

# The state of health care and adult social care in England

An overview of key themes in care  
in 2010/11





Care Quality Commission

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An overview of key themes in care in 2010/11

Presented to Parliament pursuant to section 83(4)(a) of Part 1 of the Health and Social Care Act 2008.

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# About the Care Quality Commission

The Care Quality Commission is the independent regulator of health care and adult social care services in England.

We also protect the interests of people whose rights are restricted under the Mental Health Act. Whether services are provided by the NHS, local authorities or by private or voluntary organisations, we focus on:

- **Identifying risks** to the quality and safety of people's care.
- **Acting swiftly** to help eliminate poor-quality care.
- Making sure **care is centred on people's needs** and protects their rights.

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 **Section summary**

Health and social care is constantly evolving and with it providers and services are also changing.

 **Section summary**

The opportunity to access the right treatment, at a time and place that is convenient is a priority for people using services.

 **Section summary**

People are increasingly knowledgeable about health and care and understand that they have more choice and control about accessing services.

 **Section summary**

Our early findings alongside national statistics and NHS patient surveys provide a picture of quality and safety.



# Foreword

**This is our third annual report on the state of health and adult social care in England. It covers the period April 2010 until March 2011 and is based on CQC's responsibilities under the Health and Social Care Act 2008. This is the first year that CQC is reporting on the state of care under the new Act. Accordingly, there is no comparison of data with the previous two CQC reports about the state of care in England.**

People who need care services have emphasised to us the importance of services fitting around their needs, recognising their individual requirements and treating them with dignity and respect. This year's report reviews people's experiences of access to care services, the choice and control that they have when using services, and the quality of the care that is provided.

As with the report last year, we have looked at outcomes for people and have taken a broad view across the public, private and voluntary sector providers.

We have drawn on the new evidence sets that we hold from our regulatory activity, including our enforcement actions. This year there are different reporting time frames for our compliance activity – we have a year's worth of data for the NHS providers on monitoring compliance with the essential standards of safety and quality, but only six months for adult social care and

independent health care providers. However, the data in the report provides the baseline for future comparative trends in describing the shape of the market, outcomes for people, and for enforcement activity linked to non-compliance with the essential standards.

Our data shows that care for the elderly is likely to be delivered in non-NHS care settings such as care homes or in people's own home, which is entirely to be expected. Care for those with a learning disability, challenging behaviour or mental health needs have mostly shifted from NHS facilities to private hospitals over the past few years.

The baseline findings from our compliance activity show that independent health care providers and domiciliary care agencies are more likely to involve the people who are recipients of care in the decision-making process.

The very early findings from our compliance assessments of providers around effective, safe and appropriate care and treatment found that only around 70% of the NHS hospitals and care homes with nursing we reviewed were compliant with the outcome or had minor concerns only. But again, we need to understand this in the context of the limited number of compliance reviews we have undertaken to date, and the fact that our initial reviews focused on areas where we already had concerns.

Wherever we identified poor quality care in any setting we took action where necessary, using our enforcement powers under the new legislation. We have continued to work with the other parts of the health and social care system including the providers who are responsible for safety and quality, the commissioners in PCTs and local authorities, the strategic health authorities as performance managers and with other regulators such as Monitor.

The next few years are a critical time for health and social care in England. There is the planned legislative change for the NHS and social care with the proposed NHS and Social Care Bill 2011. This will lead to new commissioning structures for the NHS working alongside the local authorities, and local HealthWatch and HealthWatch England being set up to articulate views on behalf of people who use services. The Government has also signalled that they will publish a social care White Paper in 2012.



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**Chair**  
Jo Williams

There are also considerable financial challenges for both the NHS and local authorities, with significant efficiency savings to be realised over the coming years. CQC will continue to carry out our regulatory functions and to build on the baseline data we have presented in this year's report. We will maintain a relentless focus on providers' requirements to comply with essential standards of quality and safety, and provide timely and real-time information to the public on our findings. We will respond quickly to protect people where we find non-compliance.

We will use the evidence we have alongside the system-wide data and information – to make sure that the care sector ensures that all those needing to use services have their needs assessed, get the right kind of advice, treatment and care, and are involved in the process.



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**Chief Executive**  
Cynthia Bower

# Introduction



**This report to Parliament describes the state of health care and adult social care services in England in 2010/11. We have drawn on evidence from our regulation and review activities, the views and experiences of people who use services and those who work in them, and published national statistics.**

In 2010 a new system for registering and regulating health care and adult social care in England came into effect, as a result of the Health and Social Care Act 2008. For the first time there is one set of standards – called the essential standards of quality and safety – that all registered health care and adult social care providers must meet. The essential standards each have an associated outcome describing what people using the service can expect to experience.

By 1 April 2010 we had registered all 378 NHS provider trusts in England. The registration programme continued throughout 2010 and into 2011: from October 2010, around 12,000 independent health care and adult social care providers were transferred from regulation under the Care Standards Act 2000 to the new system. This second wave of registered

providers is collectively responsible for services delivered in around 24,000 locations across England. Following this, we began to register around 9,000 primary dental care and independent ambulance providers for the first time.

CQC's job is to register providers if they meet the essential standards, check that they continue to do so, and take action if they do not. We focus our resources on assessing services at any time where there are concerns that people may be getting poor care. We identify such concerns by monitoring information from a range of sources, sharing information with many other organisations, and listening to the public, care staff and whistleblowers.

## Data used in this report

In this report, we provide an overview of registered health and adult social care providers and services. This is the first such information to be published since the new registration and regulation system under the Health and Social Care Act came into effect. Because of changes in the legal requirements for registration, it is not possible to make direct comparisons with figures about provision and capacity from previous years.



## This is our first State of Care report under the new Health and Social Care Act

We also publish findings from our regulatory and enforcement work. Much of this information is also published for the first time and, as it reflects the new regulatory system, comparisons cannot be made with previous years. Changes to our role and remit mean we can no longer report on some issues that previous State of Care reports have covered. In particular, we were previously required to assess councils' performance in commissioning adult social care, but no longer do so.

We began carrying out compliance reviews of NHS trusts and hospitals in April 2010, and of independent health care and adult social care providers in October 2010. Not every essential standard outcome is covered in every review. Responsive reviews look at fewer outcomes, as they focus on very specific issues, depending on the nature of the concern. Therefore, each compliance review will look at a different range of outcomes.

The information we report covers a range of reporting periods: for each issue, we have used the most recently available figures. For our own registration and compliance data, we have analysed information from our Customer Relationship Management database in July 2011. The information from our monitoring and

compliance activity must be treated as initial findings, as the system is still very new, and for adult social care and independent health care has been in force for less than a year. Nevertheless, we expect that the findings in this State of Care report will provide a set of useful baselines for future reports and analyses.

It is also important to note that our initial compliance reviews included a relatively large proportion that were **responsive** – conducted in response to concerns being raised about particular services – and therefore the outcomes are likely to show disproportionately high levels of non-compliance. Furthermore, the 'compliance' figures shown in the outcome tables in this report should not be taken in isolation – a provider with a 'minor concern' for an outcome would in most cases be judged compliant for that outcome.

# Summary



## **This report to Parliament describes the state of health care and adult social care services in England in 2010/11.**

It is the first state of care report in which we publish information from the new registration and regulation system under the Health and Social Care Act 2008. All registered health care and adult social care providers must now meet one set of standards – called the essential standards of quality and safety. These essential standards are described in terms of the outcomes that people using the service can expect to experience.

However, the information from our monitoring and compliance activity must be treated as very early findings, as the system is still very new, and for adult social care and independent health care has been in force for less than a year. Also, because of changes in the legal requirements for registration, it is not possible to make direct comparisons with figures about provision and capacity from previous years.

The report has four main sections dealing with: the shape of care provision; access to care and services; choice and control; and quality and safety.

## **The shape of health and social care provision**

The provision of health and social care in England is constantly evolving and changing. We have looked at information that we hold about the providers and services that we register across the country, drawing also on key external sources of information.

- There are 378 registered NHS provider trusts, who between them deliver health care in 891 NHS hospitals across England. The bed capacity in NHS hospitals has progressively reduced in recent years and continues to do so. Current capacity is just above 140,000 beds available overnight, a reduction in around 2,000 since this time last year. However, the ongoing increase in day treatment in the NHS has reduced the length of time people spend in hospital and increased overall treatment capacity.
- There were almost 2,500 independent hospitals and clinics in England in July 2011.
- We have seen that the adult social care sector continues to change over recent years as new types of provision develop to enable people to live at home for longer. The number of residential care services fell by 10% between 2004 and 2010, while the number of domiciliary care agencies increased by over a third during a similar period.

- There were 4,608 care homes with nursing in England in July 2011, most commonly caring for older people and people with dementia. There were 13,475 care homes without nursing. For these, the most common types of provision were for older people and people with a learning disability. An estimated 45% of care home places in England are occupied by people who are self-funding rather than being paid for by the state.
- There were 5,894 domiciliary care (home care) agencies in England in July 2011.

### Access to care and services

The ability for people to access the right kind of care and treatment, when they need it and in a convenient location, will always be an important priority. We have looked at access to care and services, using data published by the Department of Health, the Office for National Statistics and the NHS Information Centre as well as findings from the 2010 NHS inpatient survey.

- Department of Health figures show that, following a long period of stability, there was a slight deterioration in the first few months of 2011 in waiting times for patients admitted to NHS hospitals. For outpatients, waiting times remained steady.



# 378

registered NHS provider trusts, who between them deliver health care in 891 NHS hospitals across England.

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2,500

independent hospitals and  
clinics in England in July 2011

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- The 2010 NHS inpatient survey showed the proportion of inpatients saying that they were admitted “as soon as they thought was necessary” has been more or less the same for the past three years at around 75%. There was no change in the number of people given choice over planned admission dates, with nearly three quarters saying they were not given a choice.
- Social care has seen a continued rise in demand for services. In the last year the number of new contacts to councils responsible for providing social care rose by 4% to 2.12 million. Of these, just over half (52%) resulted in a further assessment or commissioning of ongoing service.
- Where the waiting time between first contact and completed assessment was known, 35% were assessed within two days, and 62% within two weeks, a slight improvement from the previous year. Five per cent overall waited more than three months for their assessment, the same as in the previous year.
- Evidence appears to show that the reduction in social care budgets and increased demand is resulting in local authorities tightening their eligibility criteria for people to receive state-funded community care.

### Choice and control

Greater choice and control over the care people receive continues to be a national policy priority. People are increasingly knowledgeable about health and care, and this raises their expectations and confidence when they are looking to access services.

- We began carrying out compliance reviews of NHS trusts and hospitals in April 2010, and of independent health care and adult social care providers in October 2010. Outcomes 1 and 2 relate to respecting and involving people who use services and consent to care and treatment.

Our early findings show that, in both cases, independent hospitals and clinics, and domiciliary care agencies, had the highest proportions of compliance with the outcomes.

- Thirty-two per cent of NHS patients with a planned admission said they had been given a choice of hospital for their first appointment, 58% hadn't but didn't mind and 10% said they were not offered a choice, but would have liked one.
- The NHS survey showed no change over the last year in people's access to information or involvement in decisions. Slightly over half (52%) of inpatients felt that they were "definitely" involved as much as they wanted to be; 37% said they were involved "to some extent", and 11% said that they were not involved as much as they wanted to be.
- The number of people able to exercise more choice over their social care by using a direct payment or personal budget has continued to increase. In 2009/10, 13% of adults and carers receiving council-funded social care had self-directed support. The highest proportion was carers (24%), followed by adults aged 18-64 (15%) and then people aged 65 and over (10%). Local authorities' expenditure on direct payments for adults rose by 31% in real terms to £815 million in 2009/10.
- When we register providers, we ask them how equality, diversity and human rights influence their delivery of services. Our findings show that, across both health and social care, most action has been taken to address race equality, followed by disability equality and religion and belief.
- A higher percentage of NHS trusts have taken action on all equality strands, except religion and belief, compared to adult social care services. This is probably because NHS organisations, being larger, have greater capacity to undertake equality development work.

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# 4,608

care homes with nursing in England  
in July 2011

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## Quality and safety

Quality and safety are at the heart of the essential standards, and we are able to report our very early findings on a number of the outcomes set out by the standards. We also draw on nationally published statistics and NHS patient surveys to give a rounded picture of quality and safety in the provision of care.

- Outcome 4 looks at ‘effective, safe and appropriate care’. For both NHS and adult social care providers, failure to meet the regulations on Outcome 4 was one of the three most common reasons why we served compliance actions in the period.
- On safety and suitability of premises (Outcome 10), care homes had the lowest proportions of compliance, and also the highest proportions of major concerns. Nine per cent of NHS hospitals had moderate concerns in relation to this outcome.
- We made unannounced inspections of 100 NHS hospitals to check whether older people were being treated with dignity and respect (Outcome 1), and whether they were getting food and drink that met their needs (Outcome 5). We saw many examples of excellent care, finding that 45 hospitals were meeting both of these standards. At 35 hospitals we made suggestions for improvement, although essential standards were being met. However, we found 11 hospitals that were not meeting one of the two essential standards, and in nine cases neither of the essential standards was met.
- Outcome 7 says that people can expect to be safeguarded from abuse or the risk of abuse, and their human rights respected and upheld. Our figures show that independent hospitals and clinics met this outcome most readily. But the abuse uncovered at Winterbourne View hospital highlights the failure of the system to protect people with learning disabilities, challenging behaviour and mental health problems. The safeguarding of the most vulnerable remains of utmost priority for providers, commissioners and regulators. In both the NHS and adult social care, failure to comply with Outcome 7 was one of the three most common reasons why we issued warning notices in response to major concerns.



- The reporting of patient safety incidents or near misses is an important way in which organisations can learn from mistakes and support ongoing improvement. In 2010/11 there were 1.25 million incidents reported to the National Patient Safety Agency, an increase on the 1.19 million reported in 2009/10, and continuing the year-on-year increase.
- All organisations registered with CQC must show that they can meet Outcome 8 on cleanliness and infection control. The NHS continues to make good progress in tackling MRSA and *C. difficile*. In 2010/11 there was a 22% reduction in MRSA cases compared to 2009/10, and a 15% reduction in *C. difficile* infections.
- There were once again significant improvements in efforts to eliminate mixed-sex accommodation in NHS hospitals. More respondents to the 2010 patient survey reported not having to share sleeping areas or toilet and washing facilities with patients of the opposite sex than was the case in 2009.
- The NHS inpatient survey provides valuable information about inpatients' perceptions of cleanliness:
  - There have been year-on-year improvements in perceptions of hospital cleanliness. In 2010, 66% of inpatients said their hospital room or ward was "very clean" – up from 64% in 2009.
  - In 2010 the proportion of patients reporting that, as far as they knew, doctors "always" washed their hands between touching patients rose to 78% (76% in 2009). Ninety six per cent of patients had seen promotional information asking patients and visitors to wash their hands or use hand-wash gels.
- The 2011 survey of people who use community mental health services was completed by over 17,000 people aged 16 and over. The results were very similar to those in 2010: overall, 29% of respondents rated the care they had received as excellent, 30% as very good and 20% as good. The vast majority of participants said they were listened to and had trust in their health and social care workers. However, the findings show there is room for improvement, especially in involving people more in some aspects of their care.



# 22%

reduction in MRSA cases  
compared to 2009/10

In this section, we report on the shape of services from health and social care providers. We have used information that we hold about the providers and services that we register, and drawn on key external sources of information. Because of changes introduced with the new registration system, we cannot make direct comparisons with provision and capacity in past years. In future, we will be able to use our registration data to start developing analyses of trends in provision, and will also present information about dental services and primary medical services.

# 01

## The shape of health and social care provision





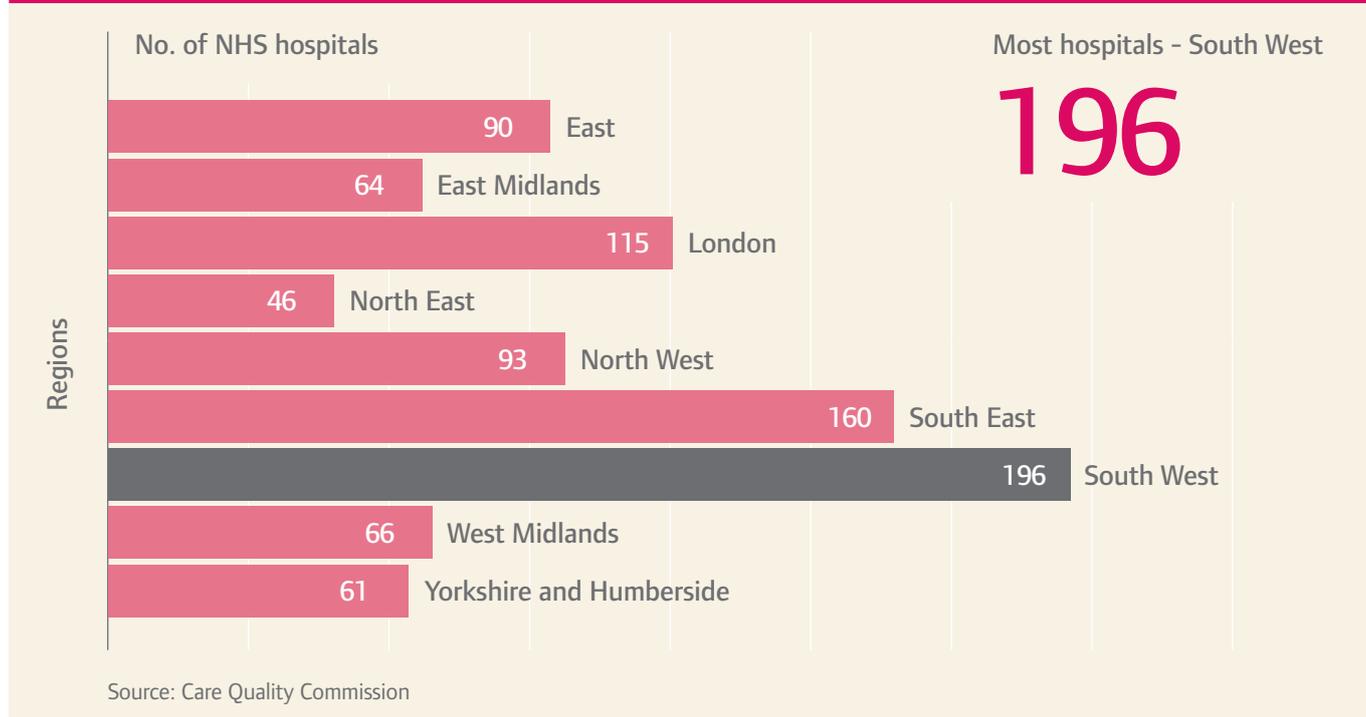
## Health care provision

### NHS hospitals

There are 378 registered NHS provider trusts, who between them deliver health care in 891 NHS hospitals across England. The most commonly registered activities are “treatment of disease, disorder, or injury” (for which 826 NHS hospitals are registered), “diagnostic and screening procedures” (735 NHS hospitals) and “surgical procedures” (443 NHS hospitals). Two-hundred and seventy-four NHS hospitals are registered to provide maternity and midwifery services, 204 to provide “family planning”

and 199 to provide termination of pregnancies. Two-hundred and thirty-nine are registered to assess or treat people detained under the Mental Health Act 1983. Figure 1 gives a breakdown by region of the distribution of NHS hospitals.

