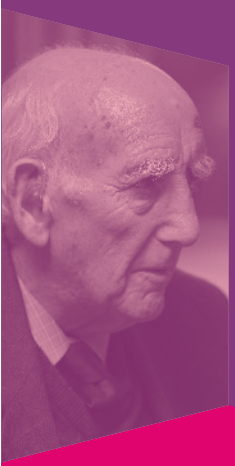
Care Quality Commission



THE STATE OF HEALTH CARE AND ADULT SOCIAL CARE IN ENGLAND

2012/13

Care Quality Commission

The state of health care and adult social care in England in 2012/13

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

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INTRODUCTION

THIS IS THE CARE QUALITY COMMISSION'S FOURTH ANNUAL REPORT TO PARLIAMENT ON THE STATE OF HEALTH AND SOCIAL CARE IN ENGLAND

The report sets out CQC's findings about the quality of care in the year to 31 March 2013. It is based on more than 35,000 inspections carried out by CQC's inspectors in 2012/13.

Since the period covered by this report, we have begun to implement our new strategy, focused on a clear and unambiguous purpose – to make sure health and social care services provide people with safe, effective, compassionate and high-quality care, and to encourage care services to improve.

To achieve this purpose, we are making major changes to how we work. We have appointed powerful new Chief Inspectors of Hospitals, Adult Social Care, and General Practice. They will be leading inspection teams that specialise in particular areas of care and these will include clinical and other experts, and people with experience of care who we call Experts by Experience.

In our consultation on our strategy, we started a conversation about the changes we needed to make to our regulatory model. We set out five questions that we want to be able to answer through this model: are services safe, effective, caring, responsive to people's needs and well-led? Our new inspections of acute hospitals, which started in September 2013, are the first to use this new model.

This State of Care report uses information drawn entirely from the existing generic regulatory model. In Part 2, where we set out the quality of care in each sector, we have used the inspection findings that relate to the existing national standards and outcome areas. We have grouped them in line with our existing guidance on standards:

1. **Safeguarding and safety**
   covering safeguarding people from abuse; cleanliness and infection control; management of medicines; and safety and suitability of premises.
2. **Care and welfare**
   covering care and welfare of people, and meeting nutritional needs.
3. **Respect and dignity**
   covering respect and involving people who use services.
4. **Suitability of staffing**
   covering staffing levels and supporting staff through training and supervision.
5. **Monitoring quality**
   covering the monitoring of service quality and responding to complaints.

The new models will be much more rigorous than the current generic model:

- They will use more specialist inspection knowledge and expertise.
- They will incorporate much more of the views and experiences of people who use services.
- They will be tailored to the very different needs of each sector.

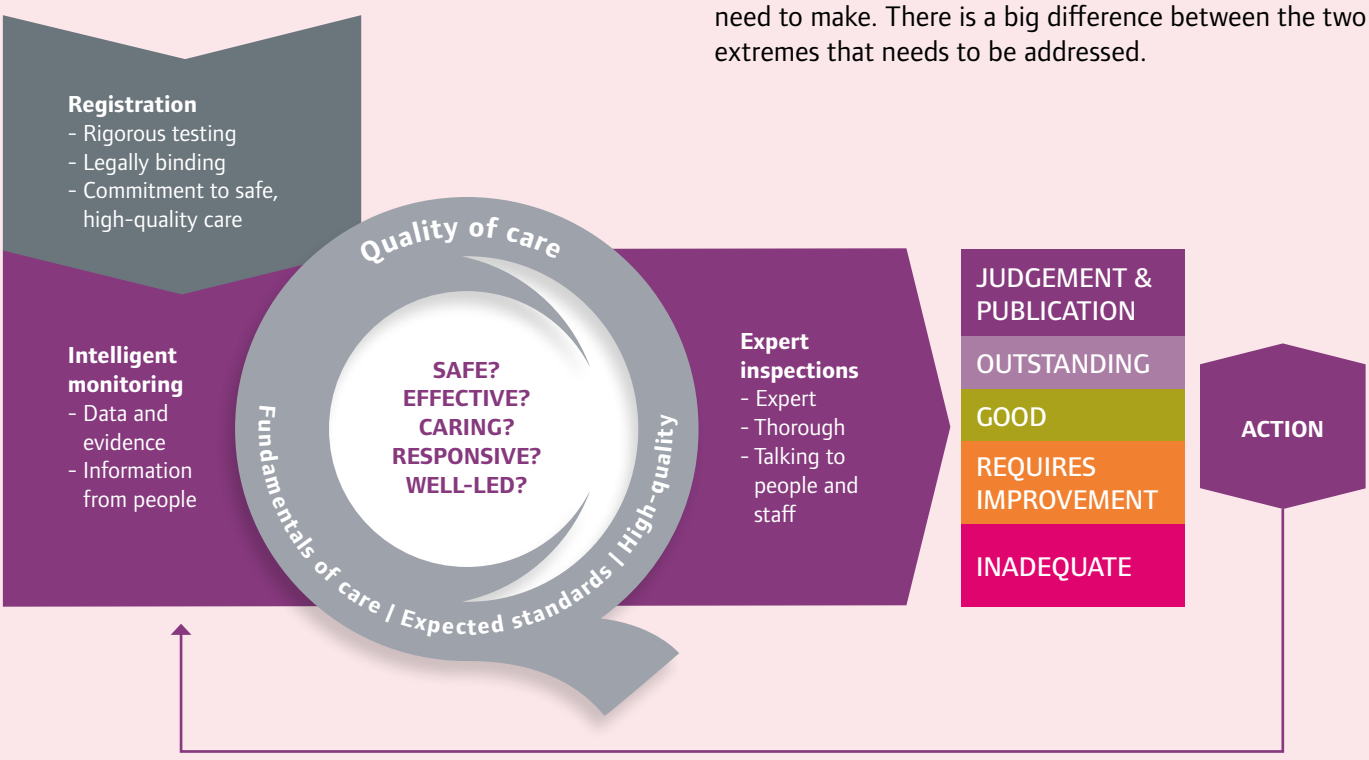
Figure 1 shows the foundation for how the new models will work.

Future reports on the state of care in each sector and overall will, therefore, be based on more thorough and rigorous data and inspection findings. The Chief Inspectors will report on their own sectors (and mental health reporting will come under the Chief Inspector of Hospitals), and the way we report will change over time to reflect the detailed model for each sector.

In our strategy, we made it clear that we will expose services providing mediocre and inadequate care. We will have zero tolerance for services where people are failed on the most fundamental aspects of care. At the other end of the spectrum we are keen acknowledge and highlight the many hospitals, care homes and other services in England where people are receiving good or outstanding care.

This report reflects particularly on this gap – between those who do it well and those who, for whatever reason, are unable to bring about the changes they need to make. There is a big difference between the two extremes that needs to be addressed.

FIGURE 1: CQC's future operating model.



SUMMARY

POOR CARE PERSISTS DESPITE IMPROVEMENTS

CQC carried out more than 35,000 inspections in 2012/13 across the care sectors that we regulate. In around 90% of cases, people were treated with dignity and respect and were receiving care, treatment and support that met their needs and was safe.

But, despite improvements in each type of care setting, we are disappointed that in around 10% of cases people received poor quality care.

KEY FINDINGS

In 2012/13 we found:

More than 9% of people aged 75 and over across England experienced at least one emergency hospital admission for a potentially avoidable condition.

The failures documented by our inspectors were not trivial matters. In around half of cases across all sectors where we found poor care, it had a 'major' or 'moderate' impact on people.

There is a noticeable gap between those providers who have taken positive action to improve the care they give to people, and those who for a variety of reasons are unable to bring about the changes they need to make.

However, there are many providers up and down the country who are delivering excellent care, and they and their staff should be congratulated for this. All must learn from their example and follow their lead.

Despite some improvements, people who have dementia continue to have poorer outcomes in hospital compared to those without dementia.

Person-centred coordinated care: Older people are increasingly arriving in A&E with avoidable conditions.

Last year, we highlighted the pressure that an ageing population, with more complex conditions, is putting on the care system across the country.

When this strain in the system becomes too great, this can have a huge impact on people, especially when they have to move from one care service to another.

We already know that many people, with a variety of conditions, are admitted to hospital when it is not in their best interests to do so. The effect that this has on people who are more vulnerable – particularly older people – is serious. It undermines their self-confidence, increasing their dependency and risking further threats to their health and wellbeing. The whole care system must aim to provide good care for people within their own homes and local community and therefore avoid the need for people to go to hospital unless absolutely necessary.

We looked closely at the numbers of older people who have had to go to hospital in an emergency for conditions that we think are generally avoidable. They are avoidable either because they should be manageable, treatable or preventable within the community, or because they can often be caused by poor care or neglect. They include a variety of conditions such as diabetes, pneumonia, respiratory diseases, bone fractures and urinary infections.

Even if people are well cared for when they reach hospital, the fact that they have had to go there in the first place could point to poor overall care. This may be the result of many factors, but high among them is the interaction between primary health care (GP services), secondary health care (hospitals) and social care (care homes and care provided in people's own homes).

Now that we regulate GP practices as well as other care settings, we intend to explore in future reports how GP practices, social care services, hospitals and community health care all work together to reduce the need for people to go into hospital unnecessarily.

Avoidable admission to hospital: key findings

- More older people are being admitted to hospital in an emergency with conditions that are generally avoidable. This is increasing faster than the growth in the older population.
- During 2012/13 more than 9% of people aged 75 and over across England experienced at least one emergency hospital admission for an avoidable condition.
- The pressure these avoidable admissions put on A&E is clear. They followed the same seasonal pattern as people waiting more than four hours in A&E. Both showed a sharp upturn in the second half of 2012/13.
- Also, among people living in care homes, hospital admissions for avoidable conditions were 30% higher for those who had dementia compared with those without dementia.
- Areas of the country that have a higher proportion of older people tend to have fewer avoidable admissions per older person.
- Overall some areas have been able to avoid these admissions, and care for people better in local care systems without the need to go into hospital. Other areas should be able to learn from those who do it best.

GO TO PAGE 8 FOR FULL DETAILS

SUMMARY

Quality of care: sector-by-sector

1 in 5

nursing home inspections revealed safety concerns.

47%

of problems uncovered in the NHS were judged to have 'major' or 'moderate' impact on patients.

ADULT SOCIAL CARE

Despite some improvements, the care received by many people was still poor in 2012/13. In most kinds of social care, our inspectors uncovered problems in more than 10% of the different aspects of care they inspected.

In half of cases where we found problems, we judged them to have a 'major' or 'moderate' impact on people. This is no better than the previous year.

There is still a huge amount for providers to do to make sure that all people are kept safe, treated with dignity and respect, and cared for in a way that meets their personal needs.

- **Nursing homes:** one in five nursing home inspections revealed safety concerns and ongoing staffing pressures. Overall, nursing homes continued to lag behind other social care settings in terms of quality and safety of care.
- **Residential care homes:** more than 10% of inspections uncovered problems with safeguarding and safety, staffing, or the care and support received by residents. And in analysing the notifications of deaths that care providers send to us, we found a link with higher staff turnover rates. This suggests that too many changes in staff may result in gaps in care. However, we found no such correlation with staff vacancy rates.
- **Home care services:** we found problems with staffing and quality monitoring in more than 10% of inspections. Our focused programme of home care inspections showed that managers need to do more to prevent late and missed visits, support staff to carry out their day-to-day work, and improve care planning.
- **Other social care services:** staffing was also an issue in services such as Shared Lives and supported living – we found problems in more than 10% of inspections.

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NHS SERVICES

In the aftermath of the failures of care at Mid Staffordshire NHS Foundation Trust, our inspectors' biggest concern in 2012/13 was that acute hospitals made no improvement in assessing and monitoring the quality of care they provided. We also found no improvement in safety and safeguarding, or in hospital patients being treated with dignity and respect.

Like adult social care, around half (47%) of the problems we uncovered in our inspections in the NHS in 2012/13 had a major or moderate impact on patients. This is a deterioration from the previous year.

- **NHS hospitals:** overall our inspectors found poor care in around one in 10 of all hospital inspections. Hospitals did not improve their assessment and monitoring of the quality of the care they provided. There was also no improvement in safety and safeguarding, or in treating people with dignity and respect.

  In addition, despite some improvements, people in hospitals who have dementia continue to have poorer outcomes. In 2012/13 the number of patients with dementia who died in hospital was more than a third higher (36%) than similar patients who did not have dementia. Those with dementia stayed in hospital on average 27% longer than matched people without dementia.
- **NHS community healthcare services:** one in eight inspections still found that patient safety was being put at risk. Staffing was also an issue, with one in 10 inspections finding a problem.

1 in 10

independent healthcare inspections were not meeting standards of safeguarding and safety.

7%

of dental care inspections raised concerns relating to safeguarding and safety.

- **NHS mental health, learning disability and substance misuse services:** there were improvements in ensuring the care and welfare of people with a mental health problem or a learning disability. However, we still uncovered problems in one in eight inspections. Staffing issues were proving the most difficult problem to resolve, with no improvement and one in 10 inspections raising concerns.

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INDEPENDENT HEALTH CARE

Although independent services generally perform better than NHS locations in terms of the safety and quality of care, our inspectors were concerned to see no improvement in the way hospitals assessed and monitored the quality of care.

