent NHS patient surveys, which CQC oversees, show variation in people's experiences when using hospital services. We analysed the survey results based on people's protected characteristics under the Equality Act 2010.

In the 2011 NHS inpatient survey we found that women, especially younger and older women (when compared to men), lesbian women and women with a mental health condition reported negative findings around being treated with respect and dignity. People with Pakistani, Bangladeshi and mixed White and Black African ethnic backgrounds

also reported negative experiences in how they were treated by staff.

The 2012 NHS A&E survey results had similar negative findings around being treated with respect and dignity for young women, gay men, lesbian and bisexual women, people with a mental health condition and older men.

Both surveys found that those with specific chronic conditions (particularly mental health conditions) were less likely than those without the listed conditions to feel that they are treated with respect and dignity.

### Variations in care quality in NHS mental health services

We had inspected 12 mental health trusts using our new approach by the end of August 2014. Some themes are already apparent. As with acute services, we have seen areas of good practice and in most core services in most services, we have encountered caring and committed staff. There were good examples of multi-disciplinary working and patient-centred care and in most areas good systems to safeguard people who use services.

Our new approach has allowed us to start integrating our programme of inspections with our responsibilities for monitoring the use of the Mental Health Act (MHA) relating to the detention, care and treatment of detained patients. Although adherence to most aspects of the MHA and its Code of Practice was good, we found that in some wards, staff were secluding patients without acknowledging that this was the case and without proper monitoring being in place. We were also concerned that not all staff working in intensive care units fully understood best practice in the use of seclusion.

People who use mental health services should have the same quality of care as people who use physical health services. This 'parity of esteem' is enshrined in law by the Health and Social Care Act 2012, and

the NHS is instructed to work towards meeting this legal requirement through the NHS Mandate.

Our new comprehensive inspections in mental health have started to shine a light on areas of poor practice, service provision and care delivery in mental health services, some of which would not be acceptable in an acute hospital.

- **Unsuitable physical environments** – some mental health wards were located in old, poorly maintained buildings which present a huge challenge for staff to meet the needs of the patients. The layout of some of these wards meant that staff could not easily observe all areas, and safety might be further compromised by the presence of potential ligature points that pose a risk to patients who are suicidal. We found that staff had not always adequately assessed the risks posed by such environmental factors, nor taken steps to protect the most vulnerable patients.

Three years after it became a requirement that all hospital accommodation is same sex, we found mental health wards that did not comply with the Department of Health guidance. In several wards the male and female toilet and bathrooms were located next to one another or patients had to pass through areas designated for the opposite sex to access bath and toilet facilities. This both compromises the dignity of people receiving care on these wards and, if coupled with poor lines of sight that impair the ability of nurses to observe the ward, can potentially put patients at risk from sexual violence.

- **Unavailability of admission beds** – in several providers we found that pressure on beds in local facilities meant that people were often being admitted to wards many miles from home or being moved from ward to ward during an admission episode. Both practices make it difficult for carers and families to maintain contact and leads to discontinuities in care.

- **Unavailability of intensive care** – a lack of psychiatric intensive care units (PICUs) was an issue in three of the first four inspections under the new approach. We found one example where it was not unusual for a distressed person in a mental health crisis to be transported more than 100 miles to a PICU. It would be very unusual for an acute hospital that admitted people with medical emergencies to have such poor access to intensive care facilities.
- **Inappropriate response in a crisis** – when a person experiences a crisis with their physical health, they would expect to be able to access an emergency healthcare facility and to be assessed by a health professional if necessary. The same should be true for people experiencing a mental health crisis. Section 136 of the Mental Health Act 1983 allows for someone believed by the police to be experiencing a mental health crisis, and who may cause harm to themselves or another person, to be detained in a public place and taken to a place of safety where a mental health assessment can be carried out. This should usually be a ‘health-based place of safety’, generally located in a mental health service or an emergency department at a general hospital. They should only be taken into police custody in exceptional circumstances. However, we know that problems accessing health-based places of safety contributed to this happening more than 7,000 times in 2012/13.

We carried out a national survey of the availability, accessibility and operation of health-based places of safety across England. While all but one upper tier local authority (that is, a county or municipal borough) area is served by a designated health-based place of safety, there is variability across the country in how they operate. This can include how they are staffed, their capacity, their use of exclusion criteria (such as intoxication or disturbed behaviour), and how providers work with other agencies, including the police.

We have used information collected through this survey to publish an online map ([www.cqc.org.uk/hbposmap](http://www.cqc.org.uk/hbposmap)) showing the location of designated health-based places of safety across England, with details of opening hours, capacity, the age groups accepted, and the local areas they are intended to serve. We will shortly be publishing a full report of the wider findings of the survey. This is one of CQC's commitments under the Mental Health Crisis Care Concordat.<sup>15</sup>

A further finding from the survey is that over one in 10 local authority areas are not served by a designated health-based place of safety which accepts young people aged 16-17. More than one in five local authority areas are not served by a designated health-based place of safety which accepts young people under the age of 16. We have called on providers that restrict access to health-based places of safety for young people to review their local protocols and to discuss with their commissioner if there is a gap in provision for a particular age group. Where there is no local place of safety specifically for young people, there must be an agreed process for identifying the most appropriate place of safety for these individuals, which in almost all cases should not be a police station.

The survey is also a component of a wider themed programme of work which CQC is undertaking on the care and support that people experience during a mental health crisis. We will shortly be publishing findings about the variation in the experience and outcomes for people who experience a mental health crisis that have been highlighted in a review of national data.

We also recently published the results of a survey of more than 13,500 people who use NHS community mental health services.<sup>16</sup> The survey found that the majority of staff providing community services 'definitely' listened carefully to people receiving services (73%) and 'always' treated them with respect and dignity (75%). But the results

highlighted serious problems with other aspects of care, suggesting that services are not engaging as they should with people using the services.

One in five people (20%) did not feel they had seen staff from the mental health services often enough to meet their needs, 23% had not been told who was in charge of their care, 23% had not agreed with someone from mental health services what care they would receive and 26% of respondents had not had a formal meeting to discuss how their care was working in the last year.

### Variations in care quality in community health services

Community health services are extremely important. They enable people to recover from illness and to live well and independently, whatever their conditions are, without the disruption of being admitted to hospital. They work with families and children, supporting their health and care needs. They are delivered in a community setting, including in people's homes, community-based clinics, community hospitals and special schools.

Services that fall within the community healthcare sector include:

- District nursing, community matron and specialist community nursing services.
- Health visiting, school nursing services and community children's services.
- Intermediate care.
- Community rehabilitation services.
- Hospice at home services.
- End-of-life care delivered at home.
- Inpatient and day-case services in community hospitals.

Up to the end of August 2014, CQC had inspected eight standalone community service providers, and also a number of community services provided by acute or mental health trusts. In our initial inspections of community health services,

we found that most staff were compassionate and caring and that patients were very positive about the quality of care that they received. However, our inspection teams identified a number of recurring issues and areas for improvement. The main themes were:

- **Staffing** – the community health service providers we inspected struggled with staffing levels in some service areas. Some were too reliant on bank staff and at some the skill mix was not appropriate, making it difficult for teams to function effectively and for people using services to receive the care they needed in a timely manner. In some services we noted longer than expected waiting times.
- **Training and competency** – there was inconsistency in the level of knowledge among staff regarding incident reporting and risk management. Learning from incidents was often not shared more widely beyond the immediate team.
- **Multi-disciplinary working** – community health services are generally made up of teams providing different services from a range of sites across a dispersed geographical area. It can sometimes be difficult to achieve coordination between teams within the provider and with other health and social care providers. Despite these challenges, in our initial inspections we generally found that multi-disciplinary working was good. However, in some cases there were concerns about silo working, for example where several teams were providing similar services but not working together. We could see that management were trying to solve this issue.

- **Leadership** – recent restructures and changes had had both positive and negative influence on the community health organisations we inspected. Some were taking the opportunity to improve their governance systems and create better connections between the teams and services, while others were struggling to maintain a clear and supportive structure. We found leadership development programmes in place to improve the quality of management. Overall, we could see the existence of clear organisational values, and management and staff commitment to deliver good care.

### Independent hospitals, mental health and community services

Our new approach to inspection will begin to be rolled out to independent healthcare services later in 2014/15. We aim to use a similar approach to the one we are using for NHS providers. We will need to adapt some elements of our approach for it to be as effective as possible, and we are working closely with representatives from the sector in developing the approach.