Hospital bed capacity in the NHS has progressively reduced in recent years.<sup>1</sup> It should be noted that changes in the number of beds cannot be used alone as a measure of NHS capacity or effectiveness, as activity levels and outcomes must also to be considered. The ongoing increase in day treatment in the NHS has reduced the length of time people spend in hospital and increased overall treatment capacity. In some cases, NHS functions have been transferred to

**Figure 1: NHS hospitals in England by region, July 2011****Table 1: NHS bed numbers in England by quarter, 2010/11**

Period	Available beds					
	Total (overnight)	General & acute (overnight)	Learning disabilities (overnight)	Maternity (overnight)	Mental illness (overnight)	Day only
Apr 10 – Jun 10	143,915	110,061	2,465	7,873	23,515	11,797
Jul 10 – Sept 10	140,230	107,197	2,237	7,867	22,929	10,872
Oct 10 – Dec 10	140,347	106,829	2,088	7,690	23,740	10,799
Jan 11 – Mar 11	141,019	107,670	1,972	7,769	23,607	11,060

Source: Department of Health, *Average Daily Available Beds Timeseries, England 2010/11*, May 2011

other services, and this may account for the reduced number of beds. NHS bed capacity for people with learning disabilities has been largely replaced over several decades by alternatives in private or voluntary sector care homes, in group homes or in individual accommodation supported by social carers.

In 2010/11 there was a change in the way information on bed numbers was collected by the NHS Information Centre. Previously statistics on the number of beds were collected by ward classification; however they are now collected in terms of consultant-led beds by consultant's main specialty. It is therefore not possible to make direct comparisons with figures from previous years.

Table 1 shows the number of available beds, open overnight, that are under the care of consultants, and the number of day-only available beds under the care of consultants, for each quarter from April 2010 through to March 2011, in NHS hospitals in England. They are sub-divided into different sectors. The figures do not include beds closed temporarily for refurbishment or cleaning, or cots on maternity wards for babies that are well.

In last year's State of Care report, we noted that the number of NHS 'geriatric' beds had fallen further in 2009/10, despite the rapidly increasing proportion of very elderly people with health and social care needs in the population. As figures for 'geriatric' beds are no longer collected, we are unable to report on this for 2010/11. However, it is likely that the trend of many years – for a diminishing proportion of long-term care for older people to be provided directly by the NHS, and a rising proportion to be provided in care homes and community settings – is continuing.

### Independent health care

Regulated independent health care includes a diverse range of private hospitals, clinics and agencies. These were previously regulated by CQC under the Care Standards Act 2000. Since October 2010, independent health care has been regulated under the new regulatory regime established by the Health and Social Care Act 2008, including compliance with the essential standards.

Our registration data show that in July 2011, there were almost 2,500 independent hospitals and clinics providing a wide range of services. The most commonly regulated activities are "treatment of



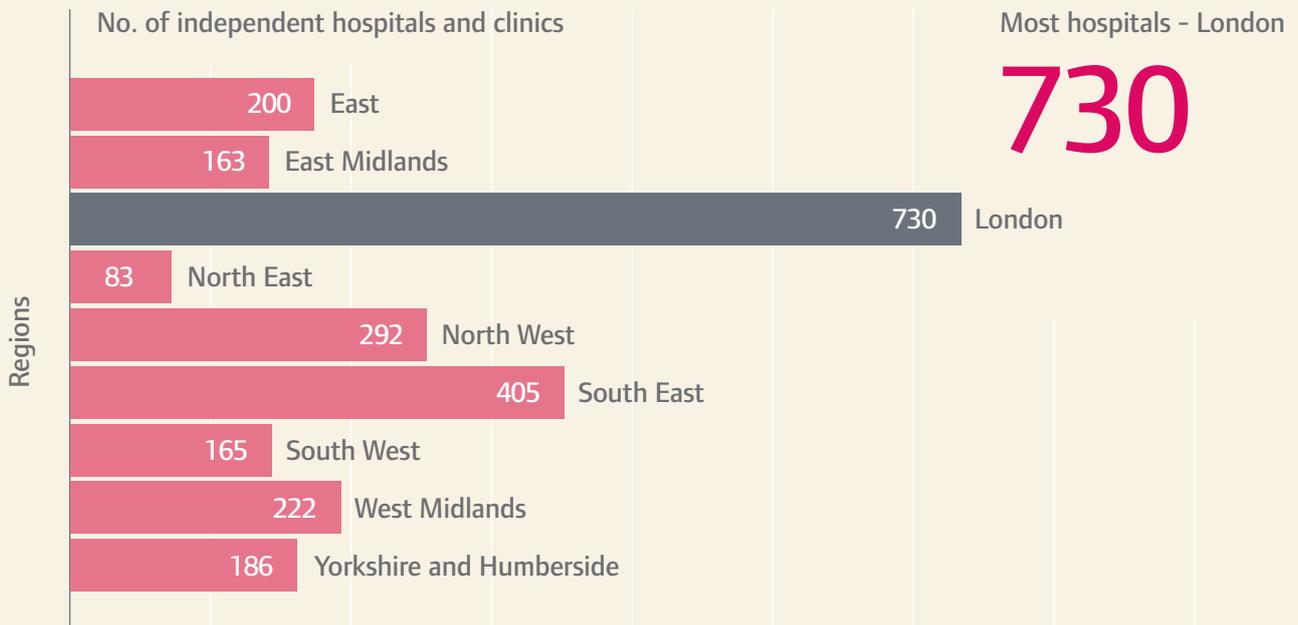

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10%

fall in numbers of residential social care services since 2004

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**Figure 2: Independent hospitals and clinics in England by region, July 2011**



Source: Care Quality Commission



## Kent Community Health NHS Trust

Kent Community Health	
County	Kent
Staff	5,700
Patients	1.4 million
Opened	2011

Part of the changing landscape of health care provision, the merger of Eastern and Coastal Kent Community Health NHS Trust and West Kent Community Health in April 2011 created one of the biggest providers of community care in England.

The merger came about because of the Transforming Community Services (TCS) programme, in which all PCTs were required to separate their provider and commissioning functions. An aim of TCS was to encourage new and different providers, increase competition, and improve the quality of services.

The formation of the new Kent Community Health NHS Trust brought together 5,700 staff including community nurses, physiotherapists, dieticians,

disease, disorder or injury” (which 2,035 independent hospitals and clinics are registered to provide), “surgical procedures” (1,104 registered to provide), and “diagnostic and screening procedures” (1,817 registered to provide). Two hundred and thirty-eight are registered to assess or treat people detained under the Mental Health Act 1983.

Other regulated activities include maternity and midwifery services (64 registered to provide), family planning (264 registered to provide), and termination of pregnancies (141 registered to provide). Ninety-five independent hospitals and clinics are registered to provide services in slimming clinics, 65 to provide “management of supply of blood and blood derived products” and 116 provide “transport services, triage and medical advice provided remotely”. London and the South East have the highest numbers of independent hospitals and clinics, with London having 30% and the South East 17% of the total (figure 2).

## Adult social care provision

The adult social care sector has been fluid and dynamic over recent years, changing as new types of provision develop to enable more people to live at home for longer. The number of residential care services fell by 10% between 2004 and 2010, while between 2005 and 2010, the number of domiciliary care agencies increased by over a third. The sector has seen expansion in models of provision such as Extra Care housing, and short-term nursing care in homes, which is replacing extended stays in hospital.

The well-publicised problems with Southern Cross as the largest provider of residential care in England have been a constant concern for the residents in their homes. It has also been a concern for their families. The overall coordination and management of the transfer of their homes to new providers has ensured that the services will continue, and that CQC will assess these providers for ongoing compliance with the essential standards.



For more information on Kent Community Health NHS Trust, visit [www.kentcht.nhs.uk](http://www.kentcht.nhs.uk)

podiatrists and many other healthcare professionals – providing healthcare to 1.4 million residents. It has 12 community hospitals, some with minor injury units, and a walk-in centre.

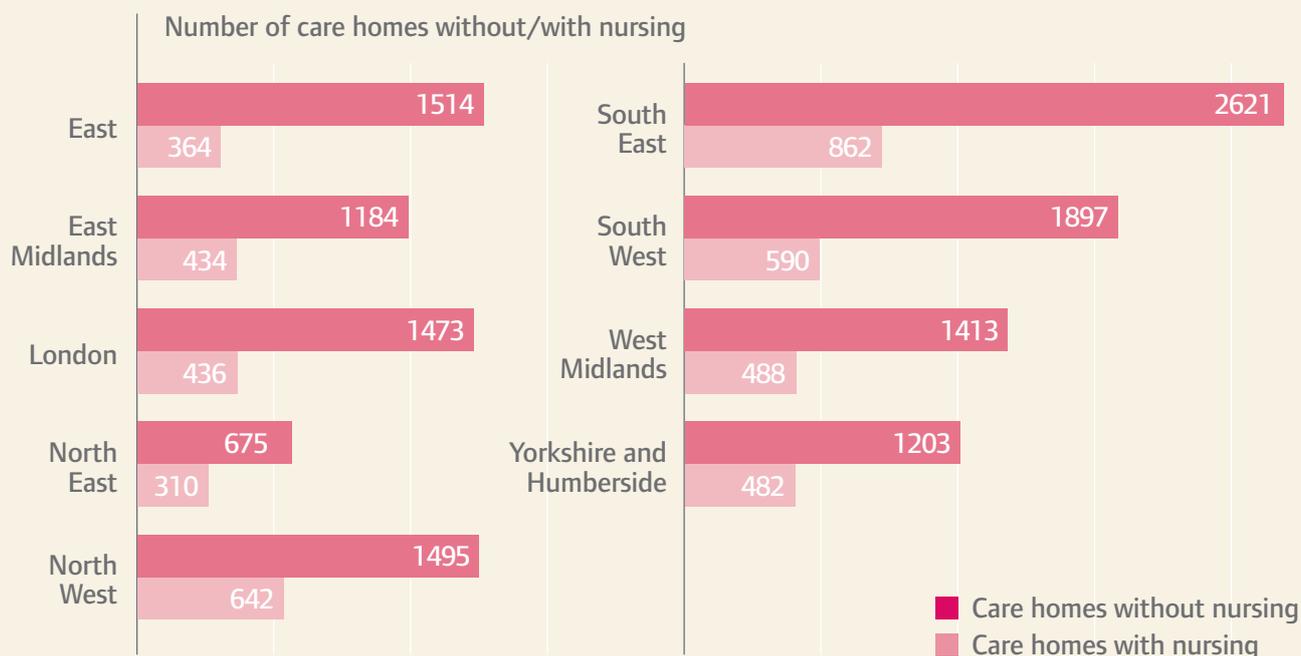
The trust has used the merger as an opportunity to take a good look at the standards of care provided by its workforce. It wanted to find ways to increase staff ownership of the new essential standards of quality and safety. These included software to help each service critically self-assess their area against the standards, staff briefings outlining the new standards, and the Staff Guide.

The Staff Guide, developed by the trust’s staff themselves, is an example of how organisations are using the standards to improve patient safety. It is an easy to read booklet that makes it clear to staff what

the standards mean for them in reality. Using plain English, the guide prompts individuals to consider the action they take day-to-day. It demystifies the legal regulations and reminds staff that regulatory compliance is really about patient outcomes and experience.

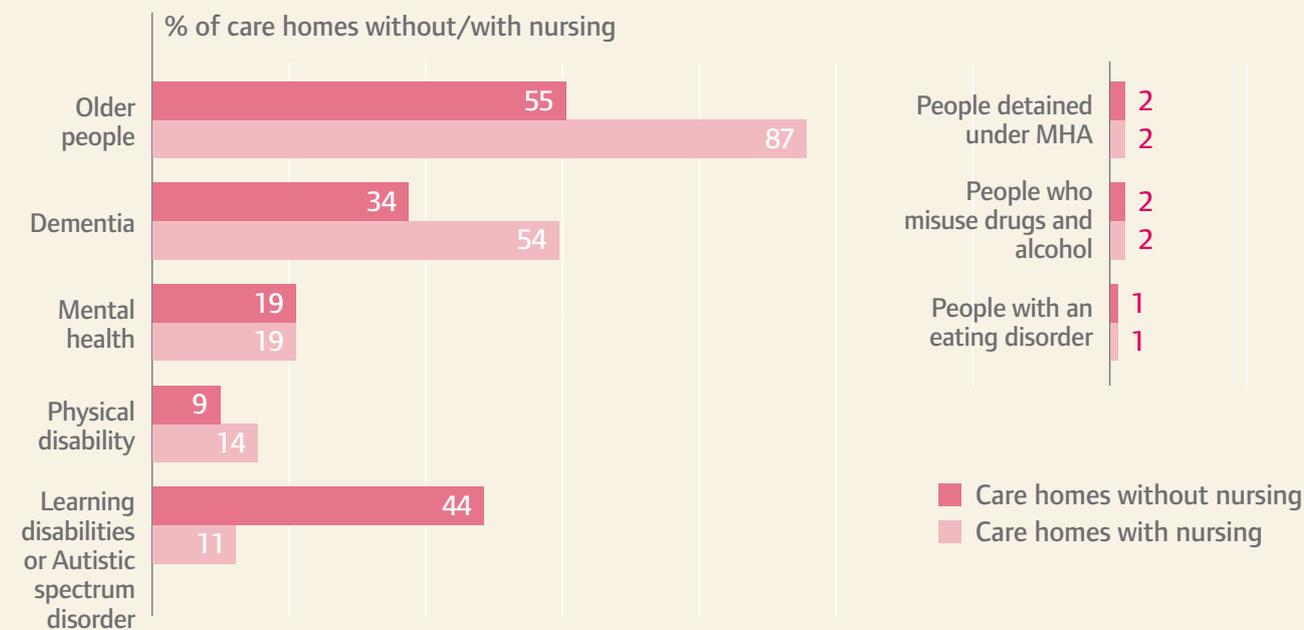
“The introduction of the essential standards of quality and safety, together with frontline inspections, has provided health and social care providers with an opportunity to change their approach to compliance. Our Staff Guide is one example where we have used the introduction of the standards to remind staff about their responsibilities”, said Jane Burgess, Standards Assurance Manager at Kent Community Health NHS Trust and author of the Staff Guide.

**Figure 3: Care homes without and with nursing in England by region, July 2011**



Source: Care Quality Commission

**Figure 4: Proportion of care homes without and with nursing in England catering for specific types of people who use services, July 2011**



Source: Care Quality Commission

CQC registration data show that there are almost 12,000 social care providers, operating services in 24,000 locations in England; around three-quarters of these locations are care homes providing nursing and/or personal care, and about a quarter are domiciliary care (home care) agencies. A small proportion are Shared Lives (171 registered locations) and supported living services (1,534 registered locations), that enable people to live in the community, Extra Care housing (564 locations), and nursing agencies (82).

An estimated 45% of care home places in England are occupied by people who are self-funding, meaning their costs are met privately rather than by the state. In addition, some people funded by local authorities have their care home fees ‘topped up’ by relatives or other third parties, to bridge the gap between what their council will pay and what the care home charges. Across England, around a quarter of local authority care home placements may be co-funded in this way. It is estimated that 168,700 older people pay privately for care in their own homes, and this increases to over 271,500 if widened to include those who pay for support with things like housework and shopping.<sup>2</sup>

Outlined below is an overview of the number of locations providing different specific regulated activities, and regional variations. Under the new regulatory regime, providers must register for each separate regulated activity provided at a given location; therefore the numbers reported under each different type of provision or activity are not mutually exclusive. Because of this change, it is not possible to make accurate comparisons with figures from previous years.

### Care homes

Registration data show that there were 4,608 care homes with nursing and 13,475 care homes without nursing in England, in July 2011. Some care homes may be registered as both ‘with nursing’ and ‘without nursing’, for example, if they take residents who need nursing care, and those who only require personal care. Therefore the numbers are not mutually exclusive. Regional variations are shown in figure 3.