- **Independent hospitals:** standards of care in 2012/13 were on the whole good although, overall, hospitals did not improve their performance in terms of monitoring quality. Overall, safeguarding and safety remained the biggest issue for hospitals, with one in 12 inspections not meeting standards.
- **Independent community health care:** services performed very well in treating patients effectively, and with dignity and respect. Safeguarding and safety was still a concern, with almost one in 10 inspections raising concerns for our inspectors.
- **Independent mental health, learning disability and substance misuse services:** these services improved in all five of our main areas of focus, and independent services almost matched the performance of their NHS counterparts in 2012/13. However, problems still remained in a number of areas, with safeguarding and safety the biggest concern.
- **Independent ambulance services:** our inspectors found that services provide effective care and treatment and in every case we looked at treated people with dignity and respect. But there were concerns about safeguarding and safety, staffing and assessing and monitoring the quality of the service.

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PRIMARY DENTAL CARE

We have fewer overall concerns with the quality and safety of dental care providers. The performance of the sector is very good compared to other parts of the health and social care system.

Dental care services generally provide effective care and treatment and treat patients with dignity and respect. However, where we did find problems, around 40% of them had a major or moderate impact on patients.

What concerns we do have relate to safeguarding and safety. On the whole, surgeries are clean, with good infection control procedures, and staff know how to protect patients from the risk of abuse. However, we did uncover problems in these areas in 7% of inspections. This is the same as last year, so there is still some work to be done by the sector to embed safe practices in all dental surgeries.

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PART ONE

STUDY ON PERSON-CENTRED COORDINATED CARE: OLDER PEOPLE INCREASINGLY ARRIVING IN A&E WITH AVOIDABLE CONDITIONS

Last year, we highlighted the pressure that an ageing population is putting on the care system across the country. People are living longer but increasingly with more complex conditions, and often with more than one long-term condition at the same time.

KEY FINDINGS

In 2012/13 we found:

More older people are being admitted to hospital in an emergency **with conditions that are generally avoidable.** This is increasing faster than the growth in the older population.

During 2012/13 **more than 9% of people aged 75 and over** across England experienced at least one emergency hospital admission for an avoidable condition.

That these admissions put pressure on A&E is clear. They followed the same seasonal pattern as people waiting more than four hours in A&E. Both showed a sharp upturn in the second half of 2012/13.

Also, among people living in care homes, **hospital admissions for avoidable conditions were 30% higher for those who had dementia** compared to those without dementia.

Areas of the country **that have a higher proportion of older people tend to have fewer avoidable admissions** per older person.

Overall **some areas have been able to avoid these admissions, and care for people better in local care systems without the need to go into hospital.** Other areas should be able to learn from those who do it best.

"There has been a rise in the number of admissions for avoidable conditions over the last six years."

When this strain in the system becomes too great, this can have a huge impact on people, especially when they have to move from one care service to another.

We already know that many people, with a variety of conditions, are admitted to hospital when it is not in their best interests to do so. The effect that this has on people who are more vulnerable – particularly older people – is serious. It undermines their self-confidence, increasing their dependency and risking further threats to their health and wellbeing.

The whole care system must aim to provide good care for people within their own homes and local community and therefore avoid the need for people to go to hospital unless absolutely necessary.

Nuffield Trust and the Health Foundation have also looked at a similar area recently. They examined the pattern of admissions from 2001 to 2013 for people with the set of 'ambulatory care sensitive' conditions that are now in the NHS Outcomes Framework. These acted as an indicator of how well primary and preventive care were working to reduce emergency admissions. Their report was published in October 2013.[1]

PREVENTION IS BETTER THAN CURE

For this report, we have looked closely at the numbers of older people who have had to go to hospital in an emergency for conditions that we think are generally avoidable. While some of these admissions may not have been treatable within the community and may require a hospital admission, should they occur, higher rates do indicate a possible failure at some point along the pathway. (For full details about this work and the conditions we chose for analysis, see Technical Annex 1.)

They are avoidable because either:

- They should be manageable, treatable or preventable within the community without the need to go into hospital:

  - Acute lower respiratory tract infections (such as acute bronchitis)

  - Chronic lower respiratory tract infections (such as emphysema and other chronic lung diseases)

  - Diabetes

  - Intestinal infections

  - Pneumonia

  - Urinary tract infections, or

- They can often be caused by poor care or neglect.

  - Food and drink issues (such as abnormal weight loss and poor intake of food and water due to self-neglect)

  - Food and liquid pneumonitis (inhaling food or drink)

  - Fracture and sprains

  - Pressure sores.

Even if people are well cared for when they reach hospital, the fact that they have had to go there in the first place could point to poor overall care. This may be the result of many factors, but high among them is the interaction between primary health care (GP services), secondary health care (hospitals) and social care (care homes and care provided in people's own homes).

We have focused on older people because they have a higher proportion of avoidable admissions, the effect that these have on their lives is that much greater, and they are much more dependent on health and adult social care services being properly integrated.

Our analysis provides a general insight into how well care providers are working together to make sure older people are properly cared for in their local communities.

WHAT WE LOOKED AT

We analysed the trends over the last six years in the numbers of older people (aged 65 and over) who had to go to hospital in an emergency for a range of conditions. We looked at how these numbers changed over time, the proportion of all hospital admissions the conditions accounted for, and how these trends compared with other hospital indicators such as A&E waiting times.

We then used statistical techniques to estimate how much variation across the country could be explained by factors such as the proportion of older people in the community, the availability of care home beds and levels of deprivation.

This particular analysis did not include dementia as a specific condition, but we do know that this has a huge impact on people's health and care outcomes. On page 29, we discuss the repeat of our analysis on the impact dementia has on the chance of being admitted to hospital. Once in hospital people with dementia are more likely to stay there longer, to be readmitted in an emergency and to die there.

OUR FINDINGS

Avoidable admissions are rising

There has been a rise in the number of admissions for avoidable conditions over the last six years. This has outstripped both overall demographic growth in the number of older people and growth in total emergency admissions among older people.

Among people who are 65 and over, the rate of avoidable admissions (per 1,000 people 65+ in the population) rose from 48 (in 2007/08) to 62 (in 2012/13) (see figure 2). The increase among people aged 75 and over was even steeper, with the rate of avoidable admissions (per 1,000 people 75+ in the population) growing from 74 (2007/08) to 99 (2012/13).

In terms of number of people aged 75 and over experiencing at least one admission during the year, the proportion changed from 7.1% of the 75 and over population in 2007/08 to 9.4% in 2012/13.

In other words, admissions for this group of conditions constituted a larger proportion of hospital workload in 2012/13 than they did six years ago, despite efforts by successive governments to move more care into the community.

Some of the conditions have seen rises: pneumonia (64% increase), inhaling food or liquid (pneumonitis) (52% increase) and urinary tract infections (45% increase). There was also a large rise in admissions for intestinal infections in 2012/13 (over 200%) although this may have been a short term increase rather than evidence of a longer term trend.

The impact this has on A&E departments

Increases in these admissions represent an additional strain on hospital emergency care services, with a corresponding knock on effect to A&E departments. Between 2007/08 and 2012/13, the proportion of emergency admissions among people aged 65 and over accounted for by these conditions increased from 8.3% to more than 10%. This shows that hospital emergency care teams are devoting an increasing proportion of their time to caring for older people with these conditions.

The proportion of these admissions among people aged 75 and over is even greater. In 2012/13, a quarter (24.6%) of all emergency admissions of that age group were avoidable, using our definition for this study. This has risen from 21.2% in 2009/10 (see figure 3).

At the same time, the proportion of people waiting more than four hours in A&E increased substantially - from 1.9% in 2008/09 to 4.1% in 2012/13 (see figure 4). Our detailed analysis of waiting times in A&E departments has shown that older age groups have a decreasing likelihood of leaving the department within four hours. A major cause of this is their increased chance of being

FIGURE 2: Rate of avoidable admissions per 1,000 people 65+ and 75+ in the population.

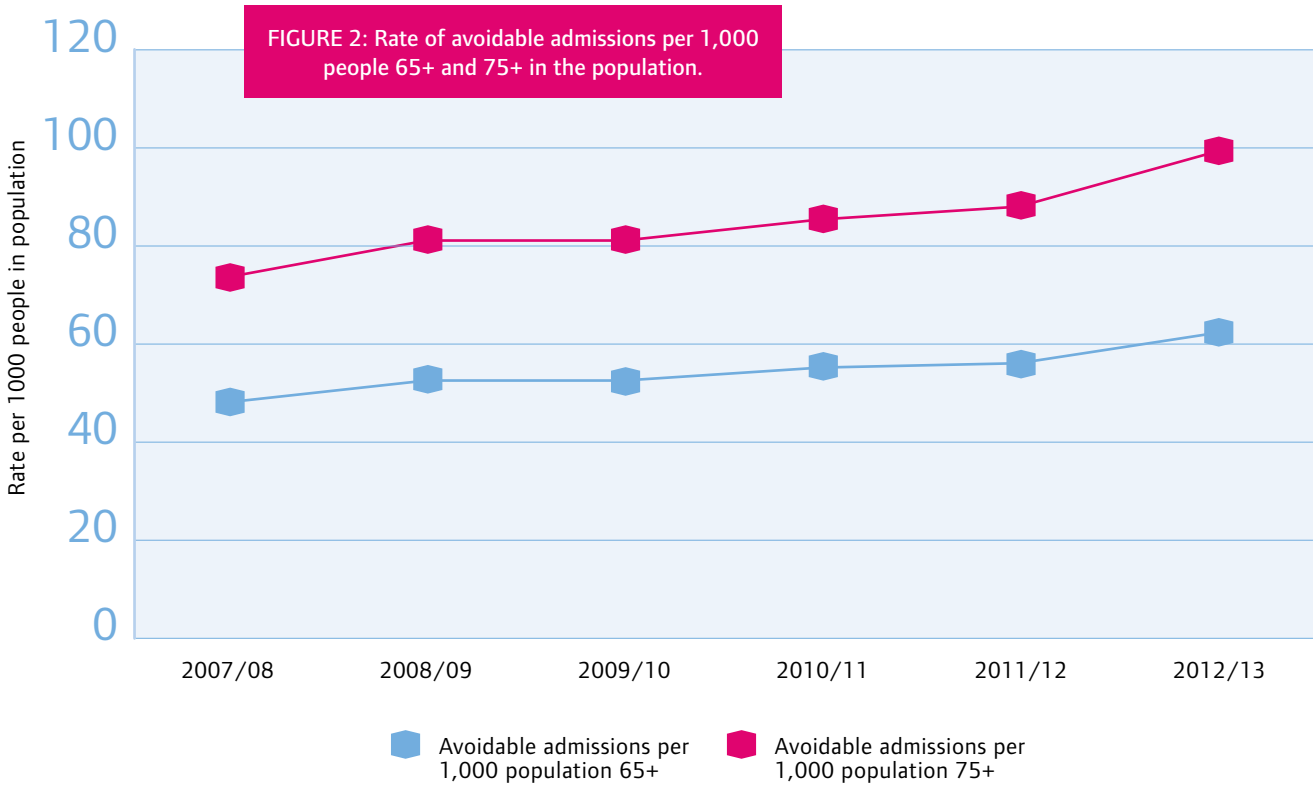
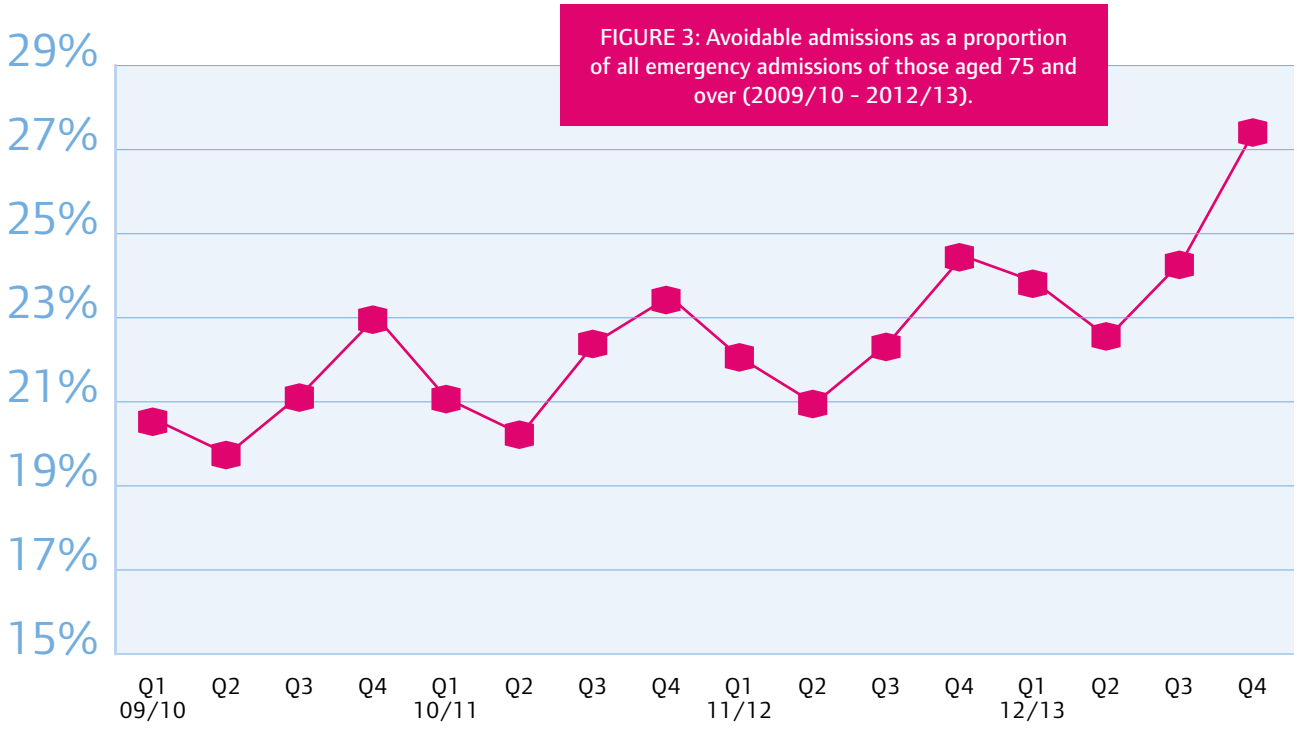


FIGURE 3: Avoidable admissions as a proportion of all emergency admissions of those aged 75 and over (2009/10 - 2012/13).



admitted and having to wait some time for this to happen.