In 2013/14, independent acute hospitals continued their good performance against the quality standards, with 99% of hospitals meeting standards on treating people with dignity and respect, and 96% meeting standards for monitoring the quality of services. In line with our findings elsewhere in this report, where there were concerns it was in relation to safeguarding and safety, with 93% of services meeting standards. The same proportion also applied to the standards relating to staffing. The same areas were the biggest concern in independent mental health services, where only 82% of inspections met all the safety standards inspected and 84% met all the standards inspected relating to the suitability of staffing.

A recent report by Centre for Health and the Public Interest looked at the risk to patient safety in private hospitals.<sup>17</sup> It found that there was a lack of reliable data to assess risk of harm to patients treated in the independent sector. There were 802 unexpected deaths in independent healthcare services reported in the four years to April 2014, but it is difficult to know if this is an under-reported figure. The report found that there is less professional clinical collaboration in the independent sector than in the NHS, and it had some concerns about clinical governance arrangements.

### Independent ambulance services

Independent ambulance services continued the good progress they made in the previous year. Ninety-eight per cent of the services we inspected in 2013/14 met the standards for treating people with dignity and respect. Our main concerns were around monitoring the quality of services (88% met these standards) and ensuring the suitability of staff (87% met the standards).

We are currently developing our new approach for ambulance services in consultation with our key stakeholders and the public to ensure we reflect the key characteristics, risks, quality issues and diversity of organisations that exist within this sector.

## CQC's role in reducing variation and encouraging improvement

Our new approach to understanding the quality of care in hospitals and mental health and community health services is radical. We are looking at, for example, safety in a completely new way. Rather than focusing on a few selected metrics, we are looking at whether there is a culture of safety throughout the service and how the provider learns when things go wrong, and how that learning is communicated and embedded with staff.

In terms of leadership, we are not looking at just the workings of the board. We are interrogating leadership at all levels within the organisation: at ward, specialty, directorate and corporate levels to understand where good leadership is happening and where the disconnections are taking place.

Hospitals and many mental health and community health providers are highly complex organisations and often highly specialist in their work. CQC's new approach is more comprehensive, and gives a louder voice to patients and their relatives and carers than ever before. We will continue to monitor services through our Intelligent Monitoring and build on the effectiveness of this in prioritising our work.

To better understand the clinical effectiveness and safety of a provider's service, our inspection teams consist of a wide range of clinical experts as well as CQC inspectors. These people are doctors, nurses and other clinical professionals who can effectively critique their peers and help ensure we really get under the skin of a hospital, mental health or community health service. When they return to their day jobs, they will also take with them valuable understanding of other services and ideas of how they might be able to improve their own. The use of such experts has positively influenced the way CQC inspects and we will build on this positive foundation over the year ahead.

To understand the complexity and experience of care we are also getting help from 'Experts by Experience' on our inspection teams. These people have used services themselves or supported loved ones who have used the service. They see what professionals can sometimes miss: the elements of care and compassion, the feeling of being safe and looked after, and the impression that you are receiving the right standard of care.

Our pilots in mental health and community trusts have shown that the new inspection model applies to these services; with adaptations to take account of the size and dispersed nature of these complex organisations. In mental health the integration of some of our Mental Health Act duties brings a new aspect to CQC's inspection approach, with a greater emphasis on human rights and increases our ability to assess the quality of the local response to mental health crises.

We are also 'learning by doing'. We are now applying the model we have developed for acute hospitals to children's and orthopaedic hospitals. The learning we have gained from focusing on eight core services in acute hospitals, we will shortly be applying to specialist services such as cardiothoracic and cancer services. We are also starting our first pilot inspections of NHS ambulance trusts.

We will continue to develop and improve our understanding and our methodology for assessing the quality of care: our upcoming work in hospitals will examine closely our safety concerns, and we aim to get to grips with the measurement of effectiveness, particularly the kinds of meaningful evidence that can be gathered. We are eager to make the best use of the stronger evidence we have through our new approach to inspection, especially the findings related to well-led organisations and the services that must tackle failures.

## Our challenge to providers and the system

To providers of acute, mental health and community health services:

- **Be open and use CQC's assessment as a stepping stone to improving your services for the people who rely on them.** CQC is not here to criticise or catch out providers, but to clearly set out the true quality of a service. This is new information, and may be new to the provider. This should be seen as an opportunity to recognise successes, focus efforts and drive improvement. By having an open and honest dialogue, a CQC inspection can be a positive driver for change. Those trusts that were first to exit special measures earlier this year were the ones that accepted findings relating to poor quality and safety and started to look for solutions, rather than defaulting to resisting the information and challenging the findings.
- **Make safety a priority, and build a safety culture.** Act on the recommendations of the Berwick Review into patient safety and embrace both the processes and systems that reliably deliver safe care, and the culture of safety where candour is encouraged and learning is embedded. With the new duty of candour regulations coming into force, this is the time to embrace a culture of safety. This new approach will be more sophisticated than the old approach of simplistically tracking hospital acquired infections; although important, they are not a valid indicator of the overall safety of a service.
- **Maintain the momentum of change following the Francis Inquiry into Mid Staffordshire.** The response in year one was all encompassing, with individual providers taking active steps to consider what changes could be made to their services. This critical self-appraisal and appetite to change for the better for the patients you serve should be maintained. There are examples of outstanding care delivered within the same financial constraints. The Francis Inquiry recommendations apply as much to mental health and community services as they do to acute hospitals.
- **Recognise and invest in your leadership from the board right through to the ward.** Each level of leadership has the capacity to effect change and act as role models, whether this is around the board room table or on the ward in the middle of the night. Strong leadership at each level of an organisation is vitally important.
- **Listen and act on feedback from staff and patients.** Grasp the opportunities that feedback represents to improve services, by considering it to be free intelligence. Don't look to blame, unless care is negligent or harm was intended, but create a culture where mistakes are admitted in order to learn from them. We have been very impressed with how staff have told us their concerns on inspection. Often these are things that they have been afraid to tell you first – there needs to be an open and honest culture so that you hear these things first hand. Use the Friends and Family Test to get both positive and negative feedback at a more granular level than has ever been attempted before in the NHS. Recognise teams who deliver consistently good care or who are able to act on and improve care for their patients.

- **Champion all the care needs of your patients and help to draw together a package of care around them.** All providers of care can have a role in enabling co-ordinated, holistic care, even if they only provide a small part of the care package. Consider how to meet the physical and mental health needs of your patients with small steps or more radical care model changes. Bring the right services to the patient rather than focus on the single episode of care or transactional treatments. There is a long way to go to reach a parity of esteem between physical and mental health; there is still too much of an automatic bias of considering access to physical health care before access to mental health care, when both are equally important to a person's overall health.

To the system leaders within NHS England, clinical commissioning groups, Monitor, the NHS Trust Development Authority, trade bodies and other organisations that can influence the system:

- **Embrace greater intelligent transparency, particularly in how we understand effectiveness.** Establish standards where there are none, measure consistently across providers, share openly (while respecting patients' rights) and help others to access and use the data to improve the quality of care.
- **Use CQC judgements fully.** Take the time to read our reports on providers you work with, and help them to act in areas that need improvement and promote areas that are good or outstanding. Through quality summits at the end of our comprehensive inspection process, or independently, seek to understand the context and detail of our findings.
- **Encourage safe innovation.** Where changes to service design or provision are necessary or desirable, ensure that the safety of patients is paramount and that the quality of care is continuously improving. In many cases, changes to service design should actively start with what is best for the patient (how they would like to engage with experts, how they want to manage their care, how they want to minimise the disruption their condition causes to their day to day lives). Safe innovation needs to be particularly around integration along care pathways, rather than just within hospitals.

- **Have the courage to tackle failure and complacency.** Great progress has been made in the last 18 months to establish a single failure regime that takes into account both quality and financial failing, and the special measures programme is gaining momentum. For those providers that are not inadequate and not in a dedicated recovery programme, help to reinforce the premise that 'requires improvement' does not equal 'good enough'. All those assessed to 'require improvement' should have active plans in place to improve. Help to drive this change by aligning your expectation of improvement behind this.
- **Understand and discharge your own responsibilities for improving the quality of care.** Although CQC does not regulate local or national commissioners, our inspections often identify problems that providers cannot put right on their own. Commit yourselves to the action plans that are developed after an inspection and consider these when deciding your priorities.