Figure 4 shows the proportion of care homes with nursing and care homes without nursing in England catering for different types of people who use services. It is usual for a care home to be registered to care for more than one type of person.



5,894

home care agencies in England in  
July 2011

For care homes with nursing, the most common type of provision is for older people and those with dementia. For care homes without nursing, the most common type of provision is for older people and those with a learning disability or autistic spectrum disorder (ASD).

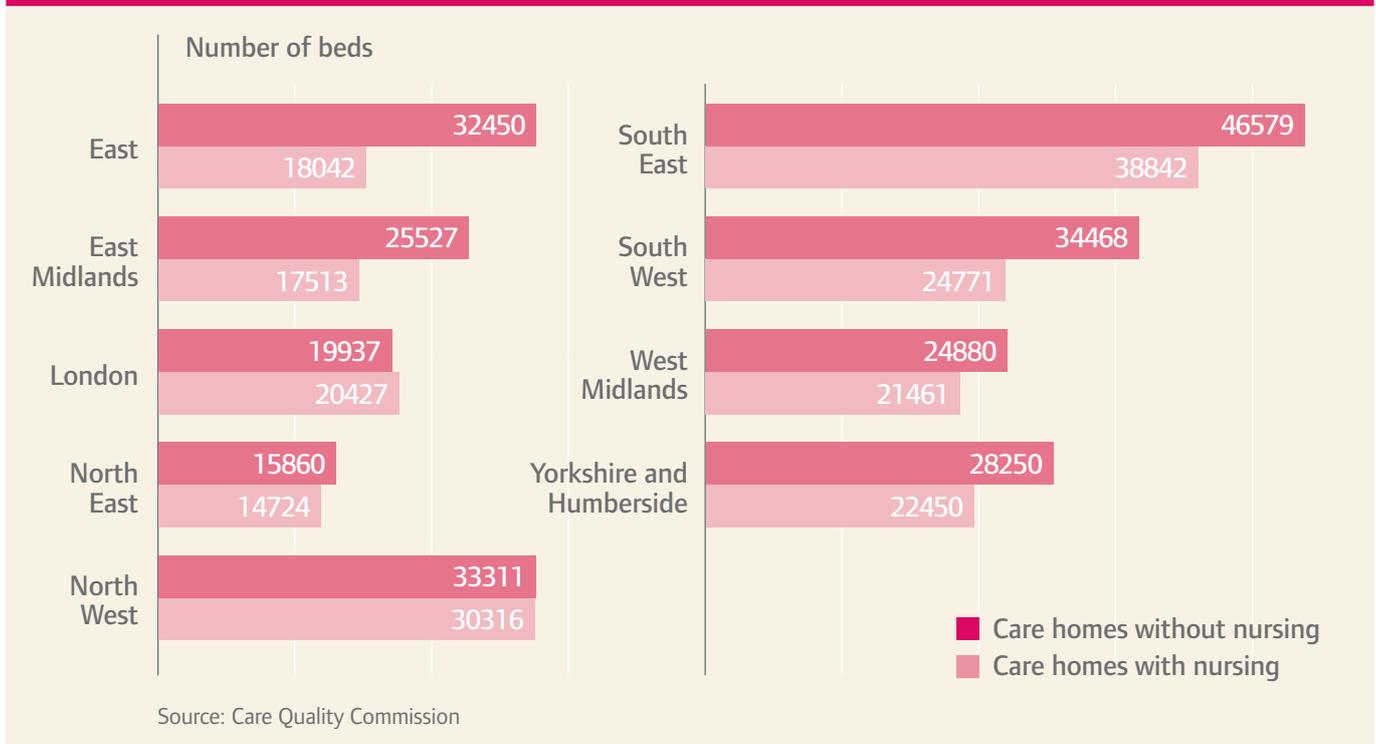
The total number of beds in registered care homes with nursing in July 2011 was 208,546. Regional variations are shown in figure 5. The greatest number of beds is found in the South East, and the fewest in the North East. The total number of beds in registered care homes without nursing in July 2011 was 261,262 with the greatest number of beds in the South East, and the fewest in the North East. Some beds may be in care homes that are registered both as ‘without nursing’ and ‘with nursing’; therefore the totals are not mutually exclusive.

### Domiciliary care (home care)

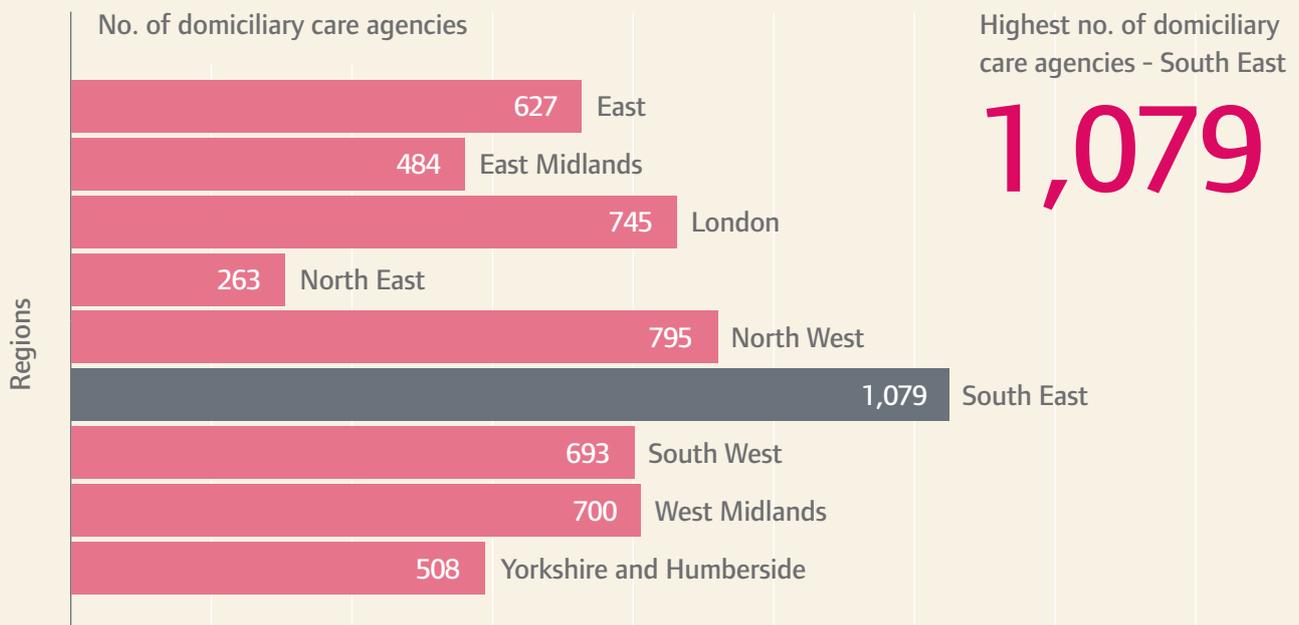
There were 5,894 home care agencies in England in July 2011, with the highest number in the South East, followed by the North West and London, and the lowest number in the North East (figure 6). It should be remembered that there is considerable variation in the size of agencies and the number of people who use their services.

Figure 7 shows the proportion of home care agencies in England catering for different types of people who use services. The most common types of provision are for older people, followed by people with dementia, those with a learning disability or ASD, and those with mental health issues. A single agency will usually be registered to provide care for more than one type of person.

**Figure 5: Beds in care homes without and with nursing in England by region, July 2011**

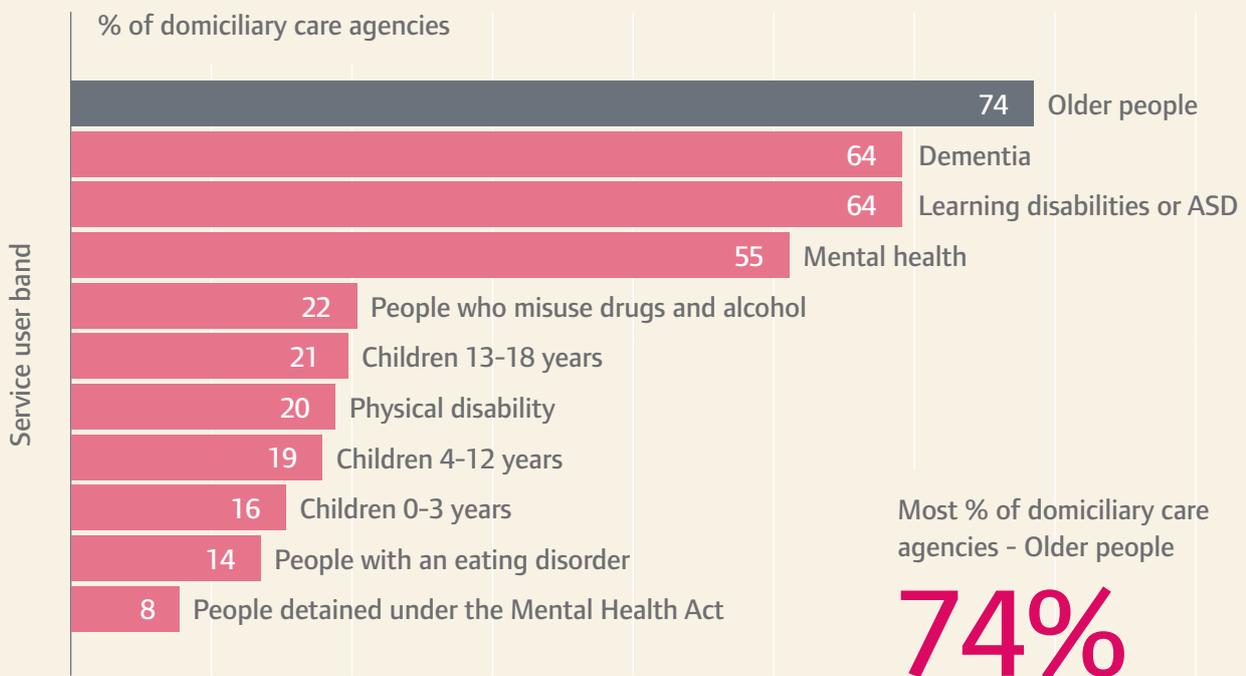


**Figure 6: Domiciliary care agencies in England by region, July 2011**



Source: Care Quality Commission

**Figure 7: Proportion of domiciliary care agencies in England catering for specific types of people who use services, July 2011**



Source: Care Quality Commission

For patients and people who use services, the ability to access the right kind of care and treatment, when it is needed and in a convenient location, will always be an important priority. In this section we look at access to care and services, drawing on statistics published by the Department of Health, the Office for National Statistics and the NHS Information Centre. We also report on findings from the 2010 NHS inpatient survey. The eighth national inpatient survey looked at the experiences of over 66,000 people discharged from hospital between June and August 2010. All participants were adults who had spent at least one night in an NHS acute hospital in 2010.

# 02

## Access to care and services





## Access to NHS care

### Waiting times for treatment in NHS acute hospitals

The NHS Constitution was published in 2009 and updated in 2010.<sup>3</sup> It sets out rights to which patients and the public are entitled. The Constitution says patients have the right to access services within a maximum waiting time of 18 weeks from referral to starting consultant-led treatment, unless a longer wait is clinically appropriate or chosen by the patient. In June 2010, the Department of Health stopped

monitoring performance against this 18 week target.<sup>4</sup> However, the NHS Operating Framework for 2011/12 said that patients' rights to maximum waiting times will continue.<sup>5</sup> It also said providers' compliance with this and the 95th percentile of waiting time (the time within which 95% of patients are treated) would be monitored.

Department of Health figures show that following a long period of stability, there was a slight deterioration in the first few months of 2011 in waiting times for admitted patients.<sup>6</sup> For non-admitted patients, waiting times remain stable.



# 4%

rise in patients visiting A&E and in people seeking support from social services

For admitted patients, the proportion treated within 18 weeks rose from just under half (48%) in March 2007 to 93% in March 2009, and remained relatively stable until February 2011, when it fell to 90%, rising to 91% in April and May 2011. In March 2007, 95% of admitted patients were treated within just over 52 weeks. By March 2009 this had come down to 20 weeks, and stayed around this level until the end of 2010 before beginning to rise. In May 2011 the figure stood at over 23 weeks.

For outpatients, the percentage treated within 18 weeks rose from 76% in August 2007 to 98% in March 2010, and has since remained broadly stable. In March 2008, 95% of non-admitted patients were treated within just under 22 weeks. This fell to under 16 weeks by March 2009, and has stayed at similar levels since.



## Rydon Ward at Somerset Partnership NHS Foundation Trust



Rydon Ward, a 32-bed ward caring for people with acute mental health needs, is part of Somerset Partnership NHS Foundation Trust. It has turned around services after CQC's investigation found a number of concerns.

A review was triggered after four serious incidents involving patients occurred in 2010. Our initial report said that patients did not feel involved in their treatment and felt they had little input into their care plans. Staff that we spoke to felt they did not have sufficient training and, in particular, had concerns about having the skills to care of people with personality disorders.

Following the review, the trust put together a robust action plan to address them. When we returned for a follow-up, staff were much more confident in caring for the patients. They thought the specialist training on working with people with a personality disorder had been excellent. One person described it as "empowering".

## Emergency and urgent admissions

For patients needing an urgent or emergency admission, waiting times appear to be worsening slightly since 2009, although it is too early to say whether this is the start of a trend.

In June 2010 the government announced that 95% of A&E patients should wait no more than four hours from arrival to admission, transfer or discharge.<sup>7</sup> This represented a relaxation of the previous 98% A&E target. Since April 2011 the four-hour waiting time standard for A&E departments has been replaced by a set of eight new A&E Clinical Quality Indicators.

Participants in the NHS inpatient survey were discharged from hospital between June and August 2010, just as the new standard was introduced. The figures from the patient survey are not directly comparable with the four-hour standard for A&E departments, as the survey only covers adults who were admitted as inpatients following their visit to an A&E department; it excludes people who attended A&E but were not admitted, as well as children, and maternity or psychiatric patients. Overall, 30% of survey respondents who had been admitted via A&E said that they waited more than four hours to be

admitted from arrival at hospital, an increase from 28% in 2009, but better than the 2002 figure of 34%.

Department of Health figures show that for the quarter April to June 2011, 3% of A&E patients waited for more than four hours, compared to 3.4% in January to March, and 3.5% in the quarter before that.<sup>8</sup> Attendance at A&E departments in England has risen each year since 2002/03, and reached 21.4 million in 2010/11, compared with 20.5 million the previous year.<sup>9</sup>

## Experiences of patients with planned admissions

The 2010 NHS inpatient survey asked people about their experiences of waiting for admission. Of those with a planned admission, there was no change since 2009 in the proportion who said they were given a choice of admission dates by their hospital: 28% said they had, and 72% said they had not been given a choice of admission dates. Seventeen per cent said their admission date had been changed once by the hospital, 3% said it had been changed two or three times, and less than 1% said it had been changed four times or more.



For more information on Somerset Partnership NHS Foundation Trust, visit [www.sompar.nhs.uk](http://www.sompar.nhs.uk)

Everyone we asked said that they had received a copy of their care plan and felt more involved in their care. Staff were keen to expand the ways that they involved people. The ward has carried out a survey to see how involved people feel and responses were very positive.

Two initiatives in particular made a real difference. Firstly, communication of key risks were reviewed and especially the shift “handover”. The handover template was developed and audited weekly initially, to identify areas of good practice and those which needed further action. Once established, the frequency of the audits reduced but learning and good practice was shared trust-wide, with all inpatients wards continuing to audit handovers.

While the risks identified on the ward were considered by staff, these were not always recorded consistently. The ward held a multi-disciplinary review of the risks for each patient and recorded this

on a daily basis, to ensure an up-to-date dynamic assessment for each patient.

Learning from these daily discussions prompted the development of a new risk screen within the electronic patient record, specifically designed to more accurately reflect the nature of the risks in terms of the most recent (acute) and the longer-term or historical risks. These changes will enable the ward staff to prioritise immediate and significant risk on the wards, while still considering previous risk history.

The trust’s Director of Operations said: “While being scrutinised is inevitably uncomfortable, we found being open, honest and transparent about our processes made this a positive learning experience for everyone involved.” Rydon’s Ward Manager said: “While this is happening, it is important to remember that we still have to deliver a safe service, so supporting staff while learning is essential.”



Thirty per cent of patients said they waited for up to one month between the first time they talked to a health professional about their referral and the time they were admitted to hospital. A further 49% waited between one and four months, 10% waited five to six months, and 12% waited more than six months. This shows no significant change since 2009.

The proportion of inpatients saying that they were admitted “as soon as they thought was necessary” has been more or less stable for the past three years at 75% in 2010 and 76% in 2008 and 2009. This is an improvement from 68% in 2002. Sixteen per cent thought they should have been admitted “a bit sooner” and 9% “a lot sooner”, representing no significant change since 2009.

### Delays in discharge from hospital

The 2010 NHS inpatient survey found no change since 2009 in people’s experiences of delayed discharge. Two-fifths (40%) of respondents said their discharge was delayed. The most commonly cited reasons were: to wait for new medicines (61% of those delayed), waiting to see the doctor (16%), waiting for an ambulance (9%), and “something else” (14%). Sixteen per cent of those delayed had to wait for up to one hour, 28% for one to two hours, 33% between two and four hours, and 23% for longer than four hours.