We compared the seasonal changes in A&E waiting times and the changes in avoidable admissions and found that they shared a similar trend over the last five years. They both showed similar quarterly and seasonal fluctuations and a sharp increase during the second half of 2012/13.

As can be seen from figure 2, there seems to have been a general acceleration in the rates and numbers of these avoidable admissions from 2010/11 onwards. This coincides with a general deterioration in performance against the A&E four-hour standard.

There are differences at regional level between the rate of these admissions and performance against the four-hour standard, so the relationship between the two is not clear cut. However, it is clear that these admissions represent an additional strain on emergency services and, given their nature, could potentially be prevented by better community care and integration of services.

Regional differences – what can we learn?

There are clear regional differences in avoidable admissions of older people. Six out of the nine regions of England (such as the North East and London) account for a greater proportion of national avoidable admissions than their proportion of the national 65 and over population (see figure 5).

On the other hand, the South East, the South West and the East accounted for a lower proportion.

We carried out statistical analysis to explore the relationships of a number of variables, at local authority level, to see whether there were any factors that were particularly associated with avoidable admissions.

We found a significant link between local authority areas with a higher proportion of people 65 and over tending to have lower rates of avoidable admissions – this may be due to a greater awareness of the needs of the elderly in these areas and a greater focus on developing systems and initiatives to reduce admissions to hospital.

However, the variable with the strongest explanatory power in our modelling was the reported health status of the older population. Better reported health correlated with lower admission rates, highlighting the importance of public health in managing demand for acute services. Correlations were also generally seen with measures of health and wealth indicating the significant effects played by deprivation. Figure 6 shows the councils in England split in to quartiles for avoidable admissions.

We also looked at the gap between the local authority areas with highest rates of avoidable admissions and those with the lowest rates. This gap has widened over the last five years.

Figure 7 shows the difference in average avoidable admissions between the 10% of local authority areas with the highest rates of admissions and the 10% with the lowest rates. The gap between the two, while fluctuating, has generally risen over the last five years. Admission rates among both the highest and lowest rate areas increased during this time.

This widening gap suggests that some areas may have been better than others at managing this problem and avoiding these admissions.

Age differences

The older people get, the more they are likely to have an avoidable admission. The greatest growth is among people aged 90 and over. Figure 7 shows avoidable admissions as a rate of each 1,000 people in the population in that age group. It is clear that the increase in avoidable admissions is outstripping the population increase over time, especially in those over the age of 90.

FIGURE 4: % of people waiting more than four hours in A&E (all types).

FIGURE 5: Regional comparison of proportion of national 65+ population (2012) and national 65+ avoidable admissions (2012/13).

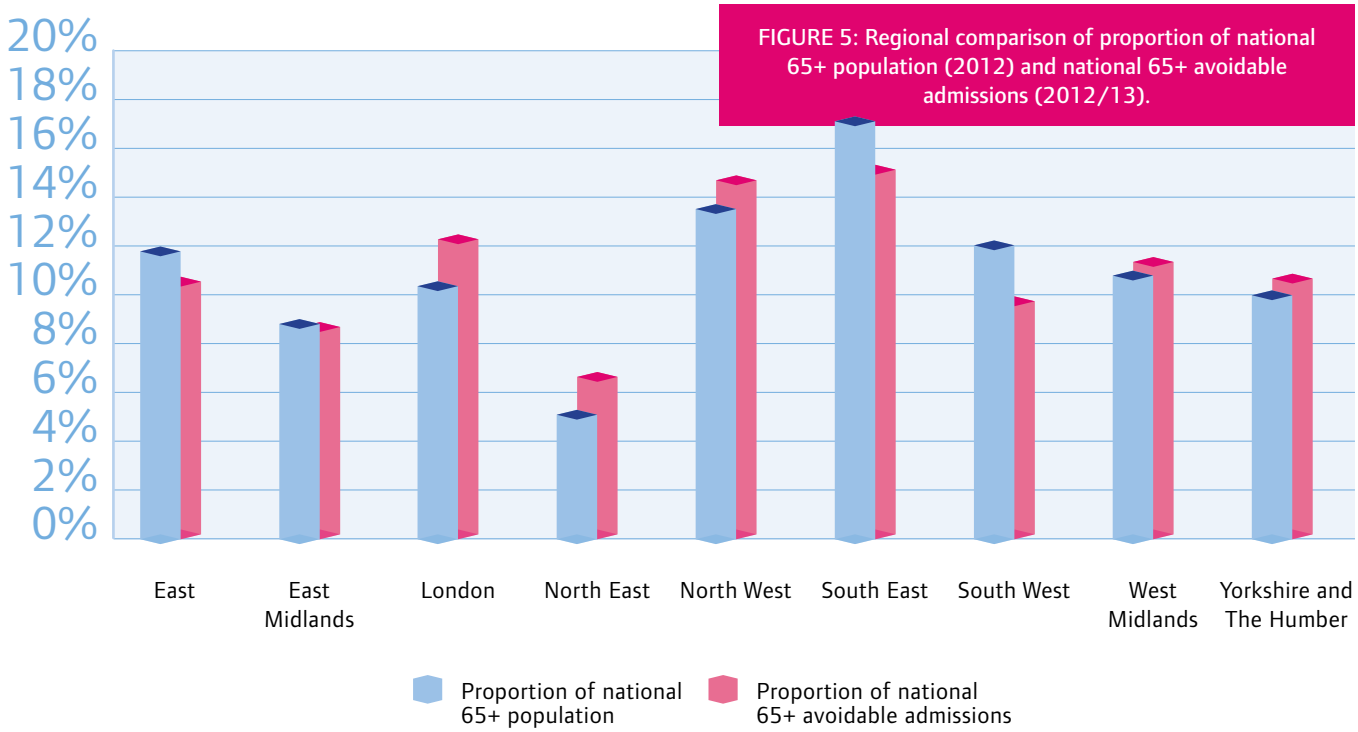


FIGURE 6: Councils with Social Services Responsibilities (CASSRs): quartiles showing rates of people aged 65 and over experiencing one or more potentially avoidable admission to hospital, 2012/13.

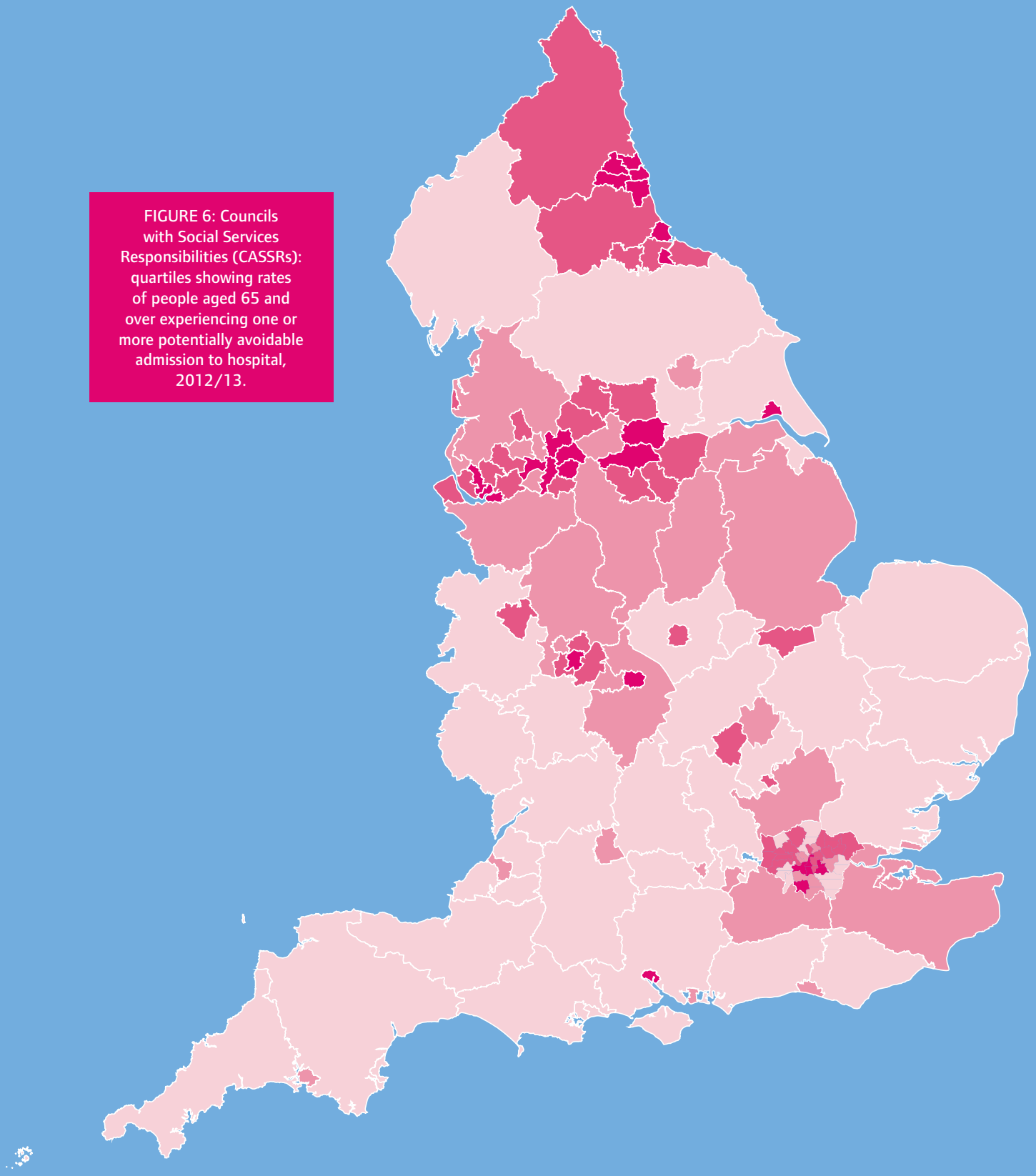


FIGURE 7: Difference in average admissions per 1,000 population 65+ in the 10% of areas with the highest and lowest rates.