## PART 4

# PRIMARY MEDICAL SERVICES AND INTEGRATED CARE

### Key points

- We inspected GP practices for the first time in 2013/14, and found variations in the quality of care.
- We inspected 30 NHS GP out-of-hours services, serving a combined population of around 19 million people – more than a third of England's population. We found that the majority of the services were safe, effective, caring, responsive and well-led.
- We found that, on average, larger GP practices delivered better quality of care than smaller practices.
- The quality of dental care was generally good, and continued to be lower risk than most other sectors.
- We carried out thematic reviews into diabetes care, dementia care and the transition to adult services by children and young people with complex physical health needs. All of these helped us to look across care sectors and understand the interaction between them.
- Our work with the primary medical services sector to understand the components of high-quality care has highlighted the importance of introducing a clear quality assessment framework, alongside better data through Intelligent Monitoring. Until now, the sector has had no robust way of assessing the overall quality of care.



## Introduction and context

Our Chief Inspector of General Practice, Professor Steve Field, leads CQC's primary medical services and integrated care inspection directorate. This covers GP practices, out-of-hours services and mobile doctors, dental care services, prison healthcare, remote clinical advice, urgent care services, integration, children's health and children's safeguarding.

Primary care has always been at the front line of the UK healthcare system. However general practice is now increasingly seen as the interface between all the different types of care on offer. GPs are expected to help patients and their families negotiate their way between hospitals and care homes, and between local authority and NHS-provided care.

There has been extensive discussion over the past year about the need to offer GP services on a 24/7 basis. Telehealth has been promoted as one possible way to achieve this but we are also seeing a number of other innovative approaches as we inspect surgeries.

Recruitment of partners is increasingly tough with young GPs being attracted overseas and others unwilling to commit to a career which, while emotionally and professionally rewarding, generates ever more demands. General practice will need to continue to adapt to ensure it provides a service that supports a changing population with changing expectations and lives.

The primary dental care system in England is still getting used to the regulation that CQC brings to their work. The last three years of inspections have shown us that the vast majority of dental care provided in England is of high quality. But local dentists, which are usually run as small businesses, also face financial and organisational challenges, along with the appearance and increasing visibility of large chains of dental surgeries and dental care provided by high street names. The sector will

find its own balance but until then dentists, like their primary care GP colleagues, face a period of uncertainty.

## What we have found

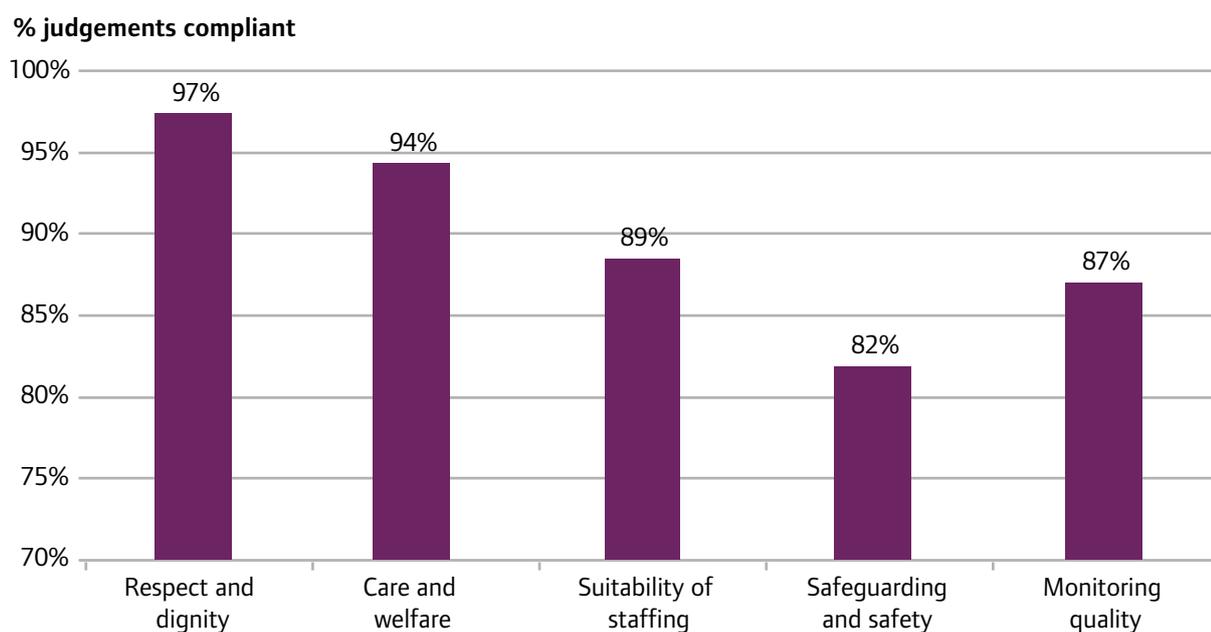
In 2013/14, CQC carried out 1,725 inspections of GP practices (the first time we had inspected these services following their registration with CQC) and 5,720 inspections of dental practices.

In both cases, our biggest concern was about safeguarding and safety. Almost one in five GP practices did not meet at least one of the standards relating to safety; for dental practices, it was one in 13 (**FIGURES 4.1 AND 4.2**). However, it is important to note that we prioritised our GP practice inspections for those practices where we already had concerns – either from their registration data or from information from other organisations such as commissioners. This means that the one in five figure is not representative of GP practices as a whole. In addition, in more than half of cases where a standard was not met, the impact on patients was judged to be minor.

2013/14 was our third year of inspecting dental practices, and we completed our programme of inspecting all practices that had registered with us in 2011. Overall, the dental care sector delivers high-quality care, and we were pleased to see further improvements in providers monitoring the quality of their services. In 2013/14, 95% met the standards we inspected, compared with 92% in 2011/12. However, performance against the main safety standards has not improved in the three years we have been inspecting them (**FIGURE 4.2**).

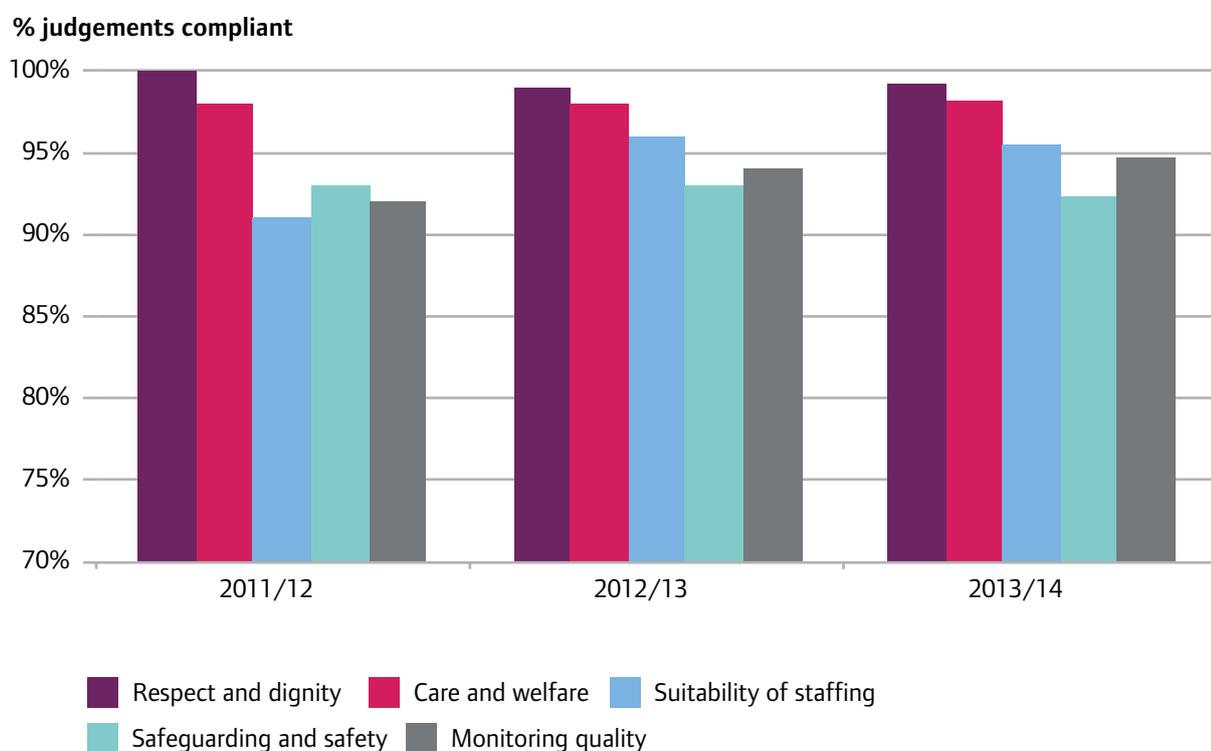
In terms of the impact of poor care on patients, both sectors showed poorer performance against standards relating to safeguarding and safety than other areas, although across all areas most of the impact on patients of non-compliance was judged by our inspectors to be minor (**FIGURES 4.3 AND 4.4**)