# 98%

of NHS outpatients treated within  
18 weeks

### Access to social care

In 2009/10, councils with adult social care responsibilities received 2.12 million new contacts from potential users of services. This represents a 4% increase from 2008/09 and an 8% increase from 2005/06. Of these, just over half (52%) resulted in a further assessment or commissioning of ongoing service in 2009/10. Around a quarter of the contacts (540,000; 26%) were self-referrals, 474,000 (22%) were referred from secondary health sources, such

as hospital wards or hospices, 272,000 (13%) were referred from primary or community health services, and 304,000 (14%) were referred by family, friends or neighbours. First assessments were completed for 699,000 new people (34%).<sup>10</sup>

### Ethnicity of people using social care services

Of the 1.7 million adults in England who received a social care service in 2009/10, 98% had their ethnic group specified. For those aged 65 and over, 96% of those whose ethnicity was specified were White, 2% Asian or Asian British, 1.5% Black or Black British, and 0.6% Chinese, Mixed or 'Other'. These proportions are in line with Office for National Statistics (ONS) estimates of the ethnic composition of the resident population of England aged 65 and over in 2009.<sup>11</sup>

For people aged 18-64 who received a social care service, 88% of those whose ethnicity was specified were White, 5% Asian or Asian British, 4.4% Black or Black British, and 2.5% Chinese, Mixed or 'Other'. These proportions compare with ONS estimates of the resident population of England aged 20-64 in 2009 as being 86.7% White, 6.6% Asian or Asian British, 3.2% Black or Black British, and 3.5% Chinese, Mixed or 'Other'.<sup>11</sup>

### Waiting times for local authority assessment

Where the waiting time between first contact with the council and completed assessment was known, 35% were assessed within two days of first contact (32% in 2008/09), and 62% within two weeks of first contact. Five per cent overall waited more than three months for their assessment, the same as in the previous year. For people with learning disabilities, around a third (34%) of assessments were completed within two days, and just over half (53%) within two weeks,

but 14% of assessments took over three months. For people with mental health issues, around half (48%) had assessments within two days, and 70% within two weeks, and 4% took more than three months.<sup>12</sup> However, it should be noted that with the increased availability of reablement programmes and more self-assessment as part of personalisation, the pace for completion of assessments is now very much driven by the person using the service.

### Eligibility criteria

Local authorities must use a national framework to assess the level of need of individuals wanting community care services, determining whether a person's need is "critical", "substantial", "moderate" or "low". Each authority sets its own eligibility criteria, deciding where the threshold lies for people to receive state-funded community care.

There is evidence that local authorities are tightening their eligibility criteria, in the face of social care budget reductions and demographic pressures. In the previous State of Care we reported that in 2009/10 three councils set their eligibility threshold at "critical" (the most restricted level of access to services), and 107 at "substantial". In May 2011 the Association of Directors of Adult Social Services published a survey completed by 148 (98%) local authorities with social service responsibilities in England. This found that 19 councils (13% of those responding) were changing their eligibility criteria for 2011/12, including 15 that were moving the threshold from "moderate" to "substantial" need. Six councils (4%) have set the threshold at "critical" and 116 (78%) at "substantial" – an increase from 70% in 2010/11. Twenty-two councils (15%) set their threshold at "moderate" and four (3%) at "low".

Supporting and enabling people to have greater choice and control over the care they receive continues to be a national policy priority. In this section, we give an overview of how health and social care providers are supporting patients and people who use services to exercise meaningful choice and control. We have drawn on our registration data and the early findings of outcomes of our compliance reviews, as well as the 2010 NHS inpatient survey and external sources such as the NHS Information Centre.

# 03

## Choice and control





## Choice and control in the NHS

Under the NHS Constitution patients and the public have the right to choose a GP surgery, to be involved and consulted about care and treatment, to be given information to enable this, and to accept or refuse treatment.<sup>13</sup> Although there is no formal monitoring system for the NHS Constitution, the NHS patient surveys provide valuable information about patients' perceptions of choice, control and involvement.

## Choice of hospital

In the 2010 NHS inpatient survey, patients with a planned admission were asked whether they had been given a choice of hospital for their first appointment. Thirty-two per cent said they had been given a choice, 58% said "no, but I did not mind", and 10% said they were not offered a choice, but would have liked one.

## Information and involvement

The 2010 survey found that slightly over half (52%) of inpatients felt that they were “definitely” involved as much as they wanted to be in decisions about their own care and treatment; 37% said they were involved “to some extent”, and 11% said that they were not involved as much as they wanted to be. These proportions are unchanged since 2009.

Having access to clear, high quality information is crucial to support patients in making informed choices and decisions about their treatment. Over three-quarters of respondents (78%) thought that they were given “the right amount” of information about

their condition or treatment, 22% said they were not given enough, and 1% thought they were given “too much”. These proportions are unchanged since 2009.

When asked whether doctors and nurses answered patients’ questions in ways they could understand, there were no changes since 2009, but some improvements compared with 2002. Over two-thirds of respondents (67%) said doctors “always” answered their questions in a way they could understand (65% in 2002), and 27% said doctors did this “sometimes” (29% in 2002). Six per cent said doctors did not answer their questions in a way they could understand. When asked the same question about nurses, 66% said “always” (63% in 2002), 29% “sometimes” (31% in 2002) and 5% said “no” (6% in 2002).



# 32%

of patients surveyed said they had been given a choice of hospital for their first appointment

**Table 2: Findings from CQC reviews of compliance with Outcome 1 on respect and involvement**

	Number of reviews	Review period	Compliant* %	Minor concerns* %	Moderate concerns %	Major concerns %
NHS hospitals	145	April 2010 – July 2011	71	23	5	1
Independent hospitals and clinics	115	Oct 2010 – July 2011	93	3	3	0
Care homes with nursing	591	Oct 2010 – July 2011	70	20	7	3
Care homes without nursing	1170	Oct 2010 – July 2011	85	9	5	1
Domiciliary care agencies	298	Oct 2010 – July 2011	90	6	3	1

Source CQC: Based on an analysis of approximately 3,500 reviews in total

\*Note that a provider with a minor concern would in most cases be judged compliant for that outcome

## Essential standards: outcomes on choice and control

We began carrying out compliance reviews of NHS trusts and hospitals in April 2010, and of independent health care and adult social care providers in October 2010. Not every essential standard outcome is covered in every review. Responsive reviews look at fewer outcomes, as they focus on very specific issues, depending on the nature of the concern. Therefore, each compliance review will look at a different range of outcomes.

The information from our monitoring and compliance activity must be treated as very early findings, as the system is still very new, and for adult social care and independent health care has been in force for less than a year.

It is also important to note that our initial compliance reviews included a relatively large proportion that were **responsive** – conducted in response to concerns being raised about particular services – and therefore the outcomes are likely to show disproportionately high levels of non-compliance. Furthermore, the ‘compliance’ figures shown in the outcome tables in this report should not be taken in isolation – a provider with a ‘minor concern’ for an outcome would in most cases be judged compliant for that outcome.

## Respect, involvement and consent

Outcome 1 of the essential standards is about respecting and involving people who use services. In services that comply with Outcome 1, people “understand the care and treatment choices available to them. They can express their views and are involved in making decisions about their care. They have their privacy, dignity and independence respected, and have their views and experiences taken into account in the way the service is delivered.”

The early findings from our compliance reviews are shown in table 2. Independent hospitals and clinics, and domiciliary care agencies, had the highest proportions of compliance with Outcome 1. Care homes with nursing had the highest proportions of moderate and major concerns.

Outcome 2 of the essential standards covers consent to care and treatment. It says people should be able to “give consent to their care and treatment, and understand and know how to change decisions about things that have been agreed previously.” As table 3 shows, independent hospitals and clinics, and domiciliary care agencies had the highest levels of compliance with Outcome 2. Just over 10% of NHS hospitals, and of care homes with nursing, had moderate or major concerns in relation to Outcome 2.

**Table 3: Findings from CQC reviews of compliance with Outcome 2 on consent to care and treatment**

	Number of reviews	Review period	Compliant* %	Minor concerns* %	Moderate concerns %	Major concerns %
NHS hospitals	86	April 2010 – July 2011	73	14	10	2
Independent hospitals and clinics	119	Oct 2010 – July 2011	93	6	0.8	0
Care homes with nursing	495	Oct 2010 – July 2011	73	16	9	2
Care homes without nursing	1050	Oct 2010 – July 2011	83	12	4	0.8
Domiciliary care agencies	274	Oct 2010 – July 2011	87	9	4	0.4

Source CQC: Based on an analysis of approximately 3,500 reviews in total

\*Note that a provider with a minor concern would in most cases be judged compliant for that outcome

## Choice and control in adult social care

In previous years, we reported on councils' performance in developing person-centred social care services. We reported on the progress local authorities were making against agreed national outcomes. With the change in our statutory responsibilities, we no longer assess local authority performance in this way. Instead, we report on some key trends in person-centred care.

### Direct payments and personal budgets

The number of people able to exercise more choice over their social care through using a direct payment or personal budget has continued to increase. In 2009/10 the figure rose to 166,000 adults.<sup>12</sup> Overall in 2009/10, 13% of adults and carers receiving council-funded social care had self-directed support. The proportion with self-directed support was highest for carers (24%), followed by adults aged 18-64 (15%) and then people aged 65 and over (10%).<sup>14</sup>

Fifty-five per cent of people with personal budgets or direct payments were aged 65 and over. Within this total, the number receiving a direct payment rose from 86,000 in 2008/09 to 107,000.<sup>12</sup> Local authorities' expenditure on direct payments for adults rose by 31% in real terms to £815 million in 2009/10.<sup>15</sup>

A survey completed by 132 councils for the Association of Directors of Adult Social Services in March 2011 found that the increase has continued further, with an estimated 338,000 using personal budgets or direct payments in England.<sup>16</sup> The survey also found that nearly all of the increase has been in 'managed' personal budgets, with no significant increase in direct payments over the previous year. However, progress remains variable, with 63% of responding councils delivering personal budgets to a third or more of eligible people, but at least 19 councils delivering them to less than a fifth of potentially eligible users. As yet, we do not have any evidence on the extent to which these rises in self-directed support may have resulted in changes to the actual composition of care packages.



## Looking after older people with dementia

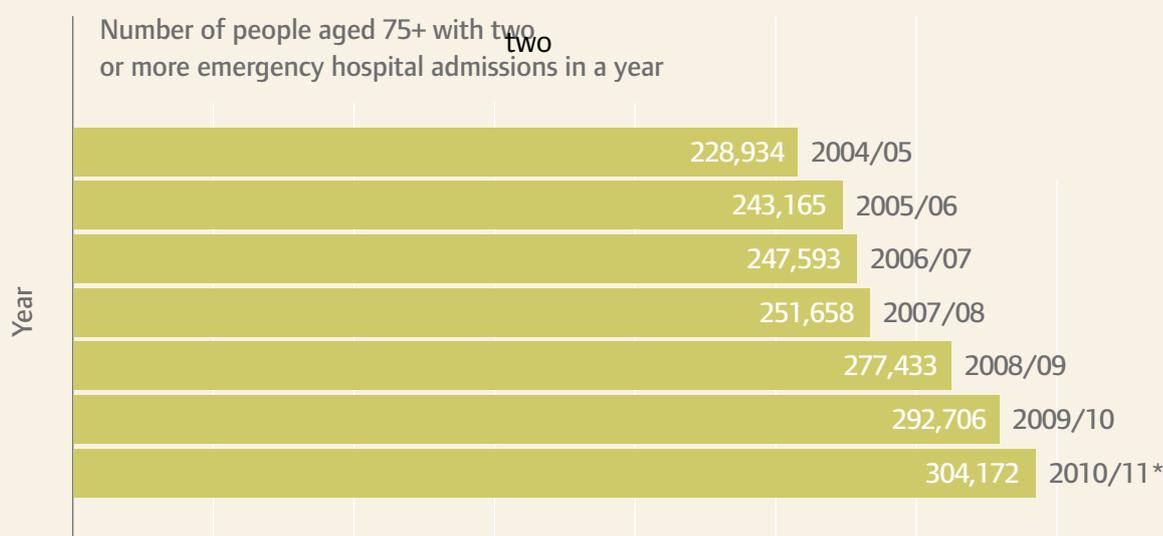


Up to half of all care homes in England care for older people with dementia, and some of our early reviews of care homes' compliance with the essential standards highlight the importance of having experienced staff.

In one example in November last year, friends and relatives of several older people with dementia contacted CQC. They wanted to share with us their experience of poor quality care at a care home. Their concerns included carers not making sure that the residents took antibiotic medicines when prescribed, and not taking appropriate measures to prevent or treat pressure ulcers.

Our inspector visited the home to observe how the people in the home were actually experiencing care in the course of the day, and talking with the

**Figure 8: People aged 75+ with two or more emergency hospital admissions in a year, 2004/05 to 2010/11**



Source: NHS Information Centre

\*see footnote on p37

residents, visitors and care staff. We found that eight of the 16 key essential standards were not being met, the most serious of which were poor administration of medicines and failure to ensure that the care and welfare of people was appropriate and safe.

We took action and asked the care home management to deliver a plan of action to make improvements. The owner of the care home quickly appointed a new care home manager, who was much more capable of introducing the changes needed. And when our inspector visited the home again two months later, the atmosphere in the home was calmer and more orderly.

In another example in December, a local council contacted us with concerns about a care home that cares for older people with dementia. Our inspector visited the care home twice in quick succession and

found that the service did not meet nine essential standards, all of them causes of major concern. The home's manager was not taking sufficient action to protect the people in her care. The owner of the care home suspended the manager immediately and replaced her with an interim manager from another care home he owned.

The new manager moved quickly to deliver an action plan, and we re-inspected the home two months later. Following this, we were able to declare that all the essential standards were being met, with the exception of just one concern: the home's sash windows needed repair before they were quite safe. We wrote to the care home about this one remaining problem.



## Reablement

Reablement has been defined as “services for people with poor physical or mental health to help them accommodate their illness by learning or relearning the skills necessary for daily living.” Reablement focuses on supporting people in developing confidence and relearning self-care skills, and helping people to “do things for themselves” rather than “having things done for them”. Reablement support is time-limited (usually for up to six weeks), outcome-focused, and aims to reduce or minimise people’s need for ongoing support after reablement. Reablement services are usually led by local authorities, although they are often developed in partnership with the NHS, and sometimes with other organisations such as charities or independent sector providers. The number of councils offering reablement services has grown. In November 2010, a report by York University cited figures held by the Department of Health that 149 out of 152 English councils with social care responsibilities had a reablement service, were extending or enhancing their service, or were in various stages of implementation.<sup>17</sup> This compares with 2006 when 60 councils had reablement services, and a further 40 were planning to establish them.<sup>18</sup>

**Table 4: Analysis of responses by equality characteristics/inclusion of human rights**

Answers to equality and human rights questions includes specific work undertaken on:	NHS trusts (n=100) 2009-10 registration applications %	Adult social care locations (n=100) 2010 registration applications %	Comparative – adult social care 2007 (n=400) %
Race equality	70	57	37
Disability equality	64	52	33
Equality on grounds of sexual orientation	23	16	9
Gender equality	22	19	11
Age equality	15	11	5
Equality on grounds of religion and belief	33	55	40
Equality for transgender people	4	1	2
Human rights	39	42	Not measured

## Repeated emergency admissions

If patients are repeatedly admitted to hospital as emergencies, this may be an indicator of poor care in the community. It could be a sign that better crisis or ongoing support is needed, to help vulnerable people get the care they need and keep out of hospital.

In last year's State of Care report, we were concerned that the number of people over 75 who had experienced two or more emergency admissions had risen between 2008/09 and 2009/10. Provisional figures for 2010/11 (which are still subject to revision) show a rise of 4% to 304,172 (figure 8).<sup>\*</sup> This compares with rises of 6% in 2009/10 and 10% in 2008/09. However, it must also be remembered that the proportion of the population aged 85 and over is increasing. As many of the 'very old' have greater health needs, this is likely to be a factor in the rise in emergency admissions.

<sup>\*</sup>2010/11 data is provisional and subject to revision until the final annual refresh National Statistics annual publication.

## enhancing

**149 out of 152 English councils with social care responsibilities had a reablement service, or were implementing one**

**Table 5: Most common actions on equality and human rights**

Rank	NHS trusts		Adult social care locations	
	Action	%	Action	%
1	Use of equality impact assessments	83	Staff equality training	69
2	Use of equality schemes	80	Use of assessment, care planning or person-centred care	65
3	Staff training	77	Use of equality policy	55
4	Ongoing engagement work with people using services	62	Race equality – removing access barriers (eg interpreters) <sup>19</sup>	43
5	Race equality – removing access barriers (e.g. interpreters) <sup>19</sup>	60	Religion and belief equality – removing access barriers (eg enabling people to attend place of worship) <sup>19</sup>	42
6	Monitoring service use/people's experiences (e.g. surveys)	59	Disability equality – removing access barriers (eg information in a range of formats) <sup>19</sup>	40
7	Developing governance of equality and human rights	51	Workforce equality initiatives	35
8	Disability equality – removing access barriers (e.g. information in a range of formats)	44	Monitoring service use/people's experiences (e.g. surveys)	34
9	Leadership initiatives about equality	41	Ongoing engagement work with people using services	31
10	Workforce equality initiatives	35	Human rights development work (excluding dignity initiatives)	29



## Equality and human rights work in health and social care

The Health and Social Care Act regulations require providers to have 'due regard' to the needs of people using their services in relation to their age, sex, religion, sexual orientation, ethnicity, cultural and linguistic background and disability.

When care providers completed their application forms as part of our registration process, we asked how equality, diversity and human rights influence their service delivery, service priorities and future plans. We have analysed a sample of responses from 100 NHS trusts and 100 adult social care services (table 4). The sample was randomly selected, but representative of the national spread of providers, in terms of region and type of trust or adult social care provider.