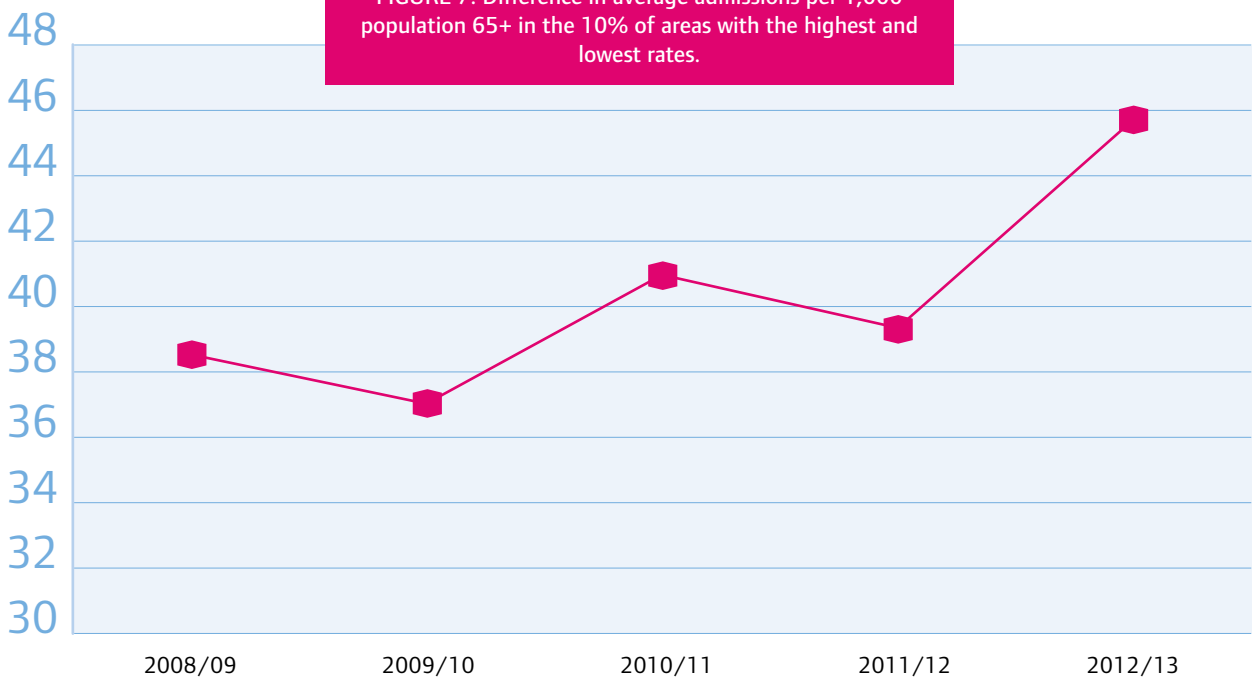
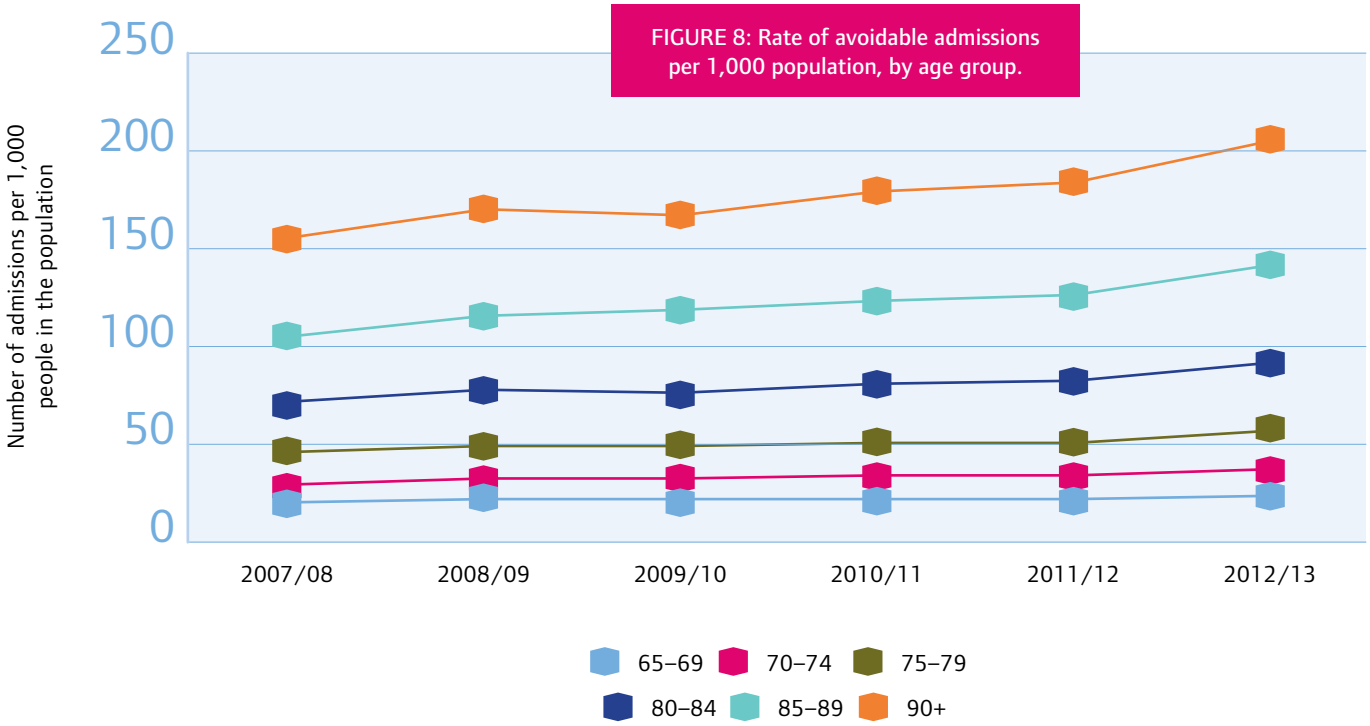
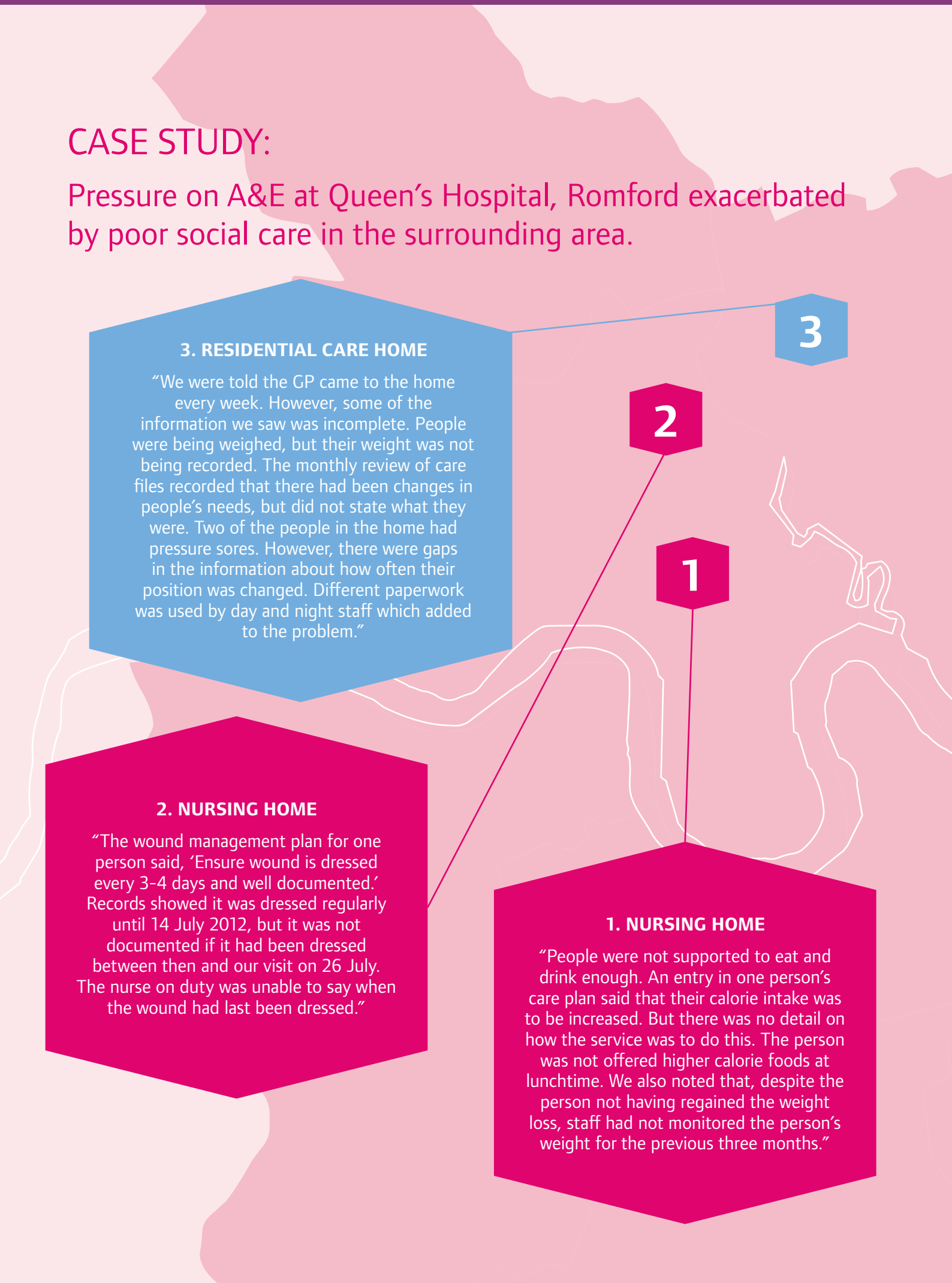


FIGURE 8: Rate of avoidable admissions per 1,000 population, by age group.



CASE STUDY:

Pressure on A&E at Queen's Hospital, Romford exacerbated by poor social care in the surrounding area.



3. RESIDENTIAL CARE HOME

"We were told the GP came to the home every week. However, some of the information we saw was incomplete. People were being weighed, but their weight was not being recorded. The monthly review of care files recorded that there had been changes in people's needs, but did not state what they were. Two of the people in the home had pressure sores. However, there were gaps in the information about how often their position was changed. Different paperwork was used by day and night staff which added to the problem."

2. NURSING HOME

"The wound management plan for one person said, 'Ensure wound is dressed every 3-4 days and well documented.' Records showed it was dressed regularly until 14 July 2012, but it was not documented if it had been dressed between then and our visit on 26 July. The nurse on duty was unable to say when the wound had last been dressed."

1. NURSING HOME

"People were not supported to eat and drink enough. An entry in one person's care plan said that their calorie intake was to be increased. But there was no detail on how the service was to do this. The person was not offered higher calorie foods at lunchtime. We also noted that, despite the person not having regained the weight loss, staff had not monitored the person's weight for the previous three months."

The emergency department at Queen's Hospital in Romford was built to deal with up to 90,000 patients a year. It now sees around 132,000.

4

5

CQC's June 2012 inspection report of Queen's Hospital:

"Staff said that, due to the high numbers of patients coming through the department, there were often delays in being able to transfer patients onto an emergency trolley. Ambulance staff told us the department was always very busy and that delays occurred on most days. The delays in 'offloading' patients prevented ambulance staff being able to return to their duties.

"Staff questioned whether more can be done externally and with other organisations to reduce the numbers of people coming into the department. They told us that when beds were not available, this had an impact on the whole department and improvements put into place did not work properly. The number of patients built up throughout the day and caused a backlog because the whole process broke down."

May 2013 follow-up: Major impact on people continues

On our first day of the inspection at 11am there were 22 patients in the 'Majors' area. On the second day of our inspection, at 10.30am, there were 30 patients. Eighteen of them had been in the emergency department for more than six hours; 10 had been there since before midnight.

We spoke to some of the nurses in 'Majors' who told us, "We can cope with the numbers if things are quiet, but when things get busy there are not enough nurses here".

4. NURSING HOME

"People who were bed bound did not have drinks readily available. One was given a drink and needed another one as they were thirsty. We did not see any other drinks in the person's bedroom, or in the bedrooms of the other five people who were bed bound. Nutritional assessments were being carried out, but that they were not always followed."

5. RESIDENTIAL CARE HOME

"The care plans for two people said that they were at 'high risk' of malnutrition, and that all fluid and food intake should be recorded daily. But on some days no fluid intake was recorded at all. We were told that people were being given fluids, but this was not being recorded properly. Without charts being completed accurately it is difficult to monitor if people have been provided with appropriate levels of food and fluids. This potentially puts people at risk."

PART TWO

SECTOR BY SECTOR: THE QUALITY OF CARE SERVICES IN ENGLAND

CQC's inspectors carried out more than 35,000 inspections in 2012/13. In around 90% of cases, people were treated with dignity and respect and were receiving care, treatment and support that met their needs and was safe.

ADULT SOCIAL CARE

NHS SERVICES

INDEPENDENT HEALTH CARE

PRIMARY DENTAL CARE

But, despite improvements in each type of care setting, we are disappointed that in around 10% of cases people received poor quality care.

KEY FINDINGS

In 2012/13 we found:

The failures documented by our inspectors were not trivial matters. In around half of cases across all sectors where we found poor care, it had a 'major' or 'moderate' impact on people – for example, people being at risk of getting the wrong medicine because records aren't updated properly.

We believe that there is a noticeable gap between those providers who have taken positive action to improve the care they give to people, and those who for a variety of reasons are unable to bring about the necessary changes.

A lack of consistency among care providers in our main areas of inspection. Care may have been good in one area, for example respect and dignity, but poorer in another, such as monitoring of quality.

There was notable variation in the quality of care that people receive across the country, in all sectors.

"If a provider was failing to deliver the quality of care that people had a right to expect, we took action"

Note on reporting methodology

For the following sector reports, we have used CQC inspection data for the year ended 31 March 2013, as well as published external sources of data across a range of subjects.

In 2012/13, a generic set of national standards of quality and safety applied across all registered healthcare and adult social care services in England (with the exception of GP practices and primary medical care services, which came into the new system from April 2013). CQC inspectors looked at different aspects of the care provided in an inspection, so only a proportion of standards were assessed each time.

If a provider was failing to deliver the quality of care that people had a right to expect, we took action that was proportionate to the impact on the people who use the service and how serious it was. We judged the impact to be 'minor', 'moderate' or 'major'.

This State of Care report uses information drawn entirely from our existing generic regulatory model. We have used the inspection findings that relate to the existing national standards and outcome areas. We have grouped them in line with our existing guidance on standards:

1. SAFEGUARDING AND SAFETY: covering safeguarding people from abuse; cleanliness and infection control; management of medicines; and safety and suitability of premises
2. CARE AND WELFARE: covering care and welfare of people, and meeting nutritional needs
3. RESPECT AND DIGNITY: covering respect and involvement of people who use services
4. SUITABILITY OF STAFFING: covering staffing levels and supporting staff through training and supervision
5. MONITORING QUALITY: covering the monitoring of service quality and handling complaints.

Note on reporting methodology (cont.)

Appendix 3 contains tables showing the overall judgements from all inspections of these selected outcome areas carried out in 2012/13. Please note that the performance figures refer to total judgements made across all inspections. They are not, therefore, a measure of the performance of locations. Many locations will have received more than one inspection in the year. Each inspection judgement is counted in the overall calculation, and each inspection may have covered a different range of standards, making multiple judgements.

Some regulations that were inspected less often in 2012/13 are not included in the five areas of focus above. Full details are shown in the appendix.

Please also note that our data on mental health, learning disability and substance misuse services was grouped together for 2012/13, and therefore we have reported on these services as one group. Going forward, we will split these out into separate reporting strands.

However, there are many providers up and down the country who are delivering excellent care, and they and their staff should be congratulated for this. The following example of excellent dementia care is just one of many. All must learn from their example and follow their lead.