**FIGURE 4.1: PERFORMANCE OF INSPECTED GP PRACTICES AGAINST QUALITY STANDARDS 2013/14**



Source: CQC compliance data, 2013/14

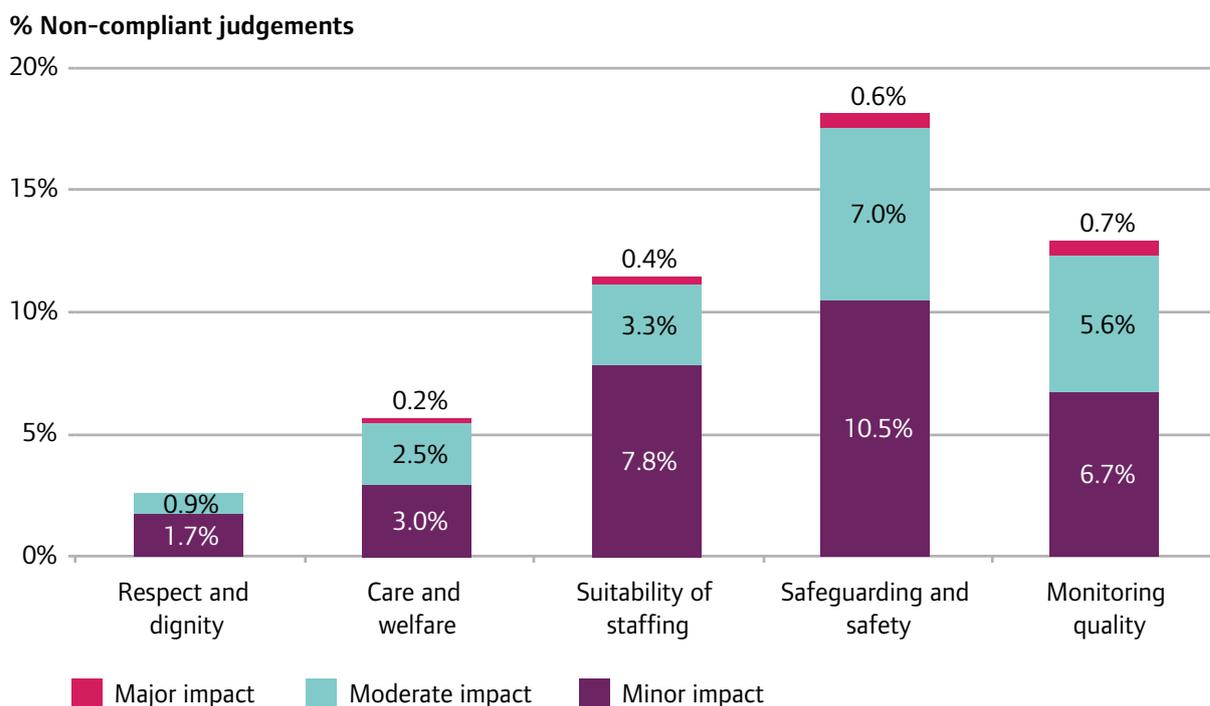
**FIGURE 4.2: TRENDS IN PERFORMANCE AGAINST QUALITY STANDARDS FOR DENTAL PRACTICES, 2011/12 TO 2013/14**



Source: CQC compliance data, 2011/12 to 2013/14

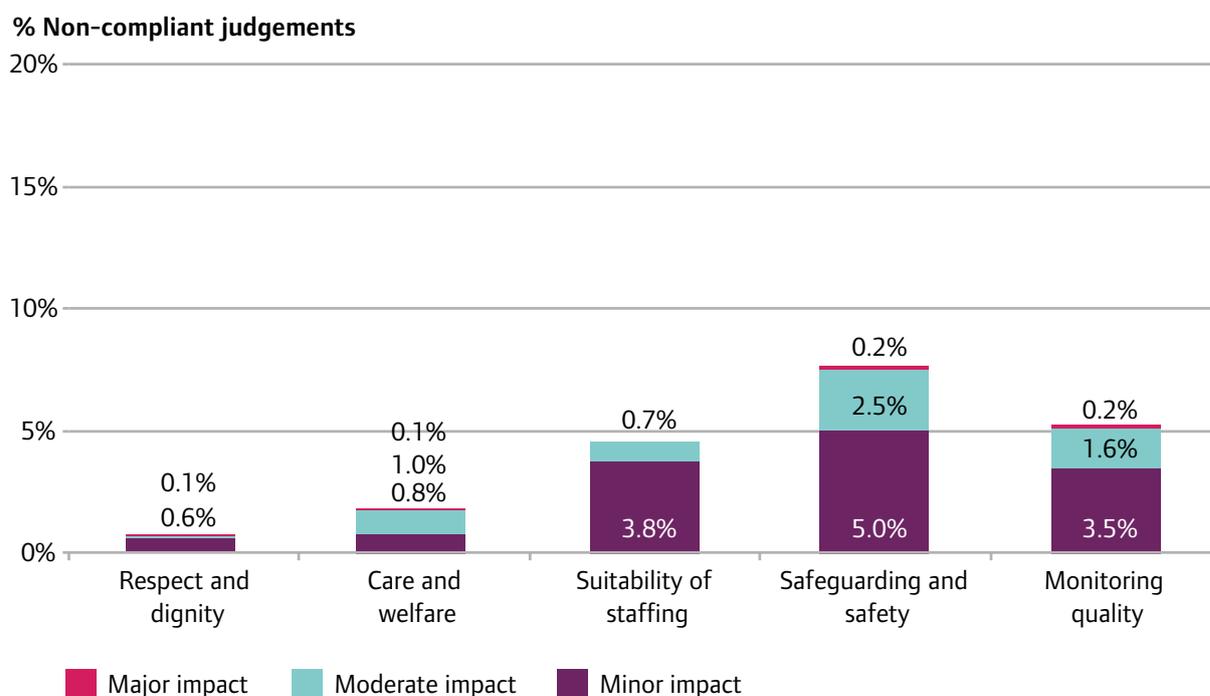


**FIGURE 4.3: IMPACT ON PATIENTS FROM NOT MEETING QUALITY STANDARDS, GP PRACTICES, 2013/14**



Source: CQC compliance data, 2013/14

**FIGURE 4.4: IMPACT ON PATIENTS FROM NOT MEETING QUALITY STANDARDS, DENTAL PRACTICES, 2013/14**



Source: CQC compliance data, 2013/14

## PRIMARY DENTAL CARE: A RELATIVELY LOW RISK ENVIRONMENT

By the end of 2013/14, we had inspected almost all of the 10,000 dental practices we regulate. During 2013/14, 95% met the standards we inspected, compared with 92% when we carried out our first inspections in 2011/12. We were pleased to see further improvements in 2013/14 in providers monitoring the quality of their services.

Our inspections of primary care dental services, including NHS and private dental services, in the last two years have identified that, compared with the other sectors we regulate, dental services present a lower risk to patients' safety. Our stakeholders also agree that the majority of dental services are safe and that the quality of care is good.

When we do have concerns, they mostly relate to the safety of services, usually around infection prevention and control, and how the provider ensures that the right systems and staff training are in place to protect patients from abuse.