### Key findings

Across both health and social care, most action has been taken on race equality, followed by disability equality and religion and belief. Legislation about equality on the grounds of religion and belief is fairly recent. The relatively high percentage of providers taking action on this is probably due to providers responding to religion and belief issues raised through race equality work, and other previous requirements regarding supporting people in their beliefs, outside equality law.

A higher percentage of NHS trusts have taken action on all equality strands, except religion and belief, compared to adult social care services. This probably reflects the larger size of NHS organisations with corresponding greater capacity to undertake equality development work. In addition, not all adult social care organisations are subject to the public sector equality duty.

Compared to 2007 data, a higher percentage of adult social care providers were taking action on all equality characteristics (except gender reassignment).

However, there are some equality issues that still receive less attention and need more work in the sector including age, gender, gender reassignment and sexual orientation.

The number of social care providers taking specific action on human rights was slightly higher than the number of NHS trusts. This may reflect the longer history of development work on key human rights concepts, such as choice and autonomy, in some social care services. There may be some under-reporting in NHS trusts; equality work is often supported or monitored by a central team whereas work on human rights, such as dignity initiatives, may be more dispersed and localised with no central reporting.

The most common actions reported by NHS trusts relate to work required under equality law: using equality impact assessments and equality schemes (table 5). Beyond these legal requirements, staff training was the most common action reported by both NHS trusts and adult social care services.

For sexual orientation, the most commonly reported action for social care services was including sexual orientation in care planning (11%) and for NHS trusts it was workforce related initiatives (10%). For age equality, there was a wider range of types of action, with none reported by more than 10% of trusts or services. Twelve per cent of trusts reported action to remove access barriers on the grounds of gender – mostly to reduce the use of mixed-sex wards.

### Equality and Human Rights Commission

It is worth noting that, shortly before this publication went to press, the Equality and Human Rights Commission published a report assessing the performance of a sample of strategic health authorities and primary care trusts in England with regard to the race, gender and disability equality duties. It can be accessed at [www.equalityhumanrights.com/news/2011/july](http://www.equalityhumanrights.com/news/2011/july).

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## action

**Across health and social care, most action has been taken on race equality, followed by disability equality and religion and belief**

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In this section, we provide an overview of developments in safe care, and report on some of the monitoring systems in place to reduce risks and keep people safe. Our report draws on nationally published statistics and the initial findings from our own compliance reviews and activities with providers.

# 04

## Quality and safety





## Patient safety incidents and alerts

The reporting of patient safety incidents or near misses is an important way in which health care organisations can learn from mistakes and support ongoing improvement. The national patient safety incident reporting system run by the National Patient Safety Agency (NPSA) enables key risks to be identified and learning to be shared, so reducing safety risks across organisations. All NHS organisations across England and Wales send confidential reports of patient safety incidents to the NPSA. The reports are then analysed to identify common risks to patients

and opportunities to improve safety. In 2010/11 there were 1.25 million incidents reported to the NPSA, an increase on the 1.19 million reported in 2009/10, and continuing the year-on-year increase in reports since the NPSA was established.<sup>20</sup> The proportion of NHS trusts reporting incidents also continued to rise in 2010, with over four-fifths of trusts now regularly reporting.<sup>20</sup> These changes are almost certainly due to improvements in reporting culture.

Since April 2010, NHS trusts have a statutory duty to notify CQC of the most serious patient safety incidents. CQC sources the majority of these data from the NPSA to reduce duplication in reporting. The NPSA forwarded information on 128,134 incidents (including some

moderate incidents not necessarily covered by the statutory duty) that took place between 1 April 2010 and 31 March 2011. We conduct statistical analyses to identify trusts with very high or low reporting levels. Reporting levels in themselves are not a strong indicator of how safe an organisation is. High numbers of notifications may indicate poor care, but could also indicate a good reporting culture; conversely low numbers of notifications may indicate good care or a poor reporting culture. We also look at timeliness of reporting. Providers are required to notify CQC (via the NPSA) without delay; however, there can be substantial delays. The information is incorporated into our Quality and Risk Profiles (QRP) for each trust, to inform the work of our compliance inspectors.

The NPSA routinely reviews all incidents resulting in death or serious harm, and where appropriate develops a rapid response report or patient safety alert, which is distributed to all NHS trusts and independent health care providers via the Central Alerting System, with a deadline for implementation. By acting on these alerts, services can reduce the risks of similar incidents happening to others in future.

The Central Alerting System issues safety alerts from the Department of Health, the NPSA, and the Medicines and Healthcare products Regulatory Authority. The system is hosted and managed by the NPSA. Since January 2011, the NPSA publishes monthly response data, based on trusts' self-reporting, showing whether they have completed the actions required in response to each safety alert. The figures for June 2011 show that there are still some trusts that have not complied with all alerts within six months of receipt.<sup>21</sup> CQC now looks at the proportion of alerts acknowledged within deadline, and the proportion of alerts completed out of those due for completion, as part of our QRP for each NHS trust. We may therefore

take compliance with safety alerts into account when assessing whether organisations are compliant with the essential standards of quality and safety.

Following the Government's review of arm's length bodies in July 2010, the Department of Health has announced that the NPSA will cease to exist in July 2012. Elements of its patient safety functions will be incorporated into the new NHS Commissioning Board.<sup>22</sup>

## Patients' perceptions of safe care in hospital and safe discharge from hospital

The NHS inpatient survey provides valuable information about patients' experiences of various aspects of their care and treatment, and enables comparisons with previous years. In this section, we report on inpatients' perceptions of safe hospital care and discharge. Many of the changes we report since 2009 are small, at one percentage point or less, but they are all statistically significant, meaning they are unlikely to have occurred by chance.

### Patients' experiences of cleanliness

There have been year-on-year improvements in patients' perceptions of hospital cleanliness since 2007. In 2010, 66% of inpatients said their hospital room or ward was "very clean", an improvement from 53% in 2007, 60% in 2008 and 64% in 2009 (figure 9). Four per cent said their rooms or wards were "not very clean" or "not clean at all", the same as in 2009.

There have been improvements in the proportion saying the toilets and bathrooms were "very clean": from 47% in 2007, 52% in 2008 and 57% in 2009 to 59% in 2010 (figure 10). Six per cent said toilets and bathrooms were "not very clean" or "not at all clean", compared with 7% in 2009.

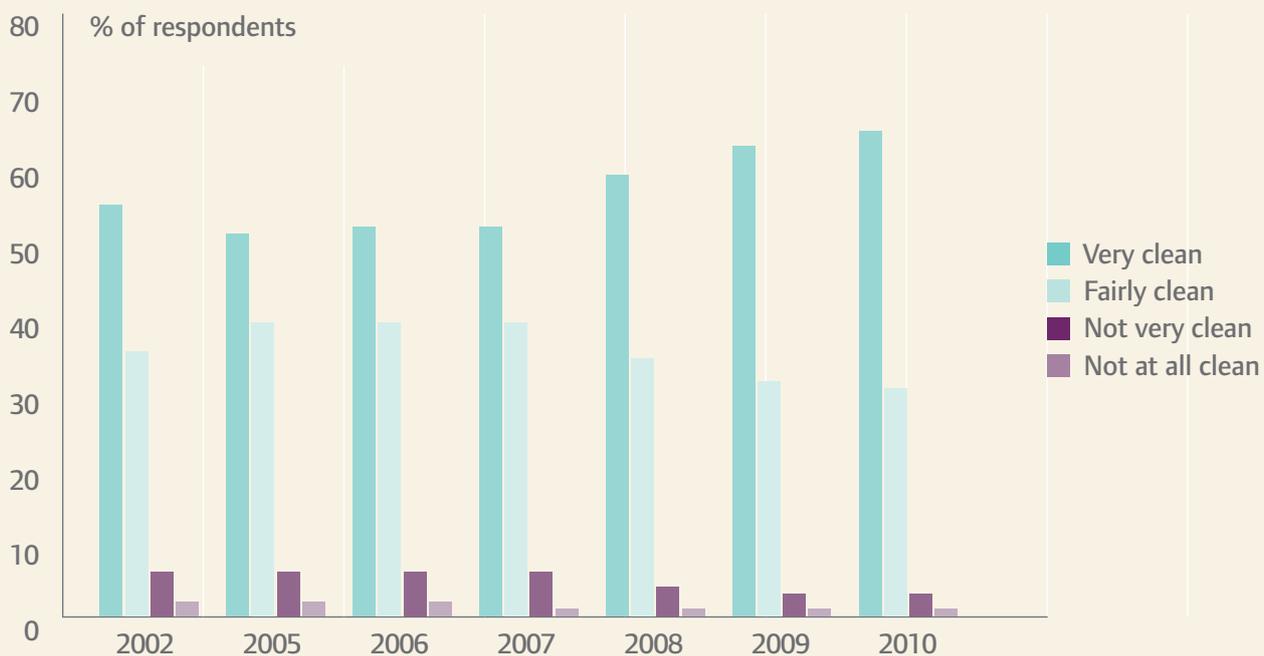
For hospital staff, washing and cleaning hands before and after touching patients is essential to control the spread of infection. In 2010 the proportion of patients reporting that, as far as they knew, doctors "always" washed their hands between touching patients rose to 78% (76% in 2009), and the proportion saying this for nurses remained at 79%, the same as in 2009.

Patients were asked if they had seen posters or leaflets asking patients and visitors to wash their hands or use hand-wash gels. Ninety-six per cent had seen these,

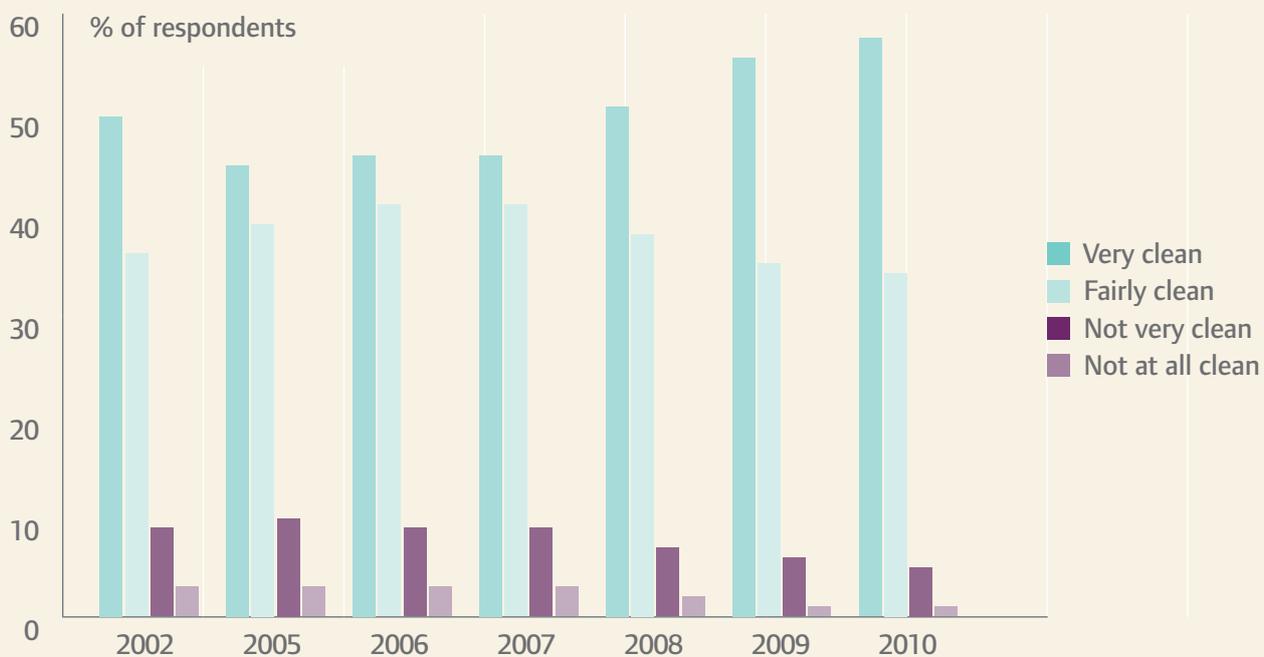


# 1.25m

patient safety incidents or near misses reported to the NPSA in 2010/11

**Figure 9: Inpatients' perceptions of cleanliness of hospital rooms and wards, 2002-2010**


Source: Care Quality Commission from NHS patient surveys

**Figure 10: Inpatients' perceptions of cleanliness of toilets and bathrooms, 2002-2010**


Source: Care Quality Commission from NHS patient surveys



and 97% said hand-wash gels had been available for people to use. Two per cent said hand-wash gel containers had been empty, and 1% could not recall seeing any hand-wash gels during their time in hospital.

### Security

Four per cent of respondents said they had felt threatened by other patients or visitors during their hospital stay, the same proportion as in 2008 and 2009. Of those who had felt threatened, almost four-fifths (78%) were emergency admissions.

A third (33%) of respondents said they had somewhere to keep their personal possessions on the ward, and could lock it if they wanted. This is an improvement from 2009 (32%). A further 62% had somewhere to keep their possessions on the ward, but could not lock it. Four per cent said they had nowhere to keep their belongings, a proportion which was unchanged since 2009.

### Responses to calls for help

We asked respondents how quickly call buttons were answered by staff. The proportion saying call buttons were answered “right away” declined from 17% in 2008 and 16% in 2009 to 15% in 2010. The proportions saying call buttons were answered in “one to two minutes” (38%) and “three to five minutes” (29%) have been unchanged since 2005. Sixteen per cent said it took “more than five minutes”, representing a 1% rise since 2009, and 1% said they never got help when using the call button (2% in 2009).

### Discharge from hospital

The 2010 survey found small improvements overall in the information given to patients on discharge from hospital, compared to previous years.

- Thirty-five per cent of respondents said they were not given written or printed information about what they should or should not do after leaving hospital, an improvement from 37% in 2009.
- The proportion of patients who said hospital staff did not tell them whom to contact if they were worried about their condition fell from 25% in 2009 to 24% in 2010.
- Thirty-two per cent of patients said that a doctor or nurse did not give their family or someone close to them all the information they needed to help care for them, an improvement from 33% in 2009.

Of those who had medicines to take home with them, 75% said that a staff member “completely” explained the purpose of the medicine in a way they could understand – no change from 2009, though a decrease from 79% in 2002. Nine per cent said that the purpose of medicines to take home was not explained by a member of staff. Seventeen per cent of those who took medicines home said they were not given clear written or printed information about their medicines, compared to 18% in 2009. Seventy-five per cent said they were “definitely” told how to take their medicines in a way they could understand; 15% were “to some extent”, and 10% said they were not told this in a way they could understand. Forty-four per cent said they were not told about side-effects of their medicines to watch out for, again representing a small improvement since 2009 when the proportion was 45%.

Communication between professionals is vital for safe patient care. Department of Health guidance states that patients should receive copies of letters sent between a patient’s hospital and family doctor. Since 2005 the patient survey has asked about this. In 2010, for the first time the majority of respondents (53%) reported that they had received copies of these letters, an increase from 47% in 2009, and 35% in 2005. Almost three-quarters (74%) said the letters “definitely” were written in a way that they could understand.

## Essential standards: outcomes on safe and effective care

A number of the essential standards relate to aspects of safe care. Outcome 4 covers the care and welfare of people who use services. Outcome 16 deals with assessing and monitoring the quality of service provision, including ensuring that people benefit from safe, quality care “because effective decisions are made and because of the management of risks to people’s health, welfare and safety”. Outcome 9 deals with management of medicines, Outcome 10 with the safety and suitability of premises where people receive care, and Outcome 11 addresses the safety, availability and suitability of equipment. Tables 6 to 10 summarise the number of compliance reviews we have conducted between April 2010 and July 2011 for different kinds of service, and the proportions that were compliant, or where concerns were found.

Outcome 4 says that people should be able to experience “effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.” The initial findings from our compliance reviews show that only around 70% of NHS hospitals and care homes with nursing were compliant with Outcome 4, or had minor concerns only (table 6). Around a sixth of care homes without

**Table 6: Findings from CQC reviews of compliance with Outcome 4 on care and welfare**

	Number of reviews	Review period	Compliant* %	Minor concerns* %	Moderate concerns %	Major concerns %
NHS hospitals	137	April 2010 – July 2011	51	16	26	7
Independent hospitals and clinics	127	Oct 2010 – July 2011	87	6	4	3
Care homes with nursing	799	Oct 2010 – July 2011	51	22	17	10
Care homes without nursing	1401	Oct 2010 – July 2011	68	16	11	5
Domiciliary care agencies	344	Oct 2010 – July 2011	73	17	7	3

Source CQC: Based on an analysis of approximately 3,500 reviews in total

\*Note that a provider with a minor concern would in most cases be judged compliant for that outcome

nursing, and a tenth of domiciliary care agencies had moderate or major concerns. For both NHS and adult social care providers, failure to meet the regulations on Outcome 4 was one of the three most common reasons why we served compliance actions in the period (requiring providers to report to us on the actions they are taking to achieve compliance) and took enforcement action in the form of issuing warning notices.

For Outcome 16, care homes with nursing and NHS hospitals had the lowest proportions of compliance. NHS hospitals had the highest proportions of moderate and major concerns (table 7).

On Outcome 9 addressing management of medicines, care homes with nursing, followed by NHS hospitals, had the lowest proportions of compliance (table 8). The highest proportion of major concerns was found in care homes with nursing, followed by independent hospitals and clinics. Although direct comparisons cannot be made, it is notable that under the previous system of National Minimum Standards, one of the main areas of non-compliance by adult social care providers was on management of medicines. At registration under the new system, there were 283 declarations of non-compliance with Outcome 9 by adult social care providers.