GOOD PRACTICE EXAMPLE

ASHLEY HOUSE, BORDON, HAMPSHIRE

DEMENTIA CARE WHERE THE STAFF VERY MUCH FOCUS ON THE NEEDS OF EACH AND EVERY PERSON

Ashley House is a care home that is registered to provide nursing care and accommodation for up to 36 people, mostly people with dementia.

Over the course of two inspections, all the people we have spoken to have said they enjoyed living there. They said they liked the staff as they were very helpful and kind.

One relative said "I just think it is excellent, the way staff talk to the residents. People are given care and respect."

Another relative told us that the registered manager had come to meet her mother at her home prior to moving to Ashley House. The meeting had been used to assess her needs and had involved her mother discussing what care and support she wanted and what she liked or disliked.

People told us that staff always knocked before entering their room and asked permission before helping them with their personal care.

During one visit we observed people being supported to have drinks in the dining room and to eat their lunch. People had various cups for their drinks which depended on their likes and abilities. On person had a cup that had two handles which enabled them to be more independent and drink unaided. Some people had china cups as this was the type they preferred.

One of the relatives we spoke with told us about the 'comfort shift' organised by the home. This was when a member of the care staff provided quiet activities such as reading and poetry after dinner in the evening. They told us that they had watched this taking place. They said it was very calming for people and had meant their relative was more settled before bed time.

In one of the visits we looked at four care plans. Each care plan was indexed which made it easier to find information. Each care plan was unique to the individual and had been regularly reviewed. Each person had taken part in a pre-admission assessment. This identified the individual needs of the resident and how the staff would meet their needs.

We observed care being delivered in a kind and caring way throughout the home. People were offered choices in respect of meals and activities. There was a range of activities available for people to choose from. These included day trips, church services, bingo, baking, and being involved in the day to day running of the home such as laying tables, which made people feel valued.

There was a range of reminiscence material throughout the home which included a beach, an office, a public house, a country kitchen and a variety of birds, animals and fish. The 'comfort shift' was led by staff and well attended by people using the service. The period between 6pm and 10pm was used as 'wind down' time where people could sit quietly and listen to a story being read. People liked the news being on in the background. The registered manager reported that people found this comforting and as a result were calmer and more relaxed before going to bed. The home was experimenting with a machine that produced familiar smells such as apple pie and fresh bread. They found that this helped to stimulate people's appetite.

The home also maintained a spiritual corner which was an important area for both people who used the service and relatives. A book of remembrance was kept and families were able to visit the home and spend time remembering their friend or relative.

PART TWO

ADULT SOCIAL CARE

Despite some improvements, the social care received by many people was still poor in 2012/13. In most kinds of social care, our inspectors uncovered problems in more than 10% of the different aspects of care they inspected.

KEY FINDINGS

In 2012/13 we found:

NURSING HOMES:

- One in five nursing home inspections revealed safety concerns, such as failing to give out medicines safely or not carrying out risk assessments when starting to care for someone, and ongoing staffing pressures.
- Overall, nursing homes continued to lag behind other social care settings in terms of quality and safety of care.

RESIDENTIAL HOMES:

- In analysing the notifications of deaths that care providers send to us, we found a link with higher staff turnover rates. This suggests that too many changes in staff may result in gaps in care. However, we found no such correlation with vacancy rates.
- More than 10% of inspections uncovered problems with either safeguarding and safety, staffing, or the care and support received by residents – for example, people not being helped to eat and drink enough.

HOME CARE SERVICES:

- We found problems with staffing and quality monitoring in more than 10% of inspections.
- Our focused programme of home care inspections showed that managers need to do more to prevent late and missed visits, support staff to carry out their day-to-day work, and improve care planning.

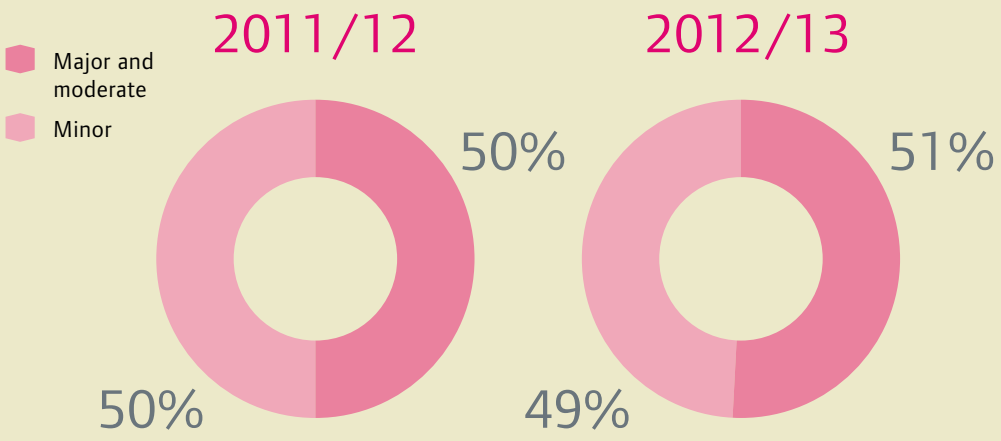
OTHER COMMUNITY SOCIAL SERVICES:

Staffing was also an issue in services such as Shared Lives and supported living – we found problems in more than 10% of inspections.

In half (51%) of cases where we found problems, we judged them to have a 'major' or 'moderate' impact on people (figure 9). This is no better than the previous year. We issued more warning notices to tackle this poor care: 818 in 2012/13, compared with 598 the previous year – an increase of almost 40%.

There is still a huge amount for providers to do to make sure that all people are kept safe, treated with dignity and respect, and cared for in a way that meets their personal needs.

FIGURE 9: When we found a problem in adult social care, what effect did this have on people who use services?



Adult social care provision

The total number of adult social care providers registered with CQC rose by 2% in 2012/13, from 12,429 to 12,670.

Continuing the trend we have seen in the last two years, the number of residential care homes (that is, those that do not provide nursing care) registered with CQC continued to decline, from 13,134 at the end of 2011/12 to 12,848 at the end of 2012/13, a drop of 2%. Similarly, the number of residential care home beds (declared at the point of registration) went down from 247,824 to 244,232.

The number of registered nursing homes was static, with 4,664 homes registered at the year end compared with 4,672 at the end of 2011/12. The number of nursing home beds rose, though, from 215,463 to 218,678.

In contrast to the decline of residential care home provision, the strong growth in home care continued the long-term trend towards people living in their own homes and communities rather than going into a care home. There were 7,420 registered home care agencies at the end of the year, a rise of 9% on the 6,830 registered at the end of 2011/12. It is noticeable that the numbers of home care agencies increased at a much greater rate than the decrease in the total number of care homes and care home beds.

TABLE 1: Adult social care locations registered with CQC.

	2011/12	2012/13
NURSING HOMES	4,672	4,664
RESIDENTIAL CARE HOMES	13,134	12,848
HOME CARE AGENCIES	6,830	7,420
OTHER COMMUNITY SOCIAL CARE SERVICES (SUCH AS SHARED LIVES AND SUPPORTED LIVING)	2,034	2,043

Across adult social care, on 31 March 2013:

- Just under half (47.6%) of the registered adult social care locations were residential homes (down from 49.3%)
- 27.5% were domiciliary care agencies (up from 25.6%)
- 17.3% were nursing homes (down from 17.5%)
- 7.6% were other social care services such as supported living services and shared lives (same as 2012).

We have put tables in appendix 2 showing the number of care homes and beds in the different regions of England, and the average population (based on the 2011 census)[2] per care home bed for:

- People overall
- Older people aged 65 and over
- People with bad or very bad health
- People who are limited in their day-to-day activity.

The greatest pressure on care home beds in terms of the 65 and over population is in London, followed by the West Midlands. London also had the highest population per care home bed who reported bad or very bad health, and who said they were limited day-to-day in their activity.

The North East has the fewest people 65 and over per care home bed, but the South East and South West had the smallest population per bed who reported bad or very bad health.

We also show in appendix 2 the number of home care agencies in each region, and the average population overall and 65 and over population per agency.

With extensive support and assistance from the Care Provider Alliance, we carried out a special data collection with registered providers of adult social care to create a baseline dataset of their funding arrangements (see Technical Annex 2 for more details). There was a good response rate. The biggest source was local authority funding without any kind of top-up payment by the person receiving the care (44.7% of places), followed by care that was paid for by the person themselves (36%) (figure 10). Smaller proportions of places were local authority funded with some top-up (9.8%) or funded by NHS continuing healthcare payments (9.1%). Very few places were local authority funded with top-up from a charity.

Regional differences are shown in figure 11. In contrast to the overall trend, in the South East and South West more places were funded by people paying for their own care (47.6% and 43.2% respectively) than were local authority funded without top-up

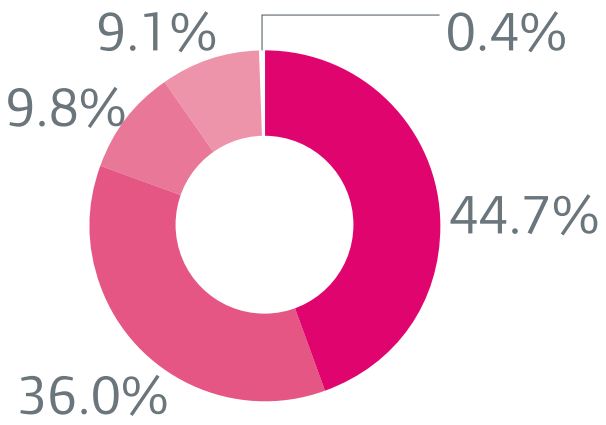


FIGURE 10: Funding sources of filled places.

- LA funded without top-up
- Pay for own care
- LA funded with top-up
- NHS Continuing Healthcare
- LA funded with charity top-up

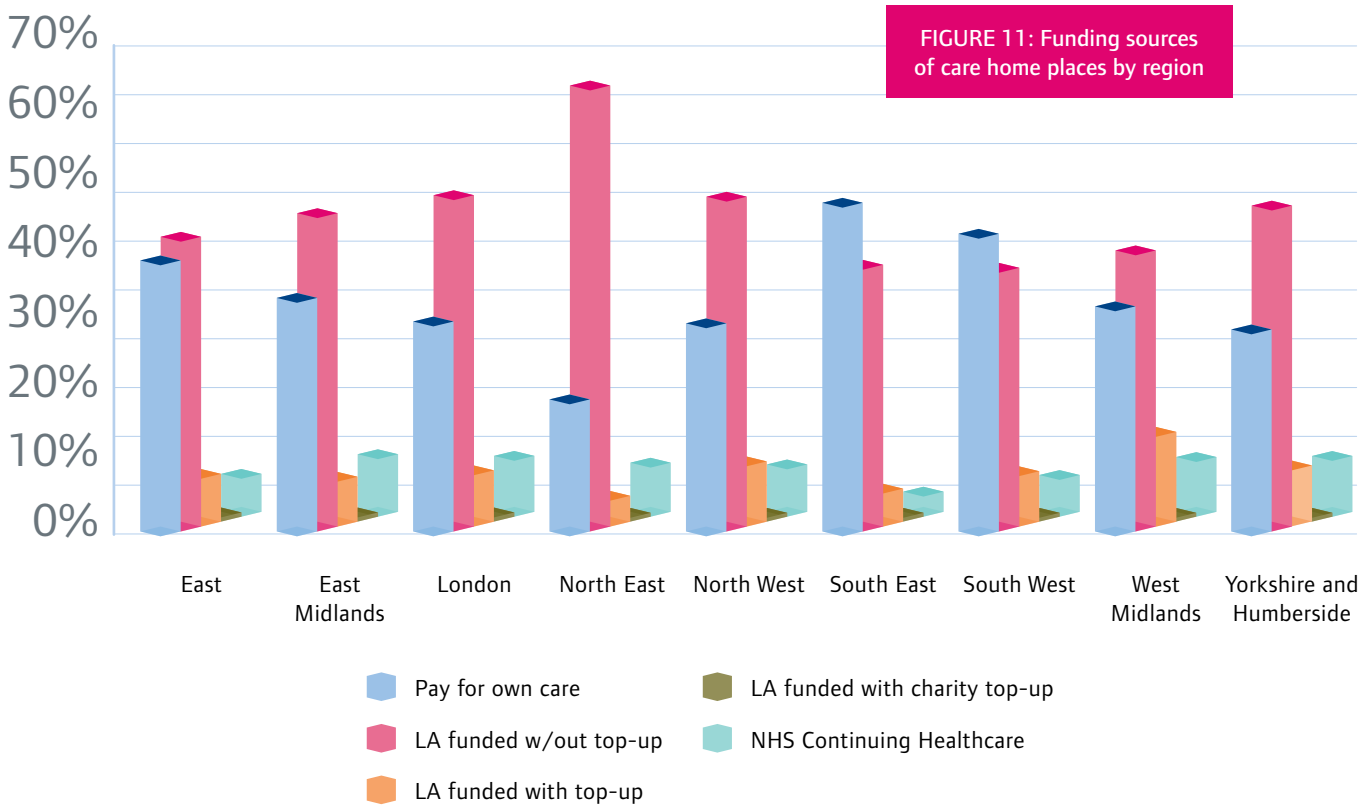


FIGURE 11: Funding sources of care home places by region

£1.1billion

Expenditure on direct payments for adults in 2011/12

payments (38.9% and 38.3%). The North East had by far the greatest proportion of places that were local authority funded without top up (64.1%).