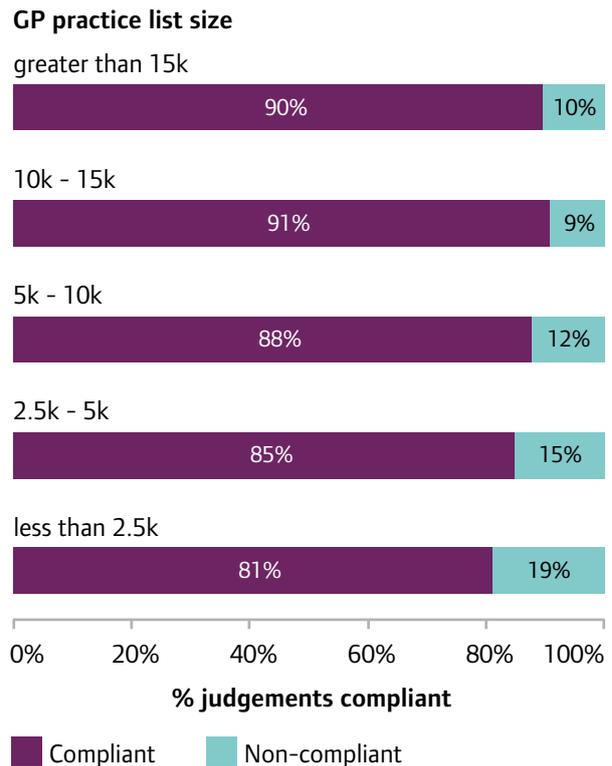
Where we have found concerns, providers have acted quickly to rectify them. In the majority of cases where our inspectors re-visited the service, they found their concerns had been addressed. This is demonstrated by the low number of warning notices we have served.

The levels of variation between our different areas of focus was also noticeable. For GP practices, there was a 15 percentage point difference between the best and worst performance against groups of standards (82% to 97%); for dental practices, there was a seven percentage point difference (92% to 99%)(see figures 4.1 and 4.2).

Within GP services, one factor that seemed to be associated with variation was the size of the practice list. Practices with smaller lists tended to have lower

levels of compliance (FIGURE 4.5). In 2013/14, only 81% of inspection judgements at practices with a patient list of less than 2,500 met the relevant standards, compared with 90% of those with more than 15,000 patients.

**FIGURE 4.5: PERFORMANCE OF GP PRACTICES AGAINST QUALITY STANDARDS, BY PRACTICE LIST SIZE, 2013/14**

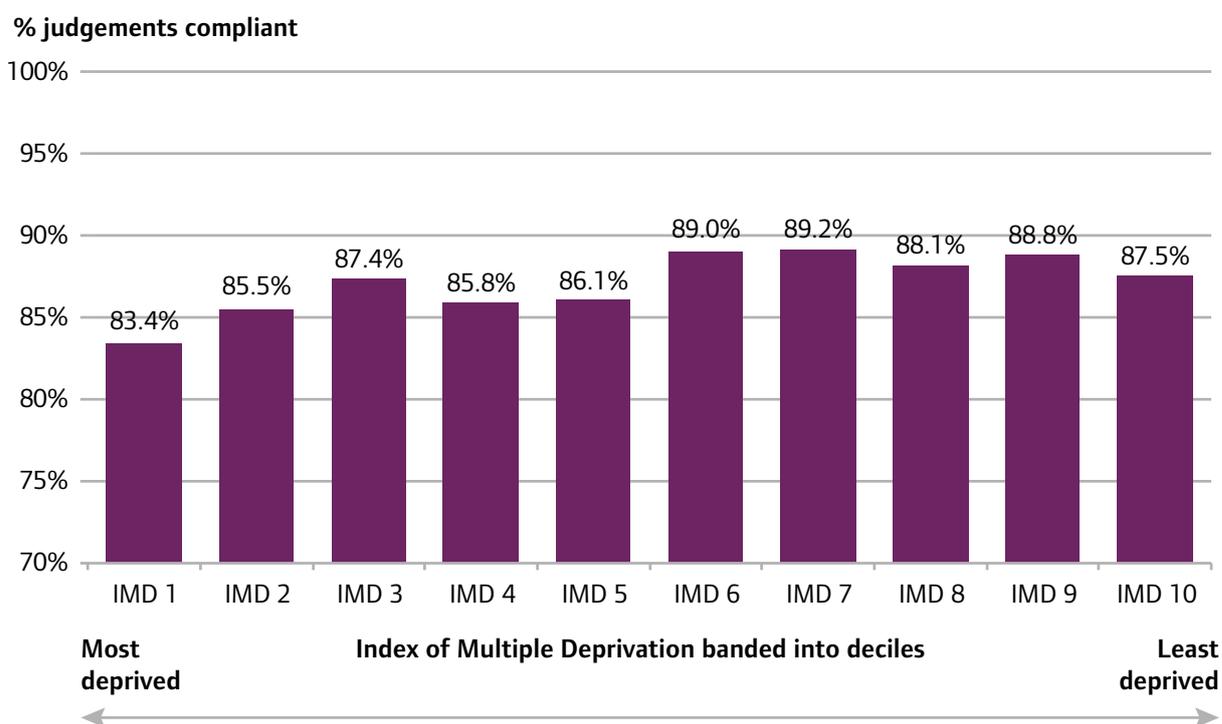


Source: CQC compliance data, 2013/14; Health and Social Care Information Centre GP practice size data, 2013

We also compared social deprivation with levels of performance against quality standards. In 2013/14, the quality of care provided by practices in areas with the highest deprivation tended to be poorer than that provided by practices in areas of lower deprivation (FIGURE 4.6).



**FIGURE 4.6: PERFORMANCE OF GP PRACTICES AGAINST QUALITY STANDARDS, BY INDEX OF MULTIPLE DEPRIVATION, 2013/14**



Source: CQC compliance data, 2013/14; Communities and Local Government, Indices of Deprivation, 2010

While the assessments that CQC has so far made against the current quality standards give us some insight, our new more rigorous approach to inspection will enable us to better understand quality. The generic model, which applied across the board for all types of care service, was limited in its ability to get under the skin of quality and safety issues in primary care services.

### GP out-of-hours services

One of the first commitments made by the Chief Inspector of General Practice was to inspect NHS GP out-of-hours services in England, which provide important services to people who need urgent access to care when their GP practice is closed. In line with our new approach, we developed a more comprehensive and GP-led approach to inspecting these services.

We inspected 30 NHS GP out-of-hours services, run by 24 registered providers, between January and March 2014. These services serve a combined

population of around 19 million people, which is more than a third of England's population. Our inspections included larger commercial providers and a range of not-for-profit social enterprises, as well as several GP co-operatives who had come together to deliver GP out-of-hours services to their local population.

Of the services we inspected, the population reach for the providers ranged from 88,000 to 1.5 million. The providers operated in inner city urban areas as well as large rural areas with low-density populations. There was a wide range in the levels of deprivation and ethnic diversity.

Out-of-hours services have often been seen as inherently higher risk than in-hours general practice because they deal with unfamiliar patients and cases are often more complex and urgent. Staff do not always have access to the patient's medical history or records. Also staff may not work regularly for the organisation, so may not know each other well, and may also be working in unfamiliar surroundings.

In addition to these inherent greater risks, there had been a number of high profile failures in recent years in out-of-hours care, in both the arrangements for how care was commissioned and how it was delivered to patients.

Overall, we were pleased to find that the majority of the services we inspected were safe, effective, caring, responsive and well-led. Many services were delivered by doctors, nurses and managers who are passionate about the quality of care and about putting patients' needs at the centre of what they do. They were also good at sharing this learning with others. We identified many examples of good practice that others should be able to learn from.

Our positive findings included:

- **Safe** – We found that most of the services we inspected were safe. We found some great examples of 'significant event analysis' in most of the providers we inspected. This was such a strong area in the services we looked at we feel that all GP services, including in-hours services, can learn from this.
- **Effective** – The vast majority of services we inspected had rigorous clinical audit systems in place. We saw many completed clinical audit cycles. We found that improvements had been made to services as a result of a wide range of quality assurance activities, including clinical audits. There were some good examples of information sharing, such as services being able to access the same GP records through the same system and special patient notes that flagged up vulnerable patients.

## OUT-OF-HOURS GOOD PRACTICE EXAMPLES

### BRISDOC HEALTHCARE SERVICES LIMITED

There was a clear recruitment and selection policy, which the provider kept under regular review to ensure it covered all of the standards set out in the NHS Employers safer recruitment guidelines. A standard operating procedure was created in November 2013 to recruit local sessional doctors to fill the clinical rota. This ensured the recruitment processes were consistent, streamlined, quick and unambiguous. Recruiting sessional doctors from the local area meant that the appointed GPs understood the make-up of the population and its needs. It provided assurance that clinicians working for the GP out-of-hours service were suitably qualified and that all employment checks had been completed and were up to date.