# 78%

of patients asked said they thought doctors always washed their hands between seeing patients

Across adult social care providers, Outcome 9 has to date been one of three outcomes most commonly not complied with, and where we have served compliance actions. These require providers to report to us showing what actions they are taking to achieve compliance. Following a compliance action, we monitor progress and will take enforcement action if not satisfied that the necessary improvements have been made. In relation to adult social care providers, failure to comply with Outcome 9 was also one of the three most common reasons why we took enforcement action in the period in the form of issuing warning notices.

**Table 7: CQC reviews of compliance with Outcome 16 on management of risk to health, welfare and safety**

	Number of reviews	Review period	Compliant* %	Minor concerns* %	Moderate concerns %	Major concerns %
NHS hospitals	148	April 2010 – July 2011	72	7	13	9
Independent hospitals and clinics	122	Oct 2010 – July 2011	90	10	0	0
Care homes with nursing	599	Oct 2010 – July 2011	69	17	10	4
Care homes without nursing	1193	Oct 2010 – July 2011	78	14	6	2
Domiciliary care agencies	320	Oct 2010 – July 2011	78	15	6	2

Source CQC: Based on an analysis of approximately 3,500 reviews in total

\*Note that a provider with a minor concern would in most cases be judged compliant for that outcome

On safety and suitability of premises, Outcome 10, care homes with nursing, followed by care homes without nursing, had the lowest proportions of compliance, and also the highest proportions of major concerns (table 9). Nine per cent of NHS hospitals had moderate concerns in relation to this Outcome.

On Outcome 11 on the safety, availability and suitability of equipment, the lowest proportions of compliance were found in NHS hospitals (table 10). NHS hospitals also had the highest proportion of moderate concerns.

**Table 8: CQC reviews of compliance with Outcome 9 on management of medicines**

	Number of reviews	Review period	Compliant* %	Minor concerns* %	Moderate concerns %	Major concerns %
NHS hospitals	92	April 2010 – July 2011	62	24	14	0
Independent hospitals and clinics	118	Oct 2010 – July 2011	82	8	4	5
Care homes with nursing	636	Oct 2010 – July 2011	61	18	13	8
Care homes without nursing	1202	Oct 2010 – July 2011	72	16	9	3
Domiciliary care agencies	295	Oct 2010 – July 2011	75	15	9	2

Source CQC: Based on an analysis of approximately 3,500 reviews in total

\*Note that a provider with a minor concern would in most cases be judged compliant for that outcome

**Table 9: CQC reviews of compliance with Outcome 10 on safety and suitability of premises**

	Number of reviews	Review period	Compliant* %	Minor concerns* %	Moderate concerns %	Major concerns %
NHS hospitals	114	April 2010 – July 2011	75	16	9	0.9
Independent hospitals and clinics	123	Oct 2010 – July 2011	88	10	2	0
Care homes with nursing	577	Oct 2010 – July 2011	69	17	10	3
Care homes without nursing	1155	Oct 2010 – July 2011	73	15	9	3
Domiciliary care agencies	222	Oct 2010 – July 2011	97	2	1	0.5

Source CQC: Based on an analysis of approximately 3,500 reviews in total

\*Note that a provider with a minor concern would in most cases be judged compliant for that outcome

**Table 10: CQC reviews of compliance with Outcome 11 on safety, availability and suitability of equipment**

	Number of reviews	Review period	Compliant* %	Minor concerns* %	Moderate concerns %	Major concerns %
NHS hospitals	98	April 2010 – July 2011	73	16	10	0
Independent hospitals and clinics	123	Oct 2010 – July 2011	94	4	0.9	2
Care homes with nursing	507	Oct 2010 – July 2011	85	7	5	3
Care homes without nursing	1033	Oct 2010 – July 2011	89	7	3	1
Domiciliary care agencies	253	Oct 2010 – July 2011	94	4	2	0.4

Source CQC: Based on an analysis of approximately 3,500 reviews in total

\*Note that a provider with a minor concern would in most cases be judged compliant for that outcome



## Monitoring of special issues

### Reducing healthcare-associated infections

Healthcare-associated infections (HCAIs) are infections acquired while people are receiving health care in hospitals, clinics or other settings. They are caused by a wide variety of micro-organisms, including bacteria from our own bodies. Some are caused by 'superbugs', which have become resistant to certain antibiotics. Although many patients recover with treatment, an infection can lead to a longer hospital stay and suffering, and HCAIs can sometimes contribute to, or cause, death.

Reducing the number of HCAIs, and achieving compliance in terms of improved standards of infection prevention and control, remains a key priority. With the introduction in 2010 of the essential standards, all organisations registered with CQC must be able to show that they can meet Outcome 8 on cleanliness and infection control. In April 2011 the Department of Health's updated *Code of Practice on the prevention and control of infections and related guidance* came into effect. This replaced previous versions of the Code of Practice and applies to all registered providers of health care and adult social care in England. As with previous versions of the Code, it lists 10 criteria used to assess whether an organisation is compliant with the regulations on cleanliness and infection control.

**Table 11: Findings from CQC reviews of compliance with Outcome 8 on cleanliness and infection control**

	Number of reviews	Review period	Compliant* %	Minor concerns* %	Moderate concerns %	Major concerns %
NHS hospitals	113	April 2010 – July 2011	83	13	4	0
Independent hospitals and clinics	115	Oct 2010 – July 2011	90	4	6	0
Care homes with nursing	566	Oct 2010 – July 2011	70	16	10	4
Care homes without nursing	1115	Oct 2010 – July 2011	72	17	8	3
Domiciliary care agencies	264	Oct 2010 – July 2011	86	9	5	0

Source CQC: Based on an analysis of approximately 3,500 reviews in total

\*Note that a provider with a minor concern would in most cases be judged compliant for that outcome

During the course of 2010 the national inspection programme for healthcare-associated infections became integrated into the work of our regional compliance teams. The national programme continued between May and September 2010, until transition and full integration with the regulatory inspection programme was achieved. The main area of focus was on community hospitals managed by primary care trusts. Trusts were chosen on a risk basis, according to information held by CQC, together with a random sample. All inspection visits were unannounced. We inspected 101 community hospitals in 42 primary care trusts, and carried out some follow-up visits from the previous inspection programme.

Since October 2010 our regional compliance teams have had responsibility for monitoring whether organisations meet the required standards on cleanliness and infection control. Early findings from our compliance reviews show that care homes with nursing and care homes without nursing had the lowest proportions of compliance, and the highest proportions of moderate and major concerns (table 11).

A number of factors can increase the risk of acquiring a HCAI, but high standards of infection control minimise the risk. The most well-known HCAs are meticillin-resistant *Staphylococcus aureus* (MRSA) and *Clostridium*

*difficile* (*C. difficile*). Cases of these rose dramatically in the 1990s, but have declined in recent years. Overall, the NHS continues to make good progress in tackling these infections. In 2010/11 there were 1,481 reported cases of MRSA bacteraemia across the NHS. This represents a 22% reduction compared to 2009/10 (1,898 cases) and means there were half as many cases as in 2008/09 (2,935).<sup>23</sup> There were 21,695 reported cases of *C. difficile* infection in the NHS in 2010/11, representing a 15% reduction compared to 2009/10 (25,604 cases) and 40% reduction compared to 2008/09 (36,095 cases).<sup>24</sup> Just over half the cases of MRSA and *C. difficile* in 2010/11 were not attributable to the hospital where the patient was admitted.<sup>25</sup> Instead, the patient may have already had the infection when they entered hospital, or been transferred from another health care facility when the infection was first diagnosed.

We collect information from the Health Protection Agency's mandatory surveillance schemes covering MRSA bacteraemia, *C. difficile* infection, and some surgical site infections and feed this information into our QRPs for each registered provider. We continue to work with other agencies to tackle these and other HCAs.

The Health Protection Agency first published surveillance data on MRSA and *C. difficile* in the independent health care sector in October 2010.

Rates for 2009/10 were 0.62 cases of MRSA bacteraemia and 5.43 cases of *C. difficile* infection per 100,000 inpatient bed-days. Note that this data cannot be directly compared with NHS figures, due to the different ways the data is collected.

## Management of controlled drugs

Controlled drugs are a group of drugs that have the potential to be misused. The Controlled Drugs (Supervision of Management and Use) Regulations 2006 were introduced following the Shipman inquiry. They require all NHS trusts and independent hospitals to appoint an accountable officer, with organisational responsibility for the management of controlled drugs. The regulations also require the reporting and sharing of controlled drugs concerns through local intelligence networks that are led by the primary care trust accountable officer.

Organisations not required by the regulations to appoint an accountable officer for controlled drugs should nevertheless ensure that they have safe arrangements in place and that they share information with their commissioners.

CQC has an external scrutiny role to oversee that regulators and agencies with controlled drug responsibilities are all working together and sharing information in relation to regulating and monitoring the safe handling of controlled drugs.

In our 2009 controlled drugs annual report, we reported that all NHS trusts and independent hospitals had appointed an accountable officer, and were developing mechanisms for the sharing of information through local intelligence networks. In 2010 we found that information sharing between organisations is continuing to improve.<sup>26</sup> However, during the NHS changes, and in particular the phasing out of primary care trusts, we note the importance of local intelligence networks having robust and firmly embedded working arrangements in place, so that these can be passed on in order to ensure a smooth transition. It is also essential that the safe management of controlled drugs continues to remain a high organisational priority.

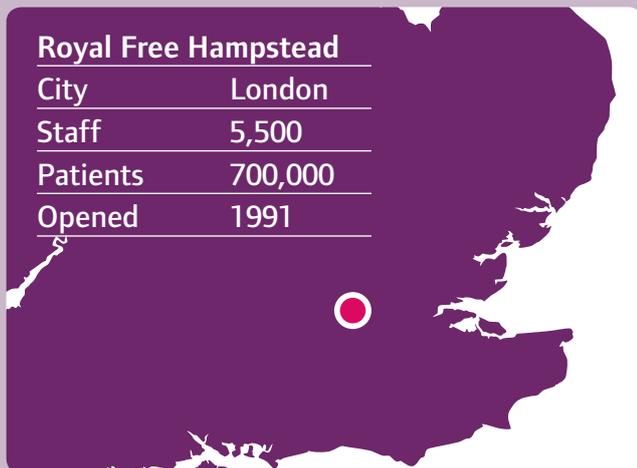
As part of our external scrutiny role we undertook an exercise in 2010 to look at temazepam prescribing within the six primary care trusts identified as having the highest prescribing levels. While it was



## Royal Free Hampstead NHS Trust

### Royal Free Hampstead

City	London
Staff	5,500
Patients	700,000
Opened	1991



In March 2011, wards for older people at the Royal Free Hampstead NHS Trust were inspected as part of a national programme. CQC's inspectors found that the services did not meet two outcomes: respecting and involving patients, and meeting their nutritional needs.

In response, the wards instigated a new 'nurse rounding' scheme – hourly checks on all patients with specific needs such as positioning or pain relief. The nurses record their checks in the patients' records, and this has resulted in patients using the call bell much less than previously.

encouraging to find there was already a great deal of work undertaken at local level to monitor prescribing of tranquillizers and sleeping tablets, our findings prompted some review of prescribing practices. This was our first project of this kind, and we will be following up with similar work in future.

### Safety in diagnosis and treatment involving radiation

Medical ionising radiation, such as from x-rays or radiopharmaceuticals, is widely used in diagnosis of disease, in cardiology, and in cancer treatment. The Ionising Radiation (Medical Exposure) Regulations 2000 were established to protect patients whose health care involves exposure to ionising radiation. CQC is responsible for enforcing these regulations in England. We must be notified whenever there has been an exposure “much greater than intended”, and we investigate them all.

In the year to 31 December 2010, we received 494 notifications of patients having exposures “much greater than intended”. This reflects a continuing upward trend – there were 483 notifications in 2009,

403 in 2008, and 327 in 2007. We estimate that we were notified of one error per 81,000 examinations in England, and we believe that the increase is largely a reflection of increased understanding and awareness of the regulations among health care professionals. The majority (83%) of incidents were from diagnostic radiology and most were ‘low-dose’, presenting minimal additional risk to patients. Around half the diagnostic radiology cases involved the wrong patient being x-rayed, either because patients were referred in error, or because operators did not make the proper identification checks before x-raying their patients. There were 26 notifications involving nuclear medicine (5% of the total), and 58 (12%) from radiotherapy departments – both rates being consistent with previous years. Overall, the variation in notifications by region is becoming more pronounced. This may be a result of differences in organisational policies of notification, with some encouraging voluntary notification of errors that are not strictly “much greater than intended” but where there is still an opportunity for shared learning from mistakes. We are aware of a small number of organisations that have not made a single notification to us, making



For more information on Royal Free Hampstead NHS Trust, visit [www.royalfree.nhs.uk](http://www.royalfree.nhs.uk)

A new system was put in place to organise meal times. Patients now have a designated member of staff to deliver their food, discuss their meal beforehand and monitor what food has been eaten. A red tray system indicates where help with eating is needed, and trained volunteers are brought in to assist patients where necessary.

A follow-up inspection in July 2011 found significant improvements. Patients were more positive about their care. They had a choice of food and access to food and drinks 24 hours a day. During mealtimes, staff were making sure patients were comfortable and checking that they had sufficient to eat and drink.

Caroline Cahill, sister on one of the wards inspected, said: “The whole environment of the ward has changed. It is much calmer and more organised.

Before, many things – like mealtimes, making sure patients could reach their call bells and most importantly that they understand the plans for their care – were seen as the concern only of the nurses. Now everyone makes it their business.”

Deborah Sanders, nurse director, said the inspection acted as a trigger for a general review of how the Royal Free checks its compliance with CQC standards and had a much wider impact. “It really helped us think very differently about how we make sure our patients are receiving the care they should. We ensured that everyone we needed to help make the required changes was involved in the detail and at every stage. We took a truly multi-system approach.”

us concerned that they cannot identify an exposure made in error that does need to be notified to us, or that they can, but are not prepared to do so, as required by the regulations.

In order to assure ourselves of compliance with the regulations, to investigate notifications in more detail, or in response to concerns raised by whistleblowers or the public, we may carry out inspections of health care organisations. Last year we inspected four cardiology departments, completing our planned inspection programme in this area. We carried out compliance inspections of two radiotherapy departments, and one inspection in response to concerns about a radiology department. We continued our pilot inspection programme in chiropractic and dental services.<sup>27</sup>

### CQC outliers programme

CQC analyses NHS data about patient outcomes to identify cases where the number of poor outcomes is significantly higher than would be expected – these are called ‘outliers’. We look at outcomes for deaths, emergency re-admissions to hospital following hip replacements, knee replacements, hernia repairs and appendectomies, and various maternity indicators. The aims of our outliers programme are to ensure adequate standards of care are being maintained, to quickly respond where the data suggest there may be serious concerns about the care that a trust is providing, and to stimulate improvements in quality of care.

When an outlier is identified through our statistical analysis, a panel of experts examines the data, and decides whether to follow it up with the trust involved. An outlier does not necessarily mean that there is a problem with quality of care at a trust, as there may be other reasons. Once we contact a trust, we expect it to investigate and respond swiftly. If a trust can provide us with good evidence that the outlier is not related to poor quality care, we will close the case. However, if a trust cannot provide such evidence, we will expect it to produce an action plan for improvement, which we will monitor. We will continue to pursue cases with a trust until a satisfactory response is received. We only close the case when we are satisfied that the trust is taking the actions needed to address poor quality care.

Between April 2010 and March 2011 we dealt with 115 alerts relating to hospital inpatient deaths (mortality). Thirty-eight (33%) cases were closed before following up with the trust, and in a further 25 (22%) cases we followed up with the trust but were satisfied that no improvement plan was required (figure 11). Forty-two cases (36%) resulted in the trust producing an action plan for improving care. A further 10 cases (9%) led to wider intervention with the trust and were subsequently closed when the intervention was completed.

During the same period we closed 32 maternity outlier cases and five emergency re-admissions outliers.

Figure 11: Outcomes from mortality alerts, outliers programme, 2010/11



Source: Care Quality Commission

## Dignity and safety of people in vulnerable circumstances

### Safeguarding

All 152 councils in England with adult social services responsibilities have social care safeguarding teams that receive safeguarding referrals. A safeguarding referral is a concern raised by a professional or member of the public that a vulnerable adult may have been, is, or might be a victim of abuse, and that has triggered an adult protection investigation or assessment. In last year's State of Care report, we reported on the number of safeguarding referrals, and councils' performance in addressing safeguarding issues and practice. In 2010, the system of performance assessment for local authorities changed with councils themselves now expected to take more responsibility for driving and monitoring improvement locally. CQC is no longer responsible for providing an overview assessment of councils' performance regarding adult social care. Therefore this year we cannot compare councils' safeguarding performance with that in previous years, as the data is no longer collected.