Local authorities still therefore provide the greatest part of funding for adult social care. Gross expenditure by local authorities per 10,000 population (at 2011/12 prices) rose nationally from 2007/08 to a peak in 2009/10 but has fallen in real terms over the last two years.[3] Overall while nationally gross current expenditure did continue to rise year on year in cash terms from £16.8 billion in 2009/10 to £17.2 billion in 2012/13, it fell in real terms. All but the North East had a peak of expenditure per 10,000 population in 2009/10, with most also reporting their lowest level of expenditure in 2012/13.

As might be expected the biggest area of adult social care spending (just over half) is on people 65 and over followed by spending on people under 65 with a learning disability (around a third). However, over this five-year period there has been a general decline in the proportion being spent on older people with a corresponding increase in the proportion spent on people under 65 with a learning disability and this pattern is consistent across all regions.

There were 139,685 learning disabled clients of working age known to all the 152 councils across England in 2012/13.[4] Out of this, 102,350 were living in their own home or with their family and friends. This represents a national average of 73%. There was considerable regional variation: in the North West, the proportion was 85% but in London, the South West and the West Midlands rates were around 66-67%.

Almost half (49%) of these people were living in settled mainstream housing with family or friends (including flat-sharing). A further quarter were in supported accommodation, lodgings or group home (accommodation supported by staff or resident caretaker), and 15% were tenants in accommodation provided through local authorities, arm's length management organisations, registered social landlords or housing associations.

Expenditure on direct payments for adults was £1.1 billion in 2011/12 compared to £360 million in 2006/07.[3] This is an increase of around 210% in cash terms and around 175% in real terms. The percentage of expenditure accounted for by direct payments to adults has increased, equating to 6% of gross current expenditure in 2011/12 compared to 2% in 2006/07.

The average cost per adult aged 18 and over supported by councils in residential care, nursing care or intensively in their own home was £608 per person per week in 2011/12, a decrease of 2% in cash terms from £623 in 2010/11, and 5% in real terms. For older people, the overall cost of nursing care (£519 per person per week) was similar to that for residential care (£522) but the cost for own provision residential care provided by the council itself was substantially higher than the cost for residential care provided by others (£475).

The average cost of home care was £17.00 per hour, unchanged in cash terms but a 2% decrease in real terms from 2010/11. However the cost of own provision home care in 2011/12, (£35.50) was higher than that for home care provided by others (£14.70). The cost of home care measured as per person per week for all adults was £206. This was highest for service users with a learning disability (£480 per person per week) and lowest for service users with a mental health problem (£140 per person per week)

This link between the commissioning of home care services and the avoidable admissions to hospital is something we intend to explore in next year's State of Care report.

FIGURE 12: Percentage of inspections that met safeguarding and safety standards in 2012/13.

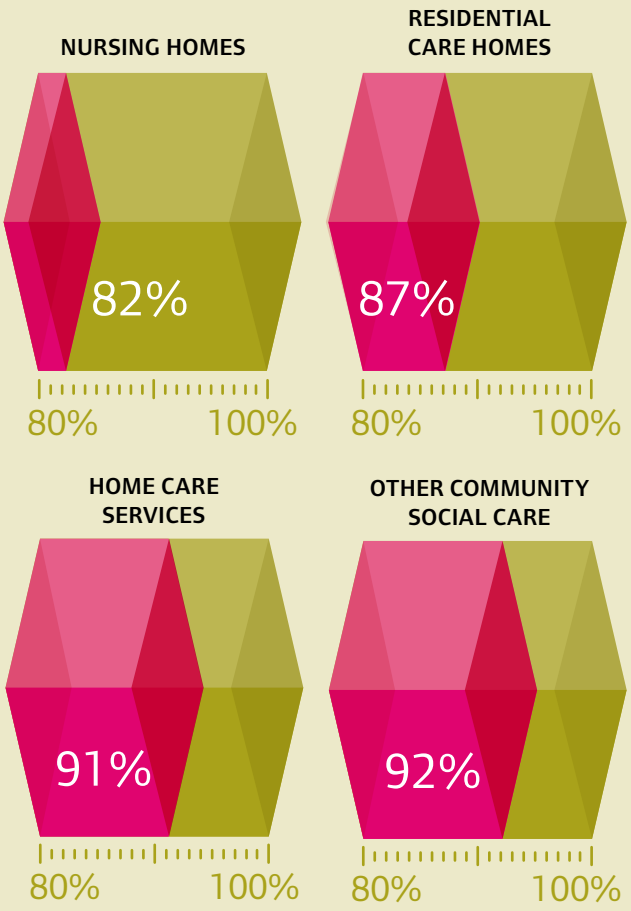
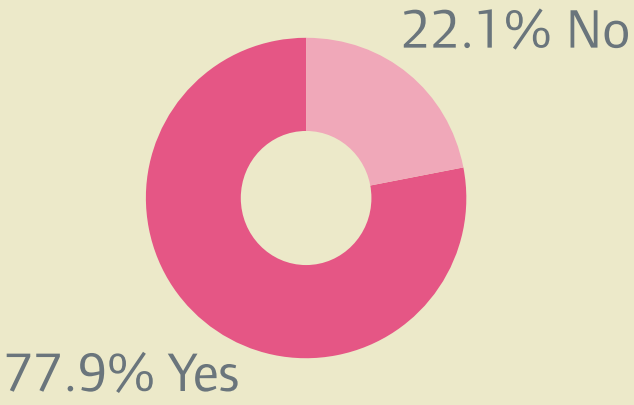


FIGURE 13: Do care and support services help you in feeling safe?



Safeguarding and safety

Our inspectors reported that all types of adult social care service improved the safety of their services in 2012/13.

In particular, services showed a better awareness of their safeguarding responsibilities and the procedures for raising concerns and contacting the local authority safeguarding team.

However, the results still leave a long way to go – particularly for nursing homes where almost one in five inspections found a problem to do with the safety of residents, and for residential homes, where the figure was one in eight. Common problems were:

- Failing to give out medicines safely, and not maintaining adequate records of to who needs which medicine.

EXAMPLE OF IMPROVING CARE

CARE CONCERN (HOMECARE) LTD, CHISWICK

HOME CARE SERVICE HAS A VERY CLEAR WHISTLEBLOWING POLICY

We inspected a home care service in London in November 2012. Relatives of people receiving care told us that they "have peace of mind" and "felt very secure" with the support the care workers gave people. They felt the care workers and office staff listened to them and acted on any concerns they had.

We looked at the staff handbook, which included the policy on whistleblowing. The care workers told us they would raise any concerns with the manager of the agency, and would feel confident in contacting the local authority safeguarding team if they felt their concerns were not acted on.

In the office there was a safeguarding flowchart on display that told staff what to do in the event of a safeguarding issue, and the responsibilities of the manager to report any concerns to the local authority.

The manager also showed us the welcome pack, which they gave to new clients. In this was a fact sheet about the different types of abuse and who they, or their relatives, could contact at the local authority if they had any concerns. Most of the relatives and people we talked to said they were aware of this information.

- Staff not having guidance on how to administer medicines that had been prescribed "as required".
- Not carrying out risk assessments at the start of people's care, or regularly reviewing them.

The third annual survey of adults receiving council-funded care services, conducted by the Health and Social Care Information Centre, took place in 2012/13.[5]

It found more people were happy with the level of support that care and support services had provided in helping them feel safe – 77.9% of the 64,320 respondents to this question, a rise of 2.4 percentage points (figure 13). People in London were the least convinced that the support they got made them feel safe (73.1%); the best region was the South West (82.4%).

Home care services also improved in the year. However, almost one in 10 inspections raised a concern about safety, and in our special programme of inspections looking into the care people receive in their own homes, we found two particular safety issues.

Firstly, continuity of care workers is very important in making people feel safe. Many people have real issues and concerns about consistency and continuity of their care, preferring their care to be delivered by the same care workers. It is extremely important for people in vulnerable circumstances to have their care provided by someone they know and not be faced with a series of strangers in their own home to carry out intimate personal care.

Secondly, we found that a number of care workers were not aware of the proper procedures when they had worries about the safety of the people in their care. It is unacceptable to come across any staff providing intimate personal care to people in their own homes who do not fully understand their responsibilities with regard to safeguarding and whistleblowing.

We found a similar problem in our special programme inspecting the care provided to older people in 500 care homes, looking at issues of respect, dignity and nutrition. In homes caring for people with dementia, including those with a dedicated dementia unit:

- Not all staff caring for people with dementia had the appropriate skills, knowledge and experience.
- Not all staff understood the Mental Capacity Act (which protects people who lack the capacity to make decisions about their own care) or the implications for people they care for.

CONTINUING POOR CARE

CARE HOME STAFF WHO STILL DIDN'T KNOW HOW TO KEEP RESIDENTS SAFE

In November 2012, we re-inspected a nursing home in Bradford, having found poor care when we had inspected in May.

We reviewed a random sample of care records and found there were still inadequate care plans and risk assessments in place. The registered manager told us they had started to review the care plans of the 18 people who lived at the home. However, they had only completed two full sets, with a third in progress. This meant 15 plans had still not been reviewed.

In the new style care plan, we found there were gaps in information and it was difficult to know the exact care needs of the person. There were not always specific plans in place to manage identified risks. For example, one person had a ''high risk'' of developing pressure sores, but there was no care plan in place to tell staff how to manage this. Another resident had fallen and injured their knee. There was no documented review of their moving plan to prevent this happening again.

At the May inspection, staff had not been able to tell us about people's care needs. This was still an issue in November. We talked to three staff members – all three gave us different views about people's needs and the support they required.

Also the home's safeguarding policy was inadequate. It guided staff on how to detect different types of abuse. But it did not tell them to whom they should report alleged abuse.

We served two warning notices on the provider as a result of what we found.

FIGURE 14: Percentage of inspections that met care and welfare standards in 2012/13.

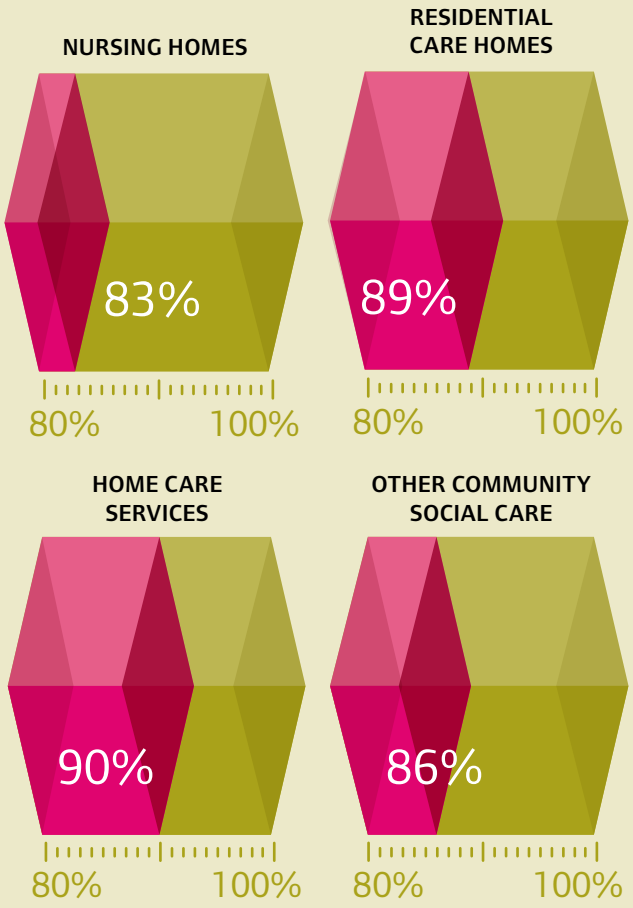
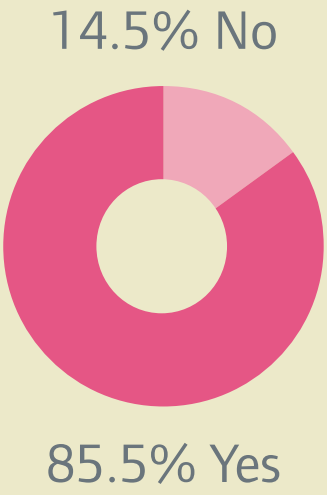


FIGURE 15: Do care and support services help you in having control over your daily life?



Care and welfare

Overall, social care services made some improvements in the effectiveness of the care they provided, compared with 2011/12. Nursing homes made the most progress, with homes in 83% of inspections meeting the standards that people have a right to expect, up from 74% the previous year.

The 2012/13 survey of adults receiving council-funded care services found that people were slightly happier with the help they had received to have control of their daily lives.[5] Of the 64,890 respondents, 85.5% (or 55,481) said they were happy in this way, a rise of 0.8 percentage points since 2011/12 (figure 15). The best region for this was the South East (87.5%); the worst was London (82.9%).

However, we are concerned that in one in eight inspections overall, our inspectors were still not satisfied that people were being cared for effectively.

We repeated our analysis of the impact of dementia on people in care homes, that we first published in our Care Update of March 2013.

In 2012/13 admissions to hospital for potentially avoidable conditions from care home postcodes were 30% higher among those with dementia than similar patients without dementia. The number of multiple emergency admissions was 10% higher for those with dementia than similar patients without dementia (see Technical Annex 3 for more details from this piece of analysis).