### CAMBRIDGESHIRE DOCTORS ON CALL LIMITED

We saw a comprehensive training matrix for all staff employed in the organisation. It was colour coded to enable managers to see at a glance when staff training was due. The provider was required to meet training requirements identified using a training needs analysis agreed with the local clinical commissioning group (CCG). Compliance with the training requirements was discussed at a monthly meeting with the CCG. At the most recent meeting, the provider agreed to additional indicators to give the CCG a better overview of training requirements in the service.

The training matrix and the reporting from this ensured that both the service and the CCG were able to maintain an up-to-date view of training requirements, enabling them to adapt and make changes in a timely way.



- **Caring** – During our inspections, we received a good level of feedback from patients about the quality of their out-of-hours services. A common theme was that the staff, particularly the doctors, were very supportive. Patients told us that they thought the care they had received was good and they felt safe. People told us that staff were kind and caring, and they felt that the GPs working for the out-of-hours service took time to listen to them and talk to them about their healthcare needs.
- **Responsive** – We saw some very positive examples of services being planned around the needs of the local population. We also saw evidence of staff engaging with the local community. We saw evidence of good rostering systems to forecast and schedule staffing levels. These were used by staff to indicate their availability and enabled managers to plan accordingly.

We were very pleased to see many examples of close working relationships with local care services, which provided joined-up care for patients. Several of the providers we inspected operated a ‘professionals’ telephone line. This enabled local healthcare professionals, such as nurses from local nursing homes, to seek medical advice without first having to call the out-of-hours service. Several providers showed us how they worked alongside other health and social care services, such as district nurses, palliative care nurses, mental health crisis teams and the voluntary sector. This showed that the out-of-hours GP services were an integrated part of the local health economy.

- **Well-led** – We found evidence of close working relationships between the services we inspected and local commissioners. There were regular meetings to discuss planning of the service. Most of the services we visited had a thorough system for dealing with complaints in a timely way. A number of services had very clear visions and values, which were made clear to staff at

all levels. Staff told us that there was a culture of openness that encouraged the sharing of information.

We did not find any examples of very poor care where we had to take enforcement action. We did however have some concerns where providers needed to improve:

- Some providers did not have safe mechanisms for storing and checking the stocks of medicines held, and recording controlled drugs.
- Some providers did not have appropriate recruitment processes in place.
- One provider did not have adequate systems for checking and monitoring equipment, including oxygen and emergency medicines.
- Some providers did not inform patients how they could make complaints about the service.

### Mental health care within primary care

Thirty per cent of all GP consultations are in relation to mental health issues.<sup>18</sup> Our new-style inspections will also look at how GPs care for and support people with mental health needs.

To understand more about this important issue, we analysed the 155 comments made on the NHS Choices website between January and May 2014 about visits to GPs about mental health issues. These 155 comments spanned 148 providers. There were 107 negative comments (69%) and 48 positive (31%).

Some of the themes emerging from the comments were similar to ones raised by people discussing physical health appointments. The positive comments focused on good, person-centred care and on being made to feel like a human being, rather than just a number. However, negative comments went into more detail and described sub-standard care:

- *Booking appointments* – A lot of people had had bad experiences in trying to pass this first hurdle. For some the issue was simply time, when ringing to get an appointment literally took hours. There was a high prevalence of no appointments being available when the person wanted them, with one being told it would take 32 days to see the GP on a non-urgent matter. Many of the comments referred to the receptionist being rude and unhelpful and on several occasions making decisions as to whether the appointment was medically necessary. Patients found it extremely frustrating and inappropriate to start describing their personal mental health problems to a non-specialist and then to be told their problem was not urgent.
- *Caring of doctors* – Any impersonal or unpleasant treatment can directly make a patient's mental health condition worse. Extensive waiting times at the surgery can be very difficult for some. Some patients described very good care and found their GPs to be supportive and empowering, enabling them to manage or even overcome their condition. In other cases, however, the care was lacking. People with mental health issues such as anxiety or depression said that they were suspected of making up physical symptoms as a result of their illness. Some said their GPs did not think mental health deterioration was a reason for an urgent appointment and review of care.
- *Reliance on medication* – Medication can be a lifesaving option, enabling mental health patients to lead normal lives. However, in some of the comments we analysed, GPs chose to medicate the patients rather than referring them onwards to therapy, or continued to give out prescriptions without assessing the patient's changing needs or discussing an alternative therapy. We also found a lack of expert knowledge of the interaction between psychiatric medication and other medications.
- *Care continuity* – Seeing different doctors was an issue for some with mental health problems. Having to describe their difficult symptoms all over again and building rapport from scratch can be a real barrier to the person receiving appropriate care. Without continuity of care no lasting patient-doctor relationship can be built.
- *Referrals* – There were difficulties in obtaining a referral, or being seen based on this referral, due to long waiting times to get the extra care.

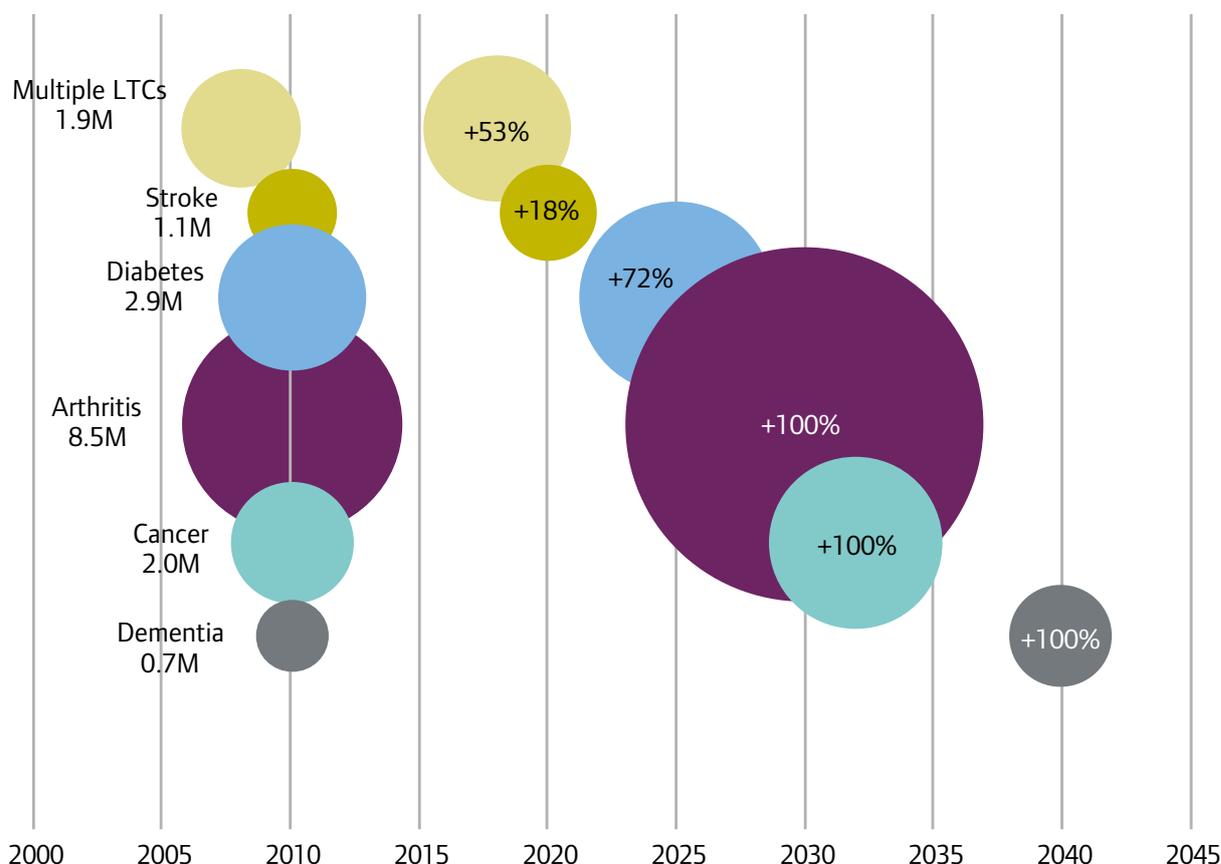
Some of the people felt that their mental health issues were at the crux of the good or bad care they received. Several mentioned that while their surgeries were able to deal with physical problems well enough, the understanding of mental health care was limited and not suited to their needs.

