Care Quality Commission

The state of health care and adult social care in England

2017/18

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Foreword

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

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

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

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

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

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

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

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

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

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

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

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

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

Ian Trenholm
Chief Executive

Peter Wyman
Chair

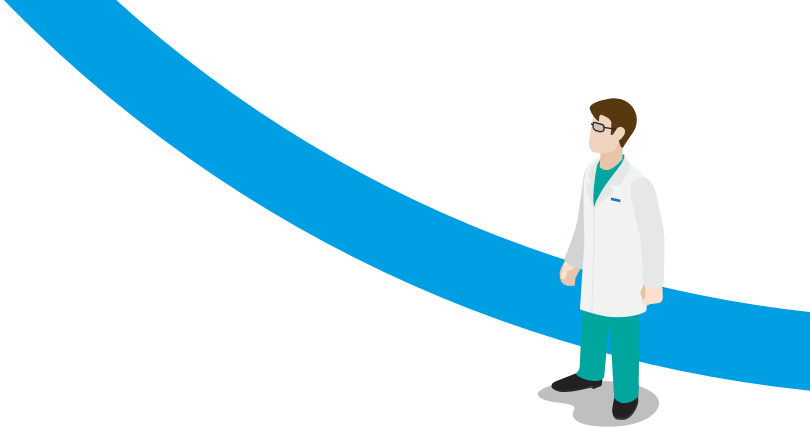
Summary

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

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

Public sentiment about health and care services remains largely positive – for example, 84% of patients said their GP practice was fairly good or very good. However, there are real concerns, such as the one in four (25%) of people receiving NHS mental health services who did not feel they got services often enough for their needs.

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



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

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

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

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

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

Quality – The overall quality of care in the major health and care sectors has improved slightly. More than nine out of 10 (91%) of GP practices and 79% of adult social care services were rated as good at 31 July 2018. More than half (60%) of NHS hospital core services and 70% of NHS mental health core services were rated as good at that date. The hallmark of high-quality care is good leadership and governance, a strong organisational culture that embraces learning, and good partnership working – services looking externally to work with others and share what they know.

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

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

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

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

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

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

Demand for urgent and emergency care services continued to rise in 2017/18, with more attendances at emergency departments than ever. The capacity of adult social care provision continues to be very constrained: the number of care home beds dropped very slightly in the year, but what was noticeable were the wide differences across the country. Across a two-year period, from April 2016 to 2018, changes in nursing home bed numbers ranged from a 44% rise in one local authority to a 58% reduction in another. Almost a third of adult social care directors (32%) said they had seen home care providers close or cease trading in the previous six months.

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

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

Working together for people who need care

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

In Kent, an acute response team brings together social care coordinators, therapists, support group workers and volunteers with NHS specialist staff such as diabetes nurses, all in a single team to support people who have fallen ill and risk being admitted to hospital. Plymouth has coordinated a council and healthcare service that prevents social isolation and loneliness, helping people to stay healthy in their homes. More than 1,100 people have used the service, which follows up to check on the wellbeing of people who sign up and then fail to attend.

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

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

In Berkshire, teams in primary, secondary and community care – including specialists such as physiotherapists and psychologists – are working with expert patients to design a streamlined single service for pain management, rather than multiple isolated pathways.

Harnessing the power of technology

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

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

Better person-centred care is possible

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

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

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

Data used in this report

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

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

199 hospices

1,336 dental practices[a]

216 independent acute hospitals

6,950 primary medical care services

21,982 adult social care services

237 independent mental health locations

10 NHS ambulance trusts

148 NHS acute hospital trusts

57 NHS or independent community health providers or locations

55 NHS mental health trusts

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

- Quantitative analysis of our inspection ratings of almost 30,000 services and providers (as set out above), drawing on other monitoring information including staff and public surveys, and performance.
- Qualitative analysis of CQC inspection colleagues' experiences of inspecting services this State of Care year. This analysis was conducted to explore factors associated with quality, including what leads to deterioration, supports improvement and helps to maintain quality. It informs part 1 of the report and our chapters on the sectors we regulate. It was based on:
  - Thematic analysis of 28 interviews with senior members of CQC's inspection directorates (CQC deputy chief inspectors and heads of inspection) and 10 focus groups with inspectors and inspection managers from adult social care, hospitals, mental health, and primary medical services inspection teams.
  - Qualitative case study analysis of 15 services that had declined from a rating of good to requires improvement or inadequate since 1 April 2017 and four locations that had maintained a rating of requires improvement since 1 April 2017. This analysis comprised inspection report analysis and interviews with lead inspectors. High-level findings from this analysis were used to inform interviews and focus groups with inspection teams.

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

- Qualitative analysis of nine interviews with Experts by Experience who had used, or cared for someone who had used, a range of health and social care services this State of Care year. This analysis aimed to understand personal experiences of care in England and informs part 1 of the report and our sector-based chapters. Data has been anonymised and any names used in the report are pseudonyms.
- Qualitative analysis to inform our chapters on Deprivation of Liberty Safeguards (DoLS) and equality in health and social care:
  - The analysis detailed in our chapter on DoLS is based on 12 interviews with inspectors and inspection managers with particular knowledge and interest in DoLS and/or the Mental Capacity Act. A case study analysis of four services that had demonstrated good or improved practice in DoLS and the MCA since 1 April 2017 was also carried out to provide further evidence of the factors associated with quality in this area.
  - For our chapter on equality in health and social care, we conducted a case study analysis of four adult social care services identified as displaying one or more areas of good practice in relation to person-centred care for lesbian, gay, bisexual and transgender people. We also carried out secondary qualitative analysis of a sample of NHS hospital trust inspection reports and a sample of responses to new-style provider information returns (PIRs). These analyses focused on the implementation of the Workforce Race Equality Standard (WRES) and adherence to the Accessible Information Standard (AIS).
- We interviewed a further nine members of the public (including Experts by Experience) to understand common experiences of people when they move between different health and social care services.
- The analytical findings have been corroborated and in some cases supplemented with expert input from our chief inspectors, deputy chief inspectors, specialist advisors and analysts to ensure that the report represents what we are seeing in our inspections.
- All interviews and focus groups took place from March to June 2018.

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

Equality in health and social care

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

Deprivation of Liberty Safeguards (DoLS)

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