In March 2011 the NHS Information Centre published experimental statistics on the abuse of vulnerable adults in England.<sup>28</sup> These were based on returns made by councils on a voluntary basis, during a six-month period

## regulations

**For both NHS and adult social care providers, failure to meet the regulations on Outcome 4 was one of the three most common reasons why compliance actions were served**

from October 2009 to March 2010. One hundred and twenty-eight of a possible 152 councils submitted data, although not all 128 submitted a fully completed return. The submitted data (which cannot be taken as a comprehensive overview across all councils) shows that 59% of safeguarding referrals related to people aged 65 and over: 11% for people aged 65 to 74, 23% for people aged 75 to 84, and 25% for people aged 85 and over. Thirty-nine per cent related to people aged 18 to 64, and age was unknown for the remaining 2%. There were more referrals recorded for women than men in all age

**Table 12: Findings from CQC reviews of compliance with Outcome 7 on safeguarding**

	Number of reviews	Review period	Compliant* %	Minor concerns* %	Moderate concerns %	Major concerns %
NHS hospitals	120	April 2010 – July 2011	69	18	9	4
Independent hospitals and clinics	122	Oct 2010 – July 2011	91	4	4	0.8
Care homes with nursing	648	Oct 2010 – July 2011	72	13	10	6
Care homes without nursing	1277	Oct 2010 – July 2011	77	11	8	4
Domiciliary care agencies	333	Oct 2010 – July 2011	83	9	5	3

Source CQC: Based on an analysis of approximately 3,500 reviews in total

\*Note that a provider with a minor concern would in most cases be judged compliant for that outcome

bands. Half (50%) of the referrals recorded were for adults with physical disabilities, 21% for adults with learning disabilities, and 20% for adults with mental health needs. For referrals where the nature of the alleged abuse was recorded, the most common (31%) were about physical abuse, followed by neglect (21%) and financial abuse (21%), emotional/psychological abuse (17%), sexual abuse (6%), institutional abuse (4%) and discriminatory abuse (1%). More than one type of abuse could be recorded in a single referral.

Outcome 7 of the essential standards covers safeguarding, and says people can expect to be safeguarded from abuse or the risk of abuse, and their human rights respected and upheld. Table 12 shows initial findings from our compliance reviews of Outcome 7.

The figures from available data show that independent hospitals and clinics had the highest proportion of compliance with Outcome 7 in the reviews we looked at, followed by domiciliary care agencies. But the BBC Panorama exposé on Winterbourne View hospital highlighted the failure of the system to protect people with learning disabilities, challenging behaviour and mental health problems. The safeguarding of the most vulnerable remains an utmost priority and is the responsibility of providers, commissioners and regulators.

For adult social care, lack of compliance with Outcome 7 was one of the three most common reasons why we served compliance actions on providers in the period, requiring clear actions to improve. In both the NHS and adult social care, failure to comply with Outcome 7 was one of the three most common reasons why we issued warning notices, in response to major concerns. If providers do not respond effectively to warning notices, we have the power to cancel registration.

While Outcome 7 is the main focus for assessing compliance and identifying safeguarding concerns, it is important to recognise that providers should also focus on a range of Outcomes including 4, 9, 10 and 11 to make sure that people who use services, workers and people who visit services are safe and that risks are managed effectively.

## Dignity in health care settings

Under the NHS Constitution patients have the right “to be treated with dignity and respect, in accordance with [their] human rights.”

The 2010 NHS inpatient survey found that 79% thought they were “always” treated with dignity and respect while in hospital; the same proportion as in 2009, and a small improvement compared with 2002. When asked whether doctors had talked in front of them “as if they were not there”, 72% of inpatients said it had not happened, 21% said it happened sometimes, and 6% said it happened often. Asked the same question about nurses, 78% said it had not happened, 17% said it happened sometimes, and 5% said it happened often. These figures are unchanged since 2009.

### Dignity and Nutrition inspection programme

In 2011, we conducted our Dignity and Nutrition programme, inspecting 100 NHS hospitals in 96 trusts to assess whether older people were being treated with dignity and respect, and whether they were getting food and drink that met their needs. Inspections were unannounced, and took place between February and May 2011. Each inspection team was made up of CQC compliance inspectors, an external nurse adviser, and an ‘expert by experience’ to provide a patient perspective. Reports of the findings were published for each hospital during the summer, with a national overview report due in autumn 2011.

We looked at whether, in relation to older people, hospitals were meeting two of the essential standards of quality and safety: Outcome 1 – respecting and involving people who use services, and Outcome 5 – meeting nutritional needs. Overall, we found that 45 hospitals were meeting both of these essential standards. We saw many examples of excellent care. At 35 hospitals we made suggestions for



79%

of hospital inpatients said they were “always” treated with dignity and respect

improvement, although essential standards were being met. In 11 cases we found hospitals were not meeting one of the two essential standards, and in nine cases that neither of the essential standards were met.

Recurring concerns relating to nutrition included:

- People not being given the assistance they needed to eat, meaning they struggled to eat and in some cases were physically unable to eat meals, or they were interrupted during mealtimes and had to leave their food.
- People's needs were not always assessed properly, meaning they didn't receive particular care that they needed, such as special diets.
- Records of food and drink taken were not kept accurately, so progress wasn't monitored.
- Many patients were not able to clean their hands before meals.

Recurring concerns about dignity and respect included:

- People's privacy and dignity was not respected, for example curtains not being properly closed when personal care was given to patients in bed.
- Call bells, which are used to summon assistance, were put out of people's reach or not responded to in a reasonable time.
- Staff speaking to people in a condescending or dismissive way.
- Both staff and patients told us that there were not always enough staff with the right training on duty to spend enough time giving care.

### Essential standards: outcomes on nutritional needs

In addition to the inspections of NHS hospitals under our Dignity and Nutrition Programme, we have monitored other registered providers and services for compliance with Outcome 5. Table 13 shows the findings across all sectors, including those from the Dignity and Nutrition programme. Outcome 5 says people should be "encouraged and supported to have sufficient food and drink that is nutritional and balanced, and a choice of food and drink to meet their different needs." Our initial findings show that

the lowest proportions of compliance were in care homes with nursing and NHS hospitals. The highest proportion of major concerns was in care homes with nursing, followed by care homes without nursing.

### Patients' experiences of hospital food

The 2010 NHS inpatient survey asked respondents about their experiences of hospital food, with results showing slight improvements. When asked whether they were given a choice of meal, 79% of people said that they were, an improvement from 78% in 2009. There was a decrease in the proportion saying that they were "sometimes" given a choice (15% in 2010 and 16% in 2009). The remaining 6% said that they were not given a choice of food, which is unchanged from 2009.

There was an increase in those rating the food as "good", rising from 35% in 2009 to 36% in 2010. Thirty per cent of people described the food as "fair", the same as 2009. The remaining 13% rated the food as "poor", a decrease from 14% in 2009.

Almost two-thirds of people said they "always" got enough help from staff to eat their meals (64%, compared with 63% in 2009), and 18% said they "sometimes" got enough help (19% in 2009).

### Mixed-sex accommodation

There were once again significant improvements in efforts to eliminate mixed-sex accommodation in NHS hospitals. Ninety-four per cent of respondents to the 2010 patient survey, whose hospital admission was planned, said that they did not share a sleeping area with patients of the opposite sex when first admitted, a rise of 2% on the previous year. And 86% of respondents who had an emergency or urgent admission said that they did not have to share a sleeping area with patients of the opposite sex when first admitted, up from 79%. The figures for patients not having to share after moving ward also rose.

Patients should not have to share toilet and washing facilities with the opposite sex, unless they need specialised equipment such as hoists or specialist baths. Eighteen per cent of respondents said that they had to use the same bathroom or shower area as patients of the opposite sex – an improvement from 23% in 2009.

## Safety and quality in maternity services

In 2011 we conducted a thematic review of all NHS acute trusts providing maternity services in England. Thematic reviews do not judge compliance or non-compliance with the standards. Instead, they use information we already have to flag up which areas might be most at risk of non-compliance for a provider.

The review focused on three areas thought to be associated with poorer outcomes: staffing, patient experience, and clinical outcomes. For each organisation we calculated an overall risk estimate for each of the three areas, identifying the most significant areas of risk of non-compliance with the essential standards. The results complement existing risk assessment tools and have been shared with our compliance teams, to inform and support their work. The review mostly confirmed concerns already on our radar, although it did raise new concerns in about 10% of cases, and we have used the results in planning the timing and focus of compliance reviews. Any evidence of non-compliance with essential standards will be published in reports of compliance reviews for individual trusts.

**Staffing:** We looked at eight measures for each provider, including staffing levels and vacancy rates. Risk estimates were on average poorest for birth to midwife ratios followed by birth to consultant ratios and midwife vacancy rates.

**Patient experience:** We looked at 10 measures, based on the results of the 2010 NHS survey of women's experiences of maternity services. Risk estimates, based on relative performance across all organisations, were on average best for how quickly any required stitches women received after the birth, and being able to choose the most comfortable position during labour. They were poorest for birth partners being made welcome by staff, followed by having skin-to-skin contact with the baby shortly after the birth.

**Clinical outcomes:** We considered six measures: rates for maternal and neonatal readmissions, emergency and elective caesareans, puerperal sepsis and perinatal mortality. Overall, clinical outcomes were an area of relatively low risk for the majority of providers.

**Table 13: Findings from CQC reviews of compliance with Outcome 5 on meeting nutritional needs**

	Number of reviews	Review period	Compliant* %	Minor concerns* %	Moderate concerns %	Major concerns %
NHS hospitals	140	April 2010 – July 2011	72	17	10	0.7
Independent hospitals and clinics	69	Oct 2010 – July 2011	100	0	0	0
Care homes with nursing	599	Oct 2010 – July 2011	71	15	10	4
Care homes without nursing	1,139	Oct 2010 – July 2011	84	9	5	2
Domiciliary care agencies	255	Oct 2010 – July 2011	92	6	2	0

Source CQC: Based on an analysis of approximately 3,500 reviews in total

\*Note that a provider with a minor concern would in most cases be judged compliant for that outcome

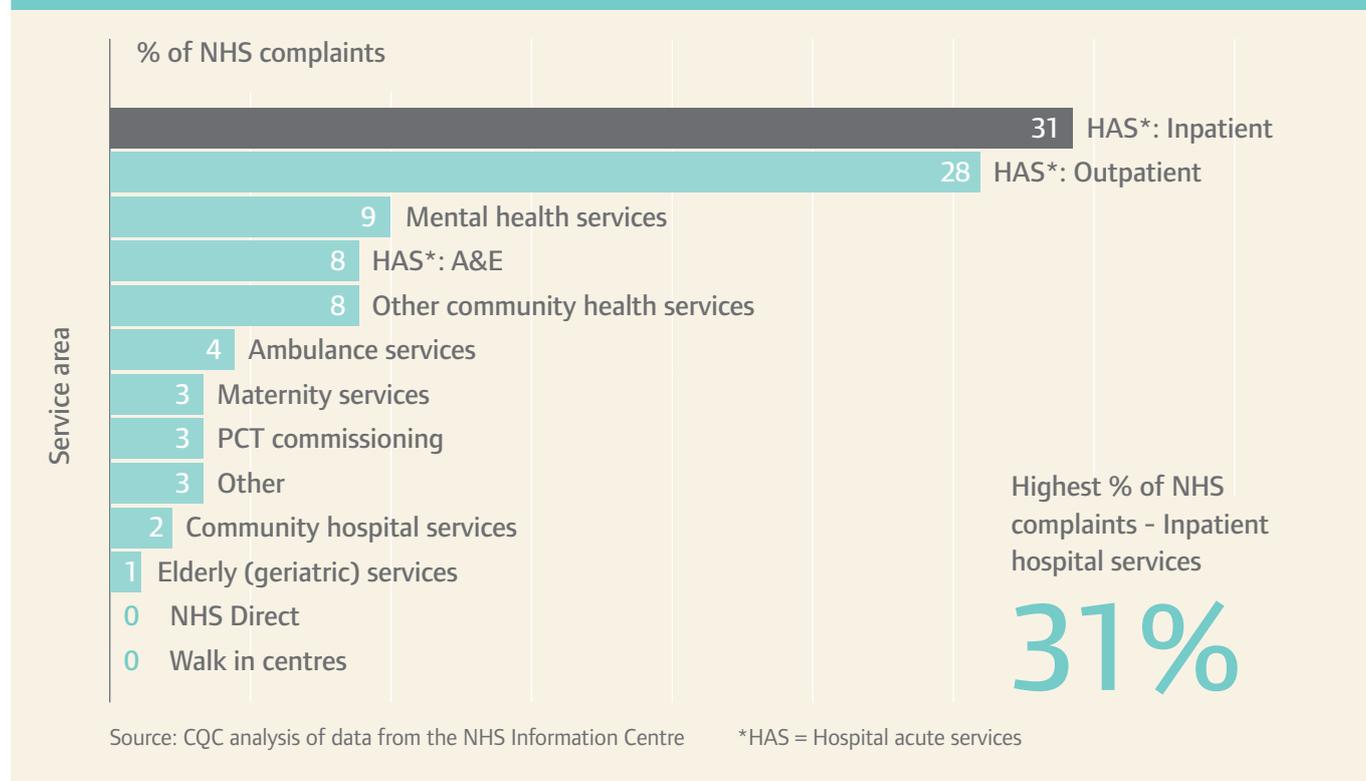
**Table 14: Findings from CQC reviews of compliance with Outcome 17 on handling of comments and complaints**

	Number of reviews	Review period	Compliant* %	Minor concerns* %	Moderate concerns %	Major concerns %
NHS hospitals	85	April 2010 – July 2011	86	9	5	0
Independent hospitals and clinics	111	Oct 2010 – July 2011	95	5	0	0
Care homes with nursing	495	Oct 2010 – July 2011	89	7	3	1
Care homes without nursing	1,020	Oct 2010 – July 2011	91	6	2	0.2
Domiciliary care agencies	284	Oct 2010 – July 2011	90	7	3	0.4

Source CQC: Based on an analysis of approximately 3,500 reviews in total

\*Note that a provider with a minor concern would in most cases be judged compliant for that outcome

**Figure 12: NHS complaints by service area, 2009/10**



## Complaints

### Essential standards: outcomes on complaints

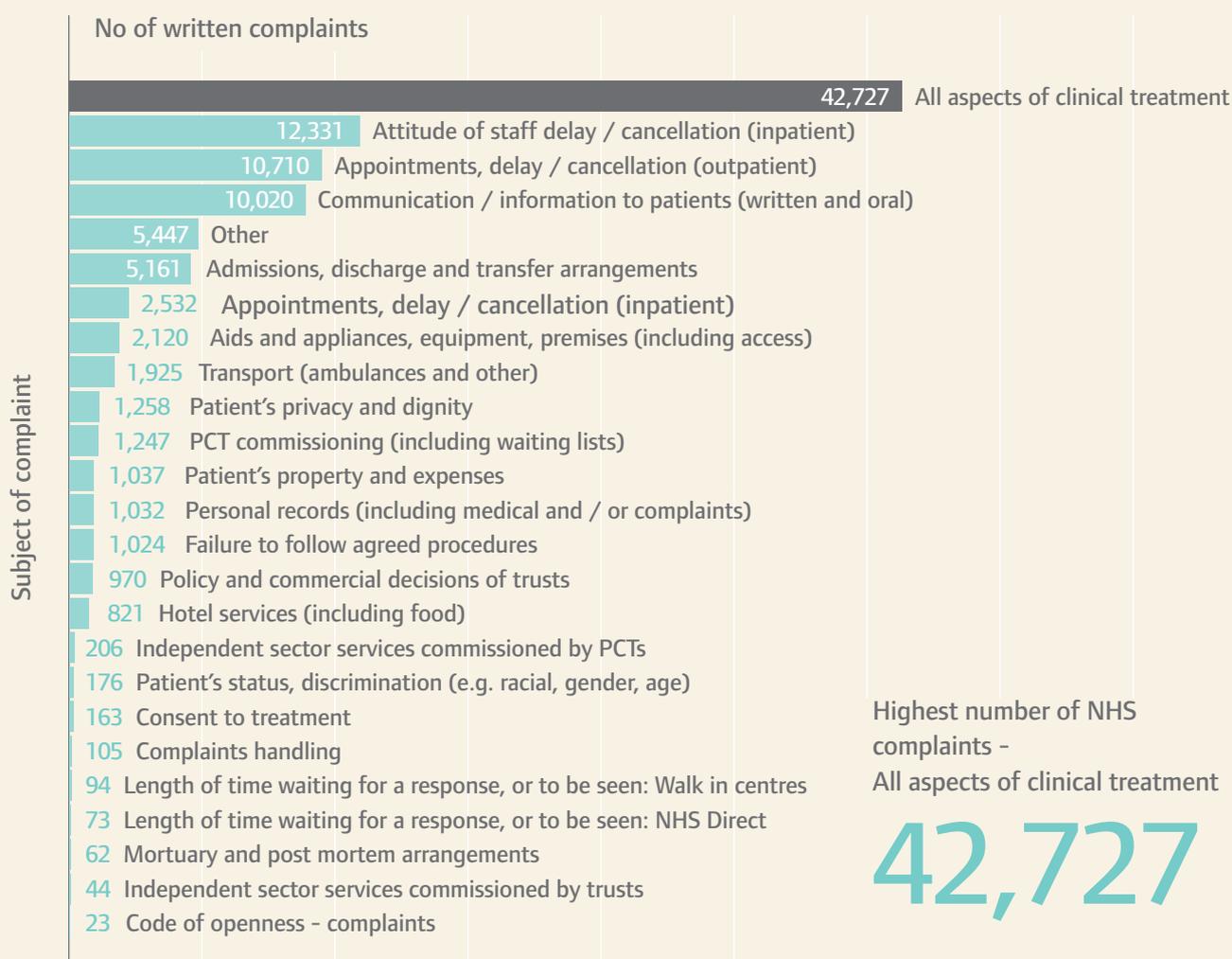
Outcome 17 of the essential standards says that “people and those acting on their behalf” should be able to expect that they “have their comments and complaints listened to and acted on effectively, and know that they will not be discriminated against for making a complaint.” Table 14 shows the percentage of reviews of Outcome 17 where we found services to be compliant or where we found concerns, for different types of provider.