### Integrated care and care for people with long-term conditions

Over the next 30 years the health and social care sector faces a forecast rise in long-term conditions and the associated challenges with care. This is even more of a challenge given that currently around 40% of people have said they do not feel supported to manage their long-term condition (NHS Outcomes framework 2012/13). From 2012 to 2042, the number of people aged over 65 in England with care needs is projected to increase by 75%. Figure 4.7 highlights the kind of rises expected.



FIGURE 4.7: EXPECTED RISE IN LONG-TERM CONDITIONS, 2010 TO 2040



Source: Department of Health, 2012; Department of Health, 2009; Parkinson's UK, 2009; Diabetes UK, 2012; Association of Public Health Observatories; Osteoarthritis Nation, 2012

Increasingly over the next few years CQC will be looking at how people experience care and how they feel it is safely coordinated around them. We will be looking along care pathways to better evolve our understanding of the quality of care as experienced by people who use services.

In 2013/14, we have already started to use our thematic work to look across care sectors and the interaction between them, with a particular focus on dementia care in hospitals and care homes, the transitions to adult services of children and young people with complex health conditions, and diabetes care.

### Diabetes care

This year we completed the first phase of a programme to look at the diabetes care pathway

across services, to better understand the experiences of care for people with long-term conditions. This involved a review of centralised information to form a national picture of the quality of diabetes care.

There are more than 3.2 million adults in England currently diagnosed as diabetic. According to Diabetes UK's 'Cost of Diabetes Report' in 2012, diabetes accounts for about 10% of the NHS budget and 80% of these costs are due to complications. Given current demographic trends, the treatment of complications associated with diabetes will become a growing burden on the NHS unless solutions can be found to improve management within the community and better empower people to take control of their condition.

Our review found that:

- Large numbers of people continue to experience potentially preventable hospital admissions related to their diabetes.
- Significant geographical variations occur in both emergency hospital admissions for diabetes and other measures of primary care performance regarding diabetes management in the community.
- The findings of the 2011/12 National Diabetes Audit indicated wide variation in delivery of diabetes care across the country. At CCG level the proportion of patients with diabetes over 12 years old receiving all eight care processes set out by the National Institute for Health and Care Excellence ranged from 19% to 78%. Likewise the proportion of patients meeting all treatment targets ranged at CCG level from 17% to 28%.
- The risk of emergency admission to hospital for diabetes is strongly linked to demographic characteristics, but geographical variations remain even when these are taken into account.
- People with diabetes are more likely to experience an emergency admission to hospital than people without diabetes.
- People with diabetes are also likely to stay longer in hospital, have a greater chance of emergency readmission and are more likely to die in hospital.
- Findings from the National Diabetes Inpatient Audit also show that, despite some improvements, there are ongoing deficiencies in the quality of care for people with diabetes while in hospital, with variations in quality between providers.

We also looked at the comments made on NHS Choices about diabetes. There were 112 comments relating to about 106 providers made between January and May 2014. Around half were positive and half were negative. The main themes were around appointment access, medicines and repeat prescriptions, and information available to patients.

The second phase of our programme, to begin in 2015, will involve inspection activities and bespoke information gathering to follow up on the findings from the data review. This will explore in-depth at a local level the causes behind variations in care and outcomes for different people.

You can read more detailed findings from our diabetes data review in the **technical annex** to this report.

## Dementia care

Dementia care is still variable and not good enough. Most of the 400,000 older people living in care homes have dementia or a similar impairment and an estimated 40% of people over the age of 65 in hospital beds will be living with dementia. The number of people living with dementia in the UK is expected to double by 2040. Health and social care providers must be equipped to meet the needs of the UK's increasing population.

In 2013/14 we completed a programme of themed inspections, looking at people's experiences of dementia care as they moved between care homes and acute hospitals. We inspected 129 care homes and 20 acute hospitals to check how people's care needs were assessed, how the care was planned and delivered, how providers worked together, and how providers monitored the quality of their care. We asked people and their families to tell us about their experiences of care and what was most important to them.

We found that the quality of care was variable in both care homes and hospitals, and that variation has a significant impact on people. Overall, we found that a person with dementia is likely to experience poor care at some point along their care pathway. Strong action is needed to improve the quality of care provided. You can read full details in our report **Cracks in the pathway**.



## Children and young people with complex physical health needs – transition to adult services

In June 2014, we published our report **From the pond into the sea**, highlighting many of the systemic problems that are letting down seriously ill children and young people at a critical time of their lives.

There are 40,000 children and young people with complex physical health needs. In this programme, we focused on the process of ‘transition’ to adult services. We found that the transition process is variable, and that previous good practice guidance has not always been implemented. We described a system which is “fragmented, confusing, sometimes frightening and desperately difficult to navigate”.

Among the unacceptable things we found were parents and young people caught up in arguments between children’s and adult health services as to where care should be provided, care services ceasing when children’s services end and adult services have not yet begun, and where transition only works where parents proactively push to make it happen.

We found examples where lack of communication between children’s teams and adult teams were causing anxiety among staff, which then filtered down to the children and young people in their care.

An urgent review is needed into how services for young people are commissioned, and for commissioners to listen more effectively to young people and their families and deliver better, more effective, joined-up services. Existing good practice guidance must be followed to ensure young people are properly supported through transition.

Our report also said that GPs should be more involved, at an earlier stage, in planning for transition. General practice has a crucial role as the single service that does not change as a result of reaching adulthood. A new enhanced service for general practice is being introduced in 2014/15 to ensure proactive care and personalised care

planning for people with complex health and care needs who may be at high risk of unplanned admission to hospital. This will be under the supervision of a named, accountable GP.

The enhanced service has a particular focus on older people, but practices will be expected to consider introducing comparable arrangements for children with complex health and care needs. CQC will be checking how GPs are responding to the needs of these young people through our inspections and ratings of general practice.

## CQC's role in reducing variation and encouraging improvement

### New approach to GP inspection

During 2013/14 we developed our new, more rigorous and expert-led approach to inspection for GP practices and out-of-hours services. We first used the new approach between January and March 2014 to look at GP out-of-hours services. We started pilot inspections of in-hours GP services in April 2014, and the first inspections of dental care services under the new approach will start later in 2014/15.

In these new inspections, we will make sure we look at the things that matter to the people who use them, and that their interests are at the heart of the questions we ask: are services safe, effective, caring, responsive and well-led?

We will put a particular focus on safety and leadership. By focusing on these elements, we want to see excellent practice spread wider so that services are delivered more consistently and to the same good quality.

As well as focusing on the five key questions, we will always look at how services are provided to people in specific population groups. For every NHS GP practice (excluding out-of-hours services) we will look at the quality of care for the following six population groups:

- Older people
- People with long-term conditions
- Families, children and young people
- Working-age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia).

By looking at services for these groups of people, we can make sure our inspections look at the

outcomes of care provided for all people, including those who are particularly vulnerable. We are only just starting to look at this sector through this lens. It is already pointing to different dimensions of quality. People in these patient groups want different things:

- **Convenient access:** For the majority of people who generally have good health and who are in the working age population, access is a key issue – they want services that fit around their lives and don't want to be denied access. Yet what is a reasonable expectation and can services meet that expectation? Can technological innovations help meet this rising expectation? GP access pilots are a good start at addressing the issue.
- **Co-ordination:** Co-ordinated care matters greatly to people with complex needs and many with long-term conditions, yet services are often fragmented. The sections above on children's services and dementia care highlight the variable and fragmented nature of services. People with complex and long-term needs want more control over the care – this includes better communication between services so that patients can have a proper joined-up conversation.

### Integration and co-ordination

There are many exciting examples of projects to develop 'integrated care' throughout the NHS. CQC is not, and will not be, a barrier to innovation that improves the quality of care and delivers safe co-ordinated care to people who use services at no greater risk.

The basic co-ordination of care from the patient's perspective is vital. We will take a number of actions over the coming year to better evolve our understanding of the quality of care as experienced by people who use services. For example, we will conduct a thematic review of co-ordinated care for people aged over 75. This will especially look at how GPs work with other services.



## Mental health in the community

In response to the new legal right to parity of esteem between mental and physical health, we will increasingly consider how mental health conditions are managed effectively in the community.