We also carried out a separate piece of work to review avoidable admissions specifically of people coming to hospital from care homes between 1 November 2011 and 31 October 2012.[6] Of particular note, we found that:

- 1% of care home postcodes had significantly higher than expected admission rates for conditions relating to infections and hygiene control,

and 2% had significantly higher than expected admission rates for conditions relating to neglect and lack of care.

- Taken together, this equates to potentially 12,900 care home residents that were at risk of going into hospital unnecessarily because of poor hygiene or poor care.
- However, it should be noted that many care homes perform very well in these areas. For each set of conditions, there were 8% of care home postcodes that had significantly lower than expected rates of admission to hospital.

There were also clear geographical variations, with more than a third of local authorities (58 authorities, 38%) having significantly higher than average rates for at least one of the indicators. Of these, 39 were found to be significantly higher than average for two or more of the headline measures.

In our special programme of inspections of 500 care homes, looking at issues of respect, dignity and nutrition, our inspectors found many homes that promote a culture of care that puts residents first:

- Staff clearly understood the preferences and care needs of residents.
- Care home providers made sure the ways staff talked to and cared for people were respectful and appropriate.
- Staff saw residents as individuals and supported them to live as independently as possible.
- Care home providers made sure that social interactions between staff and residents were seen as important as providing practical care needs.

But we also found that in one in six care homes (87 homes) people were not always supported to eat and drink sufficient amounts. Staff and managers in a number of homes did not always give people a choice of food or support them to make a choice, failed to identify or provide the support needed by people who were at risk of malnutrition, or did not ensure that there were enough staff available to support people who needed help to eat and drink.

In our themed inspections of home care services, the issue of poor care planning came up many times. Assessing people's care needs and planning their care is fundamental to delivering services. It requires high priority in terms of regular reviews and updates to make sure that care plans reflect people's current needs and preferences. This allows any changes in needs to be quickly identified and monitored. Managers and care staff must make sure they regularly assess the quality of care plans and make sure they form part of staff development plans.

Reablement and rehabilitation services are designed to assist patients who have experienced changes in their health as a result of illness, injury, or surgical procedure. The primary aim of these services is to work with patients to restore independence, through addressing any physical limitations that result from the health episode and by introducing adaptations in order to reduce the overall impact on their lives.

Data from the Adult Social Care Outcomes Framework for 2012/13 shows that the proportion of people being offered rehabilitation or reablement services increases with age.[4] In England, 7.9% of adults aged 85 and over were offered the service compared to 3.5% and 1.2% for adults aged 75-84 and 65-74 respectively.

However, the effectiveness of these services – in terms of the proportion still at home after 91 days – declines as age increases, and makes readmission more likely. In England, for those aged 85 and over, 78.0% were still at home after 91 days. For people aged 75-84 and 65-74 it was 83.7% and 85.8% respectively.

Overall there was a slight decline in the proportion of all people 65 and over who were still at home 91 days after discharge from hospital: from 82.7% in 2011/12 to 81.5% in 2012/13.

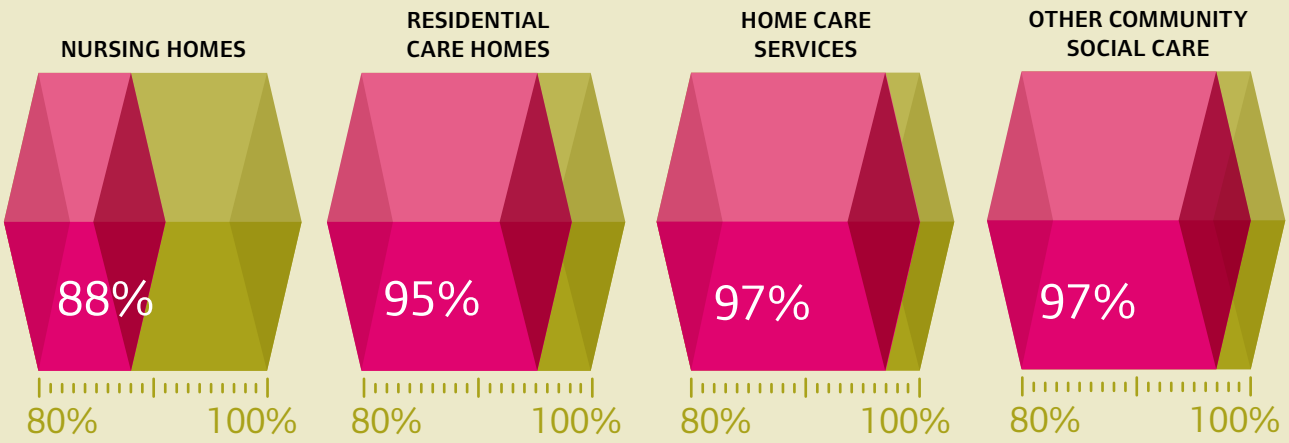
The Yorkshire & Humber region had the lowest proportion of older people, both overall and for each age group offered rehabilitation/reablement services following discharge from hospital.

London had the highest proportion of people still at home 91 days after discharge both overall and for each of the three age groups considered. The East Midlands had the lowest proportion overall and for two of the age groups (65-74 and 85 and over).

83%

of nursing home inspections met the care and welfare standards that people have a right to expect.

FIGURE 16: Percentage of inspections that met respect and dignity standards in 2012/13.



Respect and dignity

Of the five areas that we focus on, social care services performed best in respect of ensuring that people are treated with dignity and respect.

However, in our focused inspections of 500 care homes looking at issues of respect, dignity and nutrition, our inspectors found that people living in one in six of the care homes inspected (80 homes) did not always have their privacy and dignity respected or were not involved in their own care. Staff and managers in these homes:

- Talked to people using inappropriate words or manners.
- Did not close doors when providing personal care, or did not give people somewhere to keep their possessions securely.
- Did not find out how people preferred to be cared for or spend their time.
- Failed to provide choices of activities and options for people to support their independence – particularly for people with dementia.

We also found a simple indicator of whether a care home would treat a person with a caring attitude: homes that recorded people's choices and decisions about their care were more likely to be meeting the standard about involving people and treating them with respect (91%) than those that had not (41%).

Likewise, in our special inspections of home care services one indicator of better performance stood out. We asked on every visit if people's preferred

EXAMPLE OF IMPROVING CARE

BETHEL HOUSE, BARTON-ON-SEA, HAMPSHIRE

THOUGHTFUL, COMPASSIONATE CARE

We observed how staff interacted with people who lived in the home. They talked to people in a kind way and were attentive to their needs when they requested help or appeared confused. Staff made eye contact with people when talking with them, stroked their arms gently to get their attention and calmly assisted people who needed help.

We talked with two care staff who described how they ensured people's privacy and dignity was maintained. For example, they told us that they used a towel to cover people up when they were giving them personal care to preserve their dignity. They also told us that they encouraged people to wash themselves where possible as this helped promote their independence.

They described the importance of making sure that care was given in private and that, when health professionals visited the home, consultations were carried out in people's own bedrooms rather than in communal areas.

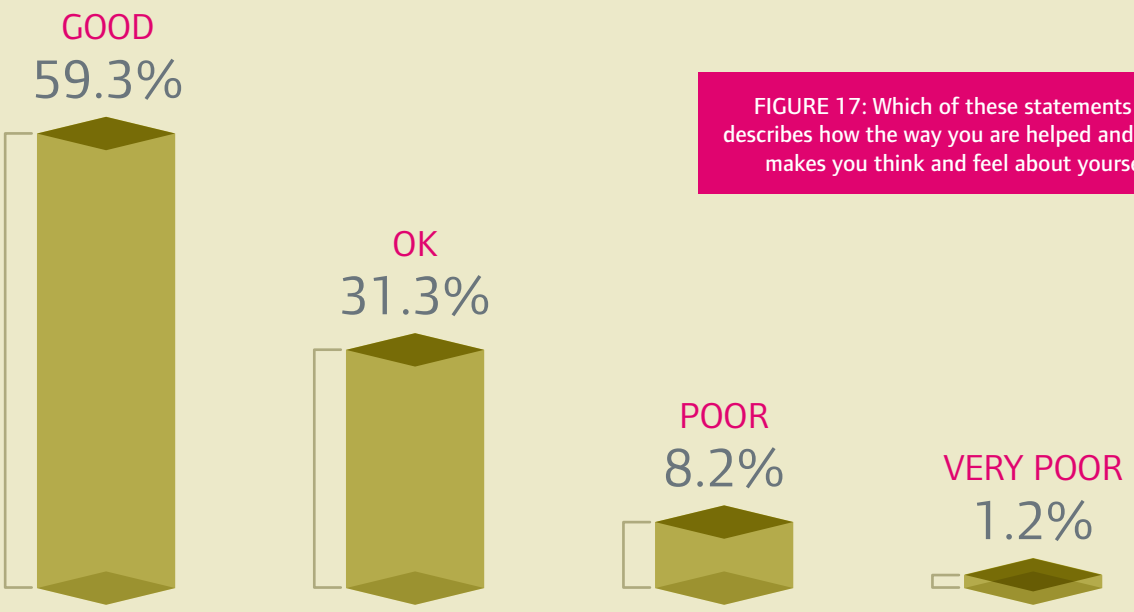


FIGURE 17: Which of these statements best describes how the way you are helped and treated makes you think and feel about yourself?

name was documented in the care provider's records. Where this was documented (in 90% of services), 98% of services met the standard on respecting and involving people. Where it was not, only 78% of services met the standard.

In the 2012/13 survey of adults who receive council-funded care services, more people said that they had as much social contact as they wanted with people they liked – up 0.9 percentage points from 2011/12 to 43.2%.[5] Despite this improvement, almost a quarter of people (22.8%) either had some social contact but did not feel it was enough, or had little social contact and felt socially isolated. People in the Yorkshire & Humber region reported the most positive experiences (46.7%) and the East Midlands the least (39.4%).

Also improved was the ability of people to spend their time as they wanted and doing things they valued or enjoyed, up 1.0 percentage point from 2011/12 to 32.5%. But this still left 7.4% of respondents saying they did nothing they valued or enjoyed with their time.

Being treated with dignity and respect cuts to the heart of what it should be like when people need to call on social care services. People want to retain as much independence as possible, and keep as much control over their lives as possible. The survey asked people whether the way they were helped and treated made them think and feel better about themselves:

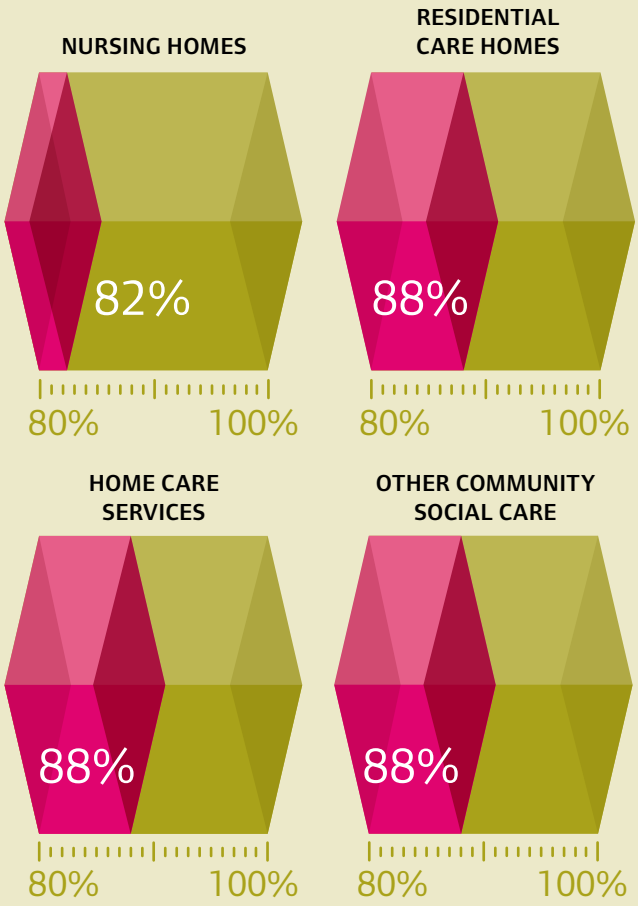
- 59.3% of respondents said it did, which is up by 0.6 percentage points from 2011/12.
- 31.3% said it did not affect the way they thought and felt about themselves
- 8.2% said this happened sometimes, and
- 1.2% said the way they were helped and treated completely undermined the way they thought and felt about themselves (figure 17).

The most positive responses were from people in the South West; (the least positive from people in the Yorkshire and Humber region and the North East.

88%

of home care inspections met the staffing standards in 2012/13.

FIGURE 18: Percentage of inspections that met staffing suitability standards in 2012/13.



CONTINUING POOR CARE

THE WRONG ATTITUDE RIGHT FROM THE START

At one care home, we saw that there was very little stimulation for people using the service. The members of staff did not interact positively with people or engage with them in any meaningful way.

We observed one member of staff come into the lounge/dining area on starting her shift, walk past the 12 people sitting in the room without speaking or acknowledging any of them, and sit at a table.

After 10 minutes of this, we asked the member of staff if she had spoken to any of the people using the service since she began her shift. She said she had not. We noticed that staff talked more to one another than they did with people using the service.

Suitability of staffing

In terms of care that is able to respond to people's needs, there were some improvements in how providers make sure there are enough staff on duty to meet the needs of the people in their care, and the extent to which those staff are supported through training, supervision and development. The biggest improvement was in nursing homes.