### Complaints in the NHS

Complaints are an extremely important way for patients to express concerns if things go wrong or they are not happy with their treatment or care. Some complainants will simply want their views to be acknowledged, whilst others seek more formal redress. For providers, complaints should provide opportunities to respond to individuals’ concerns, but also to identify and address more systemic weaknesses.

CQC receives information regarding patients’ complaints from a range of sources, including those received directly from patients and the public as well as those that have been considered by the Parliamentary and Health Service Ombudsman. This information is routinely considered as part of our compliance monitoring.

Figure 13: NHS complaints by subject of complaint, 2009/10



Source: CQC analysis of data from the NHS Information Centre

The number of complaints a provider receives is not necessarily an indication of poor care, as it could also reflect an organisational culture that encourages complaints, and makes it easy for patients to do so. We have analysed data from the NHS Information Centre on complaints made about NHS services in England in 2009/10. During this time, a total of 101,077 complaints were made. The median number of complaints per provider was 180 (but note that the analysis excludes 18 foundation trusts that did not submit voluntary returns – foundation trusts have other mechanisms for analysing and reporting on complaints). The analysis also takes no account of the relative size of trusts.

Our analysis found that in terms of service area, most complaints related to inpatient hospital services (31%), followed by outpatient hospital services (28%) (figure 12). High numbers of complaints were also seen relating to mental health services (9%), other community health services (8%) and A&E hospital services (8%).

In terms of complaints by profession, most complaints relate to the “medical” profession (44%), followed by complaints relating to “nursing, midwifery and health visiting” (22%).

The greatest number of complaints (42%) related to “all aspects of clinical treatment”, followed by “attitude of staff” (12%) (figure 13). Eleven per cent were about “delay/cancellation of outpatient appointments” and 10% about “communication/information to patients (written and oral)”.

## Complaints in independent healthcare

The Independent Sector Complaints Adjudication Service (ISCAS) operates a code of practice for handling complaints across the independent health sector. This is managed by Independent Healthcare Advisory Services. The number of people who contacted ISCAS to access its complaints procedures rose to 321 in 2010, up from 184 in 2009.

In line with other complaints handling processes, the ISCAS code of practice promotes local resolution of complaints as best practice, encouraging providers to take ownership of complaints and resolve them at an early stage. In 2010, ISCAS managed external adjudication of 22 cases that had passed beyond local resolution, a drop from 27 in 2009.

\* The 65 trusts providing community mental health services include combined mental health and social care trusts, primary care trusts that provide mental health services, and foundation trusts.

One issue raised by ISCAS in its 2010 annual report is its continuing concern that private patients treated in the NHS have no ability to complain to an external body, as the NHS Complaints Ombudsman has no jurisdiction.

## Care for people using mental health services

### Community mental health services

The 2011 survey of people who use community mental health services was completed by over 17,000 people aged 16 and over who had been in contact with NHS mental health services between July and September 2010. The survey included those who had received care under the Care Programme Approach (CPA). Participants had received care and support from services across England’s 65 NHS mental health trusts\*, for example from outpatient clinics and local teams providing crisis home treatment, assertive outreach, early intervention for psychosis, and generic community health services. Such services are the main source of specialist support for around a million people each year in England. Because of changes in some questions, not all the findings can be compared with those from the 2010 survey.

The Government strategy for mental health, *No health without mental health*, was launched in February 2011.<sup>29</sup> A key aim is to improve outcomes for people through high quality services that are accessible to all. The NHS community mental health surveys will provide valuable information to assess progress in improving people’s experiences of care and support.

### The Care Programme Approach (CPA)

The CPA was introduced in 1990 to coordinate care for people with complex mental health needs who use secondary mental health services and require the support of a multi-disciplinary team. Forty-two per cent of participants in the 2011 survey were on the CPA. There are some differences in the service requirements for people on the CPA, and as a result they may have different patterns of care. Therefore some of the findings are broken down by whether people were on CPA or not.

## Overall findings

Overall, 29% of respondents rated the care they had received from mental health services in the previous 12 months as “excellent”, 30% as “very good”, 20% as “good”, 13% as “fair”, 5% as “poor” and 4% as “very poor”. These results were very similar to those in 2010, although there was a small decrease in the proportion rating their care “very poor”. The vast majority of participants said they were listened to and had trust in their health and social care workers; that they could contact their care co-ordinator if they had problems with their care, and that they were given an out-of-office contact number for emergencies. However, the findings also show there is room for improvement, especially in involving people more in some aspects of their care.

## Medication

The survey asked about participants’ involvement in decisions about their care, including medication. Eighty-nine per cent of respondents were taking prescribed medications for their mental health condition. Of these, 56% said their views were “definitely” taken into account when deciding which medication to take, and 31% said this was the case “to some extent”. These proportions were unchanged since 2010.

Respondents who had been prescribed new medication in the previous 12 months were asked whether the purposes of the medication had been explained to them, and if they were told about possible side-effects. The findings showed no statistically significant changes since 2010, with 68% saying the medication purpose had “definitely” been explained, 25% saying “to some

extent” and 7% saying it had not been explained. Forty-four per cent said they had “definitely” been told about possible side-effects of their medication, 29% said they had been told “to some extent” and 28% said they had not been told.

People should receive regular reviews of their medication. Of those who had been taking their prescribed medication for 12 months or longer, just under four-fifths (78%) said their medicines had been reviewed in the previous 12 months, whilst 22% said their medicines had not been reviewed.

## Crisis support

Swift access to help in a crisis is vital for people receiving specialist support in the community for mental health problems. The proportion of people with an out-of-hours phone number for someone from their NHS mental health service rose from 56% in 2010 to 58% in 2011. However, this suggests there are still significant numbers of people who may have difficulties getting the help they need in a crisis.

Of those who did have an out-of-hours phone number for their local service, 37% had called it in the previous 12 months, an increase of 1% since 2010. On the last occasion they used the number, almost a quarter (24%) had experienced problems getting through to someone. Half (50%) had “definitely” received the help they wanted the last time they called the number, and over a third (35%) had “to some extent”. Sixteen per cent had not received the help they needed. This is an improvement on the 19% who gave this response in 2010, but suggests there is some way to go to ensure that everyone experiencing a mental health crisis can get urgent support.

## Knowledge of care co-ordinator or lead professional

A care co-ordinator or lead professional is the main point of contact for a person using community mental health services. For people with more complex mental health needs, who receive care from more than one agency, the role is pivotal. People who are not on the CPA require only the support of one agency, and are allocated a lead professional responsible for facilitating their care.

Although the majority of respondents on CPA knew who their care co-ordinator was (83%), the proportion who did not know rose from 10% in 2010 to 12% in 2011. The rest were unsure. For those not on CPA, 62%



# 59%

of people in the community using mental health services said the care was “excellent” or “very good”

knew who their lead professional was. There was an increase in the proportion who did not know from 27% in 2010 to 28% in 2011, and the rest were unsure.

Overall, for both those on CPA and not on CPA, there was a fall in the proportion who said they could “always” contact their care co-ordinator if they had a problem, from 74% in 2010 to 72%, and a corresponding 2% increase to 24% in those saying they could “sometimes” contact their care co-ordinator if they had a problem. Sixty-one per cent thought their care co-ordinator organised their care and services “very well” and 31% “quite well”. Five per cent thought the care co-ordinator did this “not very well” and 3% “not at all well”.

### Care plans

A care plan sets out the person’s assessed needs and how they will be met. Although people’s involvement in their own care plans is increasing, there is still much scope for improvement. People on CPA should have a comprehensive formal written care plan detailing their care and treatment. For those not on CPA, there is no formal requirement for a written care plan, but guidelines recommend that there should be some form of recorded agreement with the person receiving care and services, about how treatment will be carried out and by whom.

The majority of those on CPA said they understood their care plan, either “definitely” (44%) or “to some extent” (31%). Nine per cent did not understand it, and 16% said they did not have a care plan. More than a quarter (27%) of people on CPA who had a care plan said they had not been given or offered a written copy of the care plan.

For those not on CPA, 29% “definitely” understood their care plan, 23% understood it “to some extent”, 8% did not understand it, and the remaining 39% said they did not have a care plan. Forty-three per cent of people not on CPA who had a care plan said they had not been given or offered a written copy.

Of those who understood their care plan, slightly over half (54%) thought their views were “definitely” taken into account when deciding what was in the care plan, and just over a third (35%) thought they were “to some extent”. Just over a tenth (11%) said their views had not been taken into account, compared with 13% in 2010. A fifth (20%) said their care plan did not set out their goals, such as changes they might want to make or things they want to achieve.

Of those on CPA, over half (55%) of those who understood their care plan said it “definitely” covered what they should do if they had a crisis, with a further 28% saying it did “to some extent”. Seventeen per cent said the care plan did not cover this. For those not on CPA, 49% said their care plan “definitely” covered what to do if they had a crisis and 28% “to some extent”. The remainder (24%) said that their care plan did not cover it.

### Care reviews

A care review is a meeting between the person using services and those involved in their care to discuss how well their care has been working. People on the CPA should receive a formal review of their care at least once a year. Forty per cent of respondents on CPA said they had received more than one review in the previous year, 33% had received one review, and 26% said they had not had a review at all.

Those not on CPA should receive ongoing reviews as their needs require. Twenty-seven per cent of those who were not on CPA said they had received more than one review on the previous year, 26% had received one review, and 47% said they had not had a review at all.

### Physical health

One of the objectives of the national mental health strategy is to ensure that more people with mental health problems enjoy good physical health. Of those respondents with physical health needs, 35% said they had “definitely” received support from someone in NHS mental health services in getting help with their physical health needs, 34% said they had “to some extent”, and 31% said they had not received any support, although they would have liked it.

### Support with day-to-day living

People on the CPA should receive support with matters such as employment, housing and financial advice, if needed, as well as their clinical needs. Of those on the CPA who said they needed support with day-to-day living:

- 35% said they had not received help from anyone in NHS mental health services in the past year with finding or keeping work, e.g. through being referred to an employment scheme, but would have liked such help.



- 27% said they had not received help from anyone in NHS mental health services in the past year with finding or keeping their accommodation, but would have liked it.
- 27% said they had not been given any help from anyone in NHS mental health services in the past year with financial advice or benefits, but would have liked it.

### Care under the Mental Health Act

Each year, over 45,000 people are detained in hospital under the Mental Health Act 1983 for assessment and treatment in the interests of their own health or safety, or for the protection of others. Since November 2008, community treatment orders (CTOs) have been used in England as a way of legally supervising some patients being treated in the community after discharge from detention in hospital.

CQC has a legal duty to monitor how services are using their powers under the Act. Our Mental Health Act Commissioners aim to visit every psychiatric ward in England where patients are detained at least once every 18 months. We talk to patients in private, discuss their experiences and concerns, ensure that they understand their rights, and check that staff are using the Act correctly. CQC's annual report on the use of the Mental Health Act in 2010/11 will be published and laid before Parliament later this year. However, we are able here to point to some of the key themes our MHA Commissioners have identified based on their visits during the year.

In previous years we have also reported on the annual census on ethnicity of mental health inpatients. This year there are no findings to report as 2010 was the final year that the census was held.

### Staffing levels and bed occupancy

In our 2009/10 report on the use of the Mental Health Act, we reiterated long-running concerns about inadequate staffing levels, and over-occupancy of wards. This year we again found cause for concern. Some hospitals have reduced staffing as a cost saving measure. As a registration requirement, hospital managers must ensure that the essential standards are met, including Outcome 13 on staffing: "people are kept safe, and their health and welfare needs are met, because there are sufficient numbers of the right staff." The onus is on

hospital managers to demonstrate that they have carried out a needs analysis and risk assessment as the basis for deciding sufficient staff numbers.

Staffing shortages can exacerbate problems experienced as a result of over-occupancy. The Royal College of Psychiatrists recommends a bed occupancy rate of 85% or less, but we found the majority of acute inpatient wards we visited running at full capacity, or having more patients than beds. Lack of bed availability can lead to delays in admission, including for people who urgently need inpatient treatment and care. Our MHA Commissioners observed problems associated with overcrowding, including patients being accommodated in temporary beds and in staff rooms and areas meant for communal patient use. We also continue to encounter patients 'stuck' in inpatient facilities because of a lack of appropriate community or alternative placements, such as 'step down' services.

### Involving patients

The Mental Health Act Code of Practice requires that patients are given the opportunity to be involved in planning, developing and reviewing their own treatment and care. This is also required by Outcome 1 of the essential standards. Our MHA Commissioners saw examples of good practice, but also cases where patients had minimal involvement in such decisions. We continue to raise concerns about institutionalisation and point to ways of lessening its effects through patient involvement. For example, we believe that all detaining authorities should comply with the Code of Practice guidance that patients should be given the opportunity to record their experiences and views after restraint incidents. Similarly, many services' seclusion practices could be improved by greater patient involvement in care planning and post-incident reviews.

### Access to advocacy services

In our 2009/10 report on use of the Mental Health Act, we noted gaps in the provision of Independent Mental Health Act Advocacy (IMHA) services, which primary care trusts have had a statutory duty to provide since 2009. Under reforms in the Health and Social Care Bill, IMHA commissioning will pass to local authorities. This year there has been progress, although there are still problems with commissioning arrangements for some sites, often in relation to hospitals whose patients



# 24%

of people experienced problems when trying to phone their local out-of-hours service for support

come from a range of different primary care trust commissioning areas. Furthermore, we found that some service commissioners have curtailed non-statutory advocacy provision, but without compensatory increase in resources for IMHA services. We also found weaknesses in communications, publicity and staff knowledge of available advocacy services, resulting in many patients being unaware that they could seek advocacy support.

### Community treatment orders

Our MHA Commissioners encountered widespread misunderstanding, even among health professionals, of the legal powers of community treatment orders. For example, many people are not aware that a patient on a CTO has the right to refuse treatment while in the community, and such refusal is not sufficient cause to recall the person to hospital. More staff training is needed to avoid incidences of unlawful treatment resulting from such misunderstanding. We also found that hospitals are frequently not fulfilling their legal duties to inform patients with CTOs about their rights, both verbally and in writing.

### Complaints from people detained under the Mental Health Act

We have analysed all 581 complaints received by CQC between 1 April 2010 and 31 March 2011 from patients detained under the Mental Health Act. The five most common reasons for complaint (excluding 'other') were: complaints relating to the Mental Health Review Tribunal; nursing care and services; medical treatment; leave, parole, transfers and other absences; and domestic care, living and privacy issues. Analysed by ward type, patients in acute inpatient wards made the most complaints, with five times as many as the next highest group - people in psychiatric intensive care units. However, there are no available figures on total numbers of patients treated in each type of ward over the period, so we cannot infer anything about rates of complaints for different ward types. There were an average nine complaints per provider. Across all providers, complaints as a percentage of detained patients were 1%. For eight providers, complaints as a percentage of detained patients were higher, ranging from 2% to 5%.

## Deprivation of Liberty Safeguards

The Deprivation of Liberty Safeguards became law in April 2009 as part of the Mental Capacity Act. They provide a legal framework to ensure people are deprived of their liberty only when it is in their best interests and there is no other way to care for them or provide treatment safely. The Safeguards apply to all people aged 18 and over who lack mental capacity to give consent to the arrangements for their care or treatment, for example because of dementia or a severe learning disability.

In our report on the first year of the implementation of the Safeguards, we found that some care homes and hospitals were demonstrating good practice in using the Safeguards to protect people's rights, and in ensuring their staff were aware of their duties under the Safeguards.<sup>30</sup> We also found that many councils and primary care trusts had made good progress in implementing the Safeguards, and some had worked proactively with care homes and hospitals in their areas. Many councils and primary care trusts had worked effectively together as supervisory bodies, and established joint teams. However, we also found clear variations in organisations' understanding and practice of the Safeguards, and in staff training. We will publish our report on the second year of the Safeguards early in 2012.

The NHS Information Centre publishes quarterly and annual statistics on the use of the Deprivation of Liberty Safeguards. The most recent figures cover the second full year of the Safeguards' operation and show that, in the year to 31 March 2011, there were 8,982 applications in England for a deprivation of liberty assessment, compared to 7,157 in 2009/10.<sup>31</sup> Of these applications, 4,951 (55%) resulted in an

authorisation being granted (i.e. the deprivation of liberty was allowed). Three-quarters (75%) of the applications were by care homes to local authorities, and 25% by hospitals to primary care trusts.

Of the applications made since July 2010, two-thirds (66%) were for people with a disability that was a mental health issue, including (52%) who had dementia.\* Twenty per cent were for people with “physical disability, frailty, and/or temporary illness” and 14% for people with learning disabilities. Over half (55%) of the authorisations granted were for a person who lacked capacity because of dementia.

Sixty-nine per cent of applications were for people aged 65 or over. Although there were more applications for women than men, the rates per 100,000 population were similar: 21 applications per 100,000 men, and 23 applications per 100,000 women. The proportion of applications for people from each ethnic group was consistent with the make-up of the population as a whole, except for Asian and Asian British people, where the proportion of applications was lower.

Around 2% of applications that were not authorised involved situations where the person was nevertheless judged as being in a situation amounting to a deprivation of liberty. In these cases, the care homes and hospitals could be acting illegally, if those individuals are not swiftly cared for in less restrictive circumstances. This is a reduction from 4% in 2009/10.

As in the previous year, in 2010/11 there are regional variations in the proportion of applications made, and the rate of applications per 100,000 population. This suggests there is variation across the country in the extent to which the deprivation of liberty legislation is being used.



# 8,982

applications for a deprivation of liberty  
assessment in 2010/11

\* Before July 2010, applications could record more than one category of disability causing lack of capacity. Since July 2010 applications must only give one disability per person, and should record the person's primary disability i.e. the reason the application is being made.

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