## Our challenge to providers and the system

To providers of primary medical services:

- **There needs to be innovation to meet increasing demand, but don't wait to innovate.** Look at where you can innovate, especially where the current model of care delivery is known to be unsustainable.
  - Increase the scale of delivery of GP services by working with neighbouring practices and community care.
  - Look to technological innovations in the out-of-hours primary care sector; here technology and training has improved the quality and reliability of the service.
  - Look to community pharmacy, where innovations in embracing lifestyle changes can help manage conditions in the community and promote self-care.
- **Give priority to the basics of safe care and effective practice.**
  - Increase awareness in the practice of the importance of incident notification and the use of significant event analysis as a way of learning and improving for all team members
  - Carry out regular clinical audits; jointly with other practices where there is a common interest.
- **Be responsive to local needs and the latest issues or clinical developments.** Whether this is confronting the issue of female genital mutilation, domestic violence, or the cultural acceptance of high levels of diabetes and obesity, take action where people are at risk of harm. This is especially important when people are most vulnerable and where there is an ethical duty of care to act.
- **Empower patients in their own care and help them to make informed decisions.**
  - Helping patients to fully understand and take control of their lives, their condition and their treatments is an important way to improve their quality of life and long-term outcomes. Encourage them to join community groups that can provide support for their condition (local dementia alliances, or online diabetes groups), and encourage them to use technology to monitor their condition and become more aware of their capability for self-care (for example using a pedometer and app to track levels of activity, or using phone-based medicine reminders).
  - When making decisions about care, actively incorporate the patient into the decision process. Use all the information available, including CQC ratings, and consider the benefits of convenience alongside the benefits of receiving the best quality care available. Discuss the trade-offs between different options for treatments and different care providers.
  - Align the outcomes you seek to achieve with the outcomes that the patient wants for themselves. The patient may want to stay at home, to be pain free, or to be able to walk to the post box and back. By working out what is important to the patient, services can be much more responsive.

To the system that supports, funds and performance manages the primary medical services sector:

- **Encourage feedback within and across providers on the performance of services.**

Professional divisions should not reinforce poor care. If a community nurse sees that a patient had not received a visit by a GP when it was needed, or if an out-of-hours provider cannot access the most up-to-date medical records for a patient, raise this concern so that providers can learn and improve the care they provide. Where safety incidents occur, these should be recorded, reported and where appropriate investigated across provider boundaries where care is delivered collaboratively.

- **Encourage and enable co-ordination between providers.**

Where contracts, memorandums of understanding or other legal requirements are necessary, make sure they are in place swiftly to the benefit of patient care. Drive through team working between public health, community, mental health and primary medical services by building relationships and professional trust, underpinned by close to real-time, appropriate information sharing. Poor information sharing was a significant theme of our dementia review – good information sharing is a prerequisite for effective integrated care. Continuity of care and the important function of care co-ordination cannot be delivered without timely and complete information. GPs should be aware when one of their patients is seen at A&E or is admitted to hospital; they should know what their condition is, and when they will be discharged. This should not require daily phone calls or faxes. Giving the system the tools to be responsive and reliable is an important step in improving the quality of care for all.

- **Be responsive to the wider community needs, and develop the tools to enable this.** Consider all the resources available to the local community and maximise the potential to deliver services. We have seen excellent examples of multidisciplinary working and community engagement – such as hosting quit smoking sessions and weight loss groups in community centres alongside a drop-in GP clinic, or dental check-ups in day care centres for older people.
- **Tackle failure with courage and in the interest of patients.** While there are many examples of good and excellent care, where we find care that is inadequate it should be addressed swiftly. Denying the prevalence of poor care will not help to address it. As a system there should be support to improve, combined with the hard levers of legal registration, contract management and internal performance management of larger organisations. If a provider is de-registered by CQC, or de-commissioned by the commissioner, the system around that provider should act swiftly to protect the continuity of care for patients. This may require new providers to enter the market or existing providers to expand.



# CONCLUSION

In this report, we have set out how we have found some outstanding care and rated many services as good. We have also found services that are inadequate or require improvement. We are calling time on this variation in the quality and safety of care in England: it is too wide and it is unacceptable. The public is being failed by the numerous hospitals, care homes and GP practices that are unable to meet the standards that their peers achieve and exceed.

CQC is working hard, through better use of data, our more rigorous and expert-led inspections and our ratings, to provide robust, consistent and transparent judgements of the quality of care. Through these, we will celebrate care that is good or outstanding and we will expose care that is inadequate or needs to improve.

We are calling on care providers, commissioners and system leaders to use our judgements to have the greatest impact on improving care for people in England.

Providers, professionals, commissioners and system leaders should use them to improve the quality of the services they provide. The most important step for improvement is to acknowledge where improvement is needed. Our judgments should help providers understand the quality of the services they provide, and help them focus their improvement efforts.

# REFERENCES

1. Nuffield Trust, *Into the red? The state of the NHS' finances*, July 2014
2. [www.gov.uk/government/publications/mental-health-crisis-care-agreement](http://www.gov.uk/government/publications/mental-health-crisis-care-agreement)
3. National Audit Office, *Adult social care in England: overview*, March 2014
4. [http://supremecourt.uk/decided-cases/docs/UKSC\\_2012\\_0068\\_Judgment.pdf](http://supremecourt.uk/decided-cases/docs/UKSC_2012_0068_Judgment.pdf) and [http://supremecourt.uk/decided-cases/docs/UKSC\\_2012\\_0068\\_PressSummary.pdf](http://supremecourt.uk/decided-cases/docs/UKSC_2012_0068_PressSummary.pdf)
5. [www.publications.parliament.uk/pa/ld201314/ldselect/ldmentalcap/139/13902.htm](http://www.publications.parliament.uk/pa/ld201314/ldselect/ldmentalcap/139/13902.htm)
6. Corallo AN, Croxford R, Goodman DC, Bryan EL, Srivastava D & Stukel TA, 'A systematic review of medical practice variation in OECD countries', *Health Policy*, 2014 Jan;114(1): 5-14. doi: 10.1016/j.healthpol.2013.08.002. Epub 2013 Aug 23
7. [www.oecd.org/health/health-systems/medical-practice-variations.htm](http://www.oecd.org/health/health-systems/medical-practice-variations.htm)
8. Wennberg JE & Gittelsohn AM, 'Small area variations in health care delivery: a population-based health information system can guide planning and regulatory decision-making', *Science*, 182 (117) (1973), pp. 1102-1108
9. Wennberg JE, *Tracking Medicine: A Researcher's Quest to Understand Health Care*, Oxford University Press, 2010
10. Bernal-Delgado E, García-Armesto S, Peiró S, Atlas VPM Group, 'Atlas of Variations in Medical Practice in Spain: the Spanish National Health Service under scrutiny', *Health Policy*, 2014 Jan;114(1):15-30. doi: 10.1016/j.healthpol.2013.07.013. Epub 2013 Sep 10
11. Gusmano MK, Weisz D, Rodwin VG, Lang J, Qian M et al, 'Disparities in access to health care in three French regions', *Health Policy*, 2014 Jan;114(1):31-40. doi: 10.1016/j.healthpol.2013.07.011. Epub 2013 Aug 5
12. Swedish Association of Local Authorities and Regions and Swedish National Board of Health and Welfare Publikationsservice, *Quality and Efficiency in Swedish Health Care – Regional Comparisons 2012*
13. [www.cqc.org.uk/content/adult-social-care](http://www.cqc.org.uk/content/adult-social-care); [www.cqc.org.uk/content/hospitals-0](http://www.cqc.org.uk/content/hospitals-0); [www.cqc.org.uk/content/gp-practices-and-out-hours-services](http://www.cqc.org.uk/content/gp-practices-and-out-hours-services)
14. Bessa I, Forde C, Moore S and Stuart M, *The National Minimum Wage, earnings and hours in the domiciliary care sector*, University of Leeds, February 2013
15. [www.gov.uk/government/publications/mental-health-crisis-care-agreement](http://www.gov.uk/government/publications/mental-health-crisis-care-agreement)
16. [www.cqc.org.uk/content/community-mental-health-care-must-improve-warns-regulator](http://www.cqc.org.uk/content/community-mental-health-care-must-improve-warns-regulator)
17. Centre for Health and the Public Interest, *Patient safety in private hospitals – the known and the unknown risks*, August 2014
18. [www.mentalhealth.org.uk/publications/fundamental-facts/](http://www.mentalhealth.org.uk/publications/fundamental-facts/)



## How to contact us

Call us on 03000 616161

Email us at [enquiries@cqc.org.uk](mailto:enquiries@cqc.org.uk)

Look at our website [www.cqc.org.uk](http://www.cqc.org.uk)

Write to us at

### Care Quality Commission

Citygate

Gallowgate

NE1 4PA

Follow us on Twitter @CareQualityComm

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