However, overall, this remains a problem area for many services. The relevant staffing standards were met in only 87% of inspections across all social care settings.

In our themed inspections of home care services, we noted that the needs of older people who receive care in their own home are now known to be more complex, and in many cases this will be due to an increased prevalence of dementia. Assessing the care needs of people in their own homes is highly specialised and requires distinctive approaches that recognise the unique nature of the setting where care is delivered.

Staff meetings, development, appraisal and supervision are crucial. However, we found that they are not happening consistently across services. The increasing complexity of the needs of people receiving home care mean that ongoing staff development and training is more important than ever.

We analysed a number of measures to determine the impact that staffing levels have on the care that people receive (see Technical Annex 4 for more detail from this piece of analysis). We took the

workforce measures from Skills for Care's National Minimum Data Set for Social Care (NMDS-SC) database, which we use in our role as regulator. They cover factors such as vacancy and turnover rates, whether registered managers are appropriately qualified, and proportions of staff, or staff hours, allocated to various roles.

Our analysis compared these factors with death notifications from care providers. We found there was a link with higher staff turnover rates, mostly in care homes without nursing provision. This suggests that too many changes in staff may result in gaps in care. We found no correlation with vacancy rates, perhaps indicating that existing staff feel they have to pull together and cover the gaps, provided there is not too much staff turnover. However, these may be due to other factors not accounted for.

Supporting frontline care staff

In the wake of the Francis Inquiry into Mid-Staffordshire NHS Foundation Trust, and reports of failings in other hospitals and care homes, the Secretary of State for Health asked Camilla Cavendish (who has subsequently joined CQC as a non-executive director) to review what can be done to ensure that unregistered staff in the NHS and social care treat all patients and clients with care and compassion.[7]

There are more than 1.3 million frontline staff who are not registered nurses but who now deliver the bulk of hands-on care in hospitals, care homes and the homes of individuals. The Cavendish Review's terms of reference included recruitment, training, supervision, support and public confidence. In social care it said that:

- "Social care support workers are increasingly taking on more challenging tasks, having to look after more frail elderly people. The phrase "basic care" significantly understates the work of this group. Helping an elderly person to eat and swallow, bathing someone with dignity and without hurting them, communicating with someone with early onset dementia; doing these things with intelligent kindness, dignity, care and respect requires skill.
- Social care employers are striving to train, retain and motivate staff under considerable financial pressure. They find it difficult to navigate the sea of vocational qualifications and training courses which has developed in response to changing fashions in government funding. Lack of faith in the system has led to duplication, as employers develop their own in-house courses, and retrain new staff irrespective of what training they have had elsewhere.
- Too many workers do not see caring as a career, with opportunities to progress. The fragmented nature of the sector, lack of faith in qualifications and lack of portable skills do not help. The Review recommended that employers be consulted on the possibility of creating a career development framework for health and social care workers."

In May and June 2013, CQC's inspectors carried out a survey of the induction and preparation arrangements for new care staff in social care settings and in hospitals.

The vast majority of locations reported that inductions do occur for new staff. Induction training was provided in-house in more than half of all cases. Buddying with an experienced worker and shadowing them was the most common approach, and the one cited as the most helpful. E-learning was said to be the least helpful.

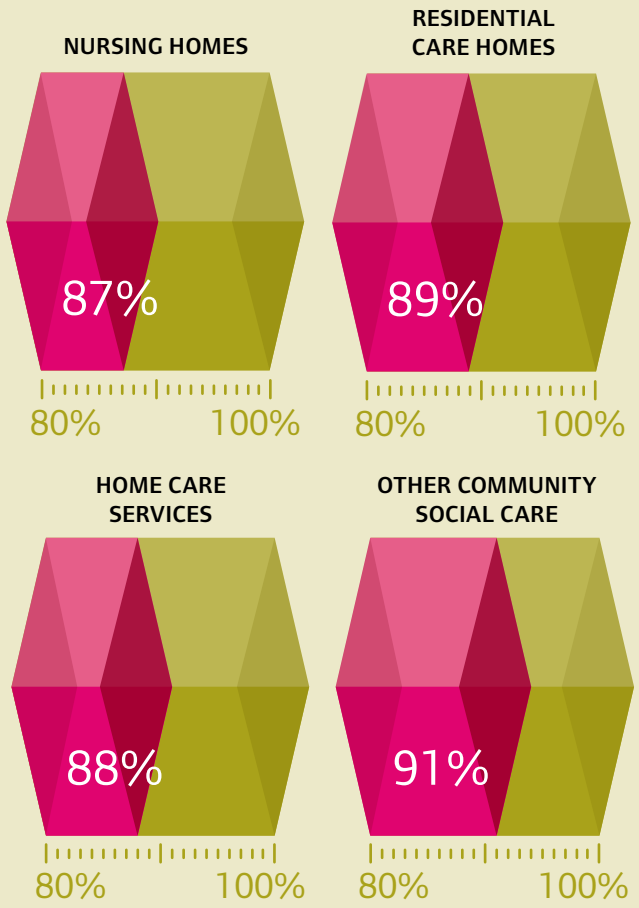
In most cases both managers and new care staff said that the process had "very much prepared" or "quite a bit prepared" the staff to carry out the role. However, a small proportion (1%) of new staff said they felt "not at all prepared".

Where managers said that their staff were not "very much prepared", the most common issues were staff not feeling confident about involving people in planning their own care or recognising the early signs of changing condition and what to do about it. Although interpretation, and care assistant responsibilities, for these areas varied across settings.

Some social care staff said they had been asked to provide care or support unsupervised where they felt unsafe (3%) or unprepared (5%).

This area will be a focus for us under our new modes of regulation for adult social care, in particular when we ask whether services are well-led.

FIGURE 19: Percentage of inspections that met monitoring quality standards in 2012/13.



CONTINUING POOR CARE

MANAGERS FAIL TO SUPPORT NEW AND INEXPERIENCED STAFF

During an inspection of a home care agency, we found that it was not a care service that people could rely on. New and inexperienced staff were not adequately supported by the agency to care for people safely and to an appropriate standard.

When we carried out a follow-up inspection, we could see that the care visits were still not being managed well. Some hadn't happened due to errors in the visit rotas. And care workers had still not received the training they needed to carry out their work safely and competently.

There had been a high turnover of care workers at the agency, suggesting a lack of support, supervision and training for staff. Overall the leadership and organisation at this agency was poor, and it was consistently affecting the ability of staff to meets people's needs.

Monitoring quality

Big challenges remain for the adult social care sector as a whole in terms of making sure good management and leadership is in place to ensure the safety and welfare of the people they care for.

Despite improvements, our inspectors found shortcomings in at least one in 10 inspections. In nursing and residential homes, the biggest problem continued to be the lack of a good registered manager in place at the care home, or often the absence of one altogether.

Very often, all it took was a change in registered manager following action by CQC for the quality of care, and the experience of residents, to be dramatically improved.

In our programme of home care inspections, the most common theme related to late or missed calls. This has a significant impact on people using services, given their dependency on care workers. Being dependent and having to wait for a visit from their care workers left many people feeling vulnerable and undervalued.

We found that managers in some providers were failing to assess the impact of late or missed calls, and therefore failing to monitor and address this vital element of delivering care. All providers need to learn from those that are delivering high quality care.

PART TWO

NHS SERVICES

In the aftermath of the failures of care at Mid Staffordshire NHS Foundation Trust, our inspectors' biggest concern in 2012/13 was that acute hospitals made no improvement in assessing and monitoring the quality of the care they provided.

KEY FINDINGS

In 2012/13 we found:

NHS COMMUNITY HEALTH CARE:

One in eight inspections still found that patient safety was being put at risk.

Staffing was also an issue, with one in 10 inspections finding a problem.

NHS MENTAL HEALTH, LEARNING DISABILITY AND SUBSTANCE MISUSE SERVICES:

There were improvements in ensuring the care and welfare of people with a mental health problem or a learning disability. However, we still uncovered problems in one in eight inspections.

Staffing issues were proving the most difficult problem to resolve, with no improvement and one in 10 inspections raising concerns.

We also found no improvement in safety and safeguarding, or in hospital patients being treated with dignity and respect.

Like adult social care, around half (47%) of the problems we uncovered in the NHS in 2012/13 had a 'major' or 'moderate' impact on patients. This is a deterioration from the previous year (figure 20). As a result, we increased our enforcement action. Our average enforcement rate for NHS providers (that is, the proportion of times we took enforcement action when we found standards were not being met) more than doubled, from 3% in 2011/12 to 6.5% in 2012/13.

NHS HOSPITALS:

Overall our inspectors found poor care in around one in 10 of all hospital inspections.

Hospitals did not improve their assessment and monitoring of the quality of the care they provided.

There was also no improvement in safety and safeguarding, or in treating people with dignity and respect.

Despite some improvements, people in hospitals who have dementia continued to have poorer outcomes. In 2012/13 the number of patients with dementia who died in hospital was more than a third higher (36%) than similar patients who did not have dementia. Those with dementia stayed in hospital more than a quarter longer (27%) than those without dementia.

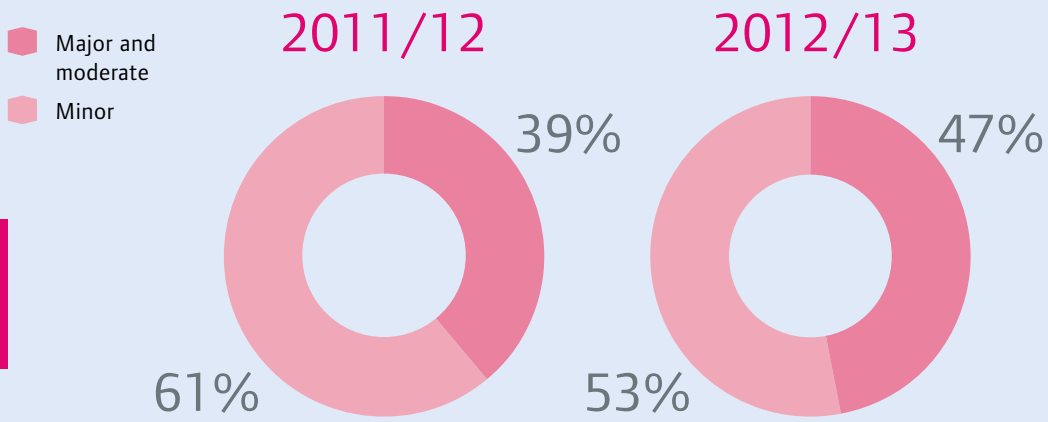


FIGURE 20: When we found a problem in the NHS, what effect did this have on patients?

NHS provision

The ongoing consolidation in the number of NHS providers and locations continued, with the number of providers falling from 291 at the end of 2011/12 to 261 at the end of 2012/13, and the number of locations decreasing from 2,396 to 2,179.

The number of NHS hospital locations and NHS mental health, learning disability and substance misuse services fell, but there was an increase in community healthcare locations registered with CQC.

We have put tables in appendix 2 showing the number of registered locations in the different regions of England, and the average population (based on the 2011 census)[2] per location for:

- People overall
- Older people aged 65 and over
- People with bad or very bad health
- People who are limited in their day-to-day activity.

For NHS hospitals, the South West has the lowest number of people per hospital in all four categories. In contrast Yorkshire and the Humber region had the largest number of people per hospital for all of these characteristics.

The South West had the highest number of people 65 and over per NHS community location as well

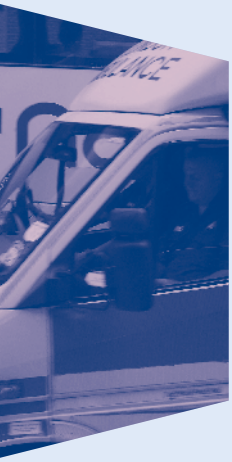


TABLE 2: NHS locations registered with CQC

	2011/12	2012/13
TOTAL NHS LOCATIONS	2,396	2,179
*CONSISTING OF**		
NHS HOSPITAL LOCATIONS	1,003	976
NHS MENTAL HEALTH, LEARNING DISABILITY AND SUBSTANCE MISUSE SERVICES	746	709
NHS COMMUNITY HEALTHCARE LOCATIONS AND & GP OUT-OF-HOURS SERVICES	1,079	1,157

* Locations may offer more than one type of service. Therefore there is overlap within these location figures.

TABLE 3: NHS overnight beds.

	ALL WARD TYPES (OVERNIGHT)			
	2010/11	2011/12	2012/13	% CHANGE (SINCE 2010/11)
Q1	144,455	137,354	137,287	⌄ 5.0%
Q2	141,477	138,525	135,559	⌄ 4.2%
Q3	141,630	137,963	136,111	⌄ 3.9%
Q4	142,319	140,454	138,239	⌄ 2.9%
ANNUAL AVERAGE	**142,470**	**138,574**	**136,799**	⌄ **4.0%**

TABLE 4: NHS daycase beds.

	ALL WARD TYPES (DAYCASE)			
	2010/11	2011/12	2012/13	% CHANGE (SINCE 2012/13 - 2010/11)
Q1	11,783	10,692	11,532	⌄ 2.1%
Q2	10,990	11,460	11,717	⌃ 6.6%
Q3	10,916	11,316	11,812	⌃ 8.2%
Q4	11,328	11,715	11,916	⌃ 5.2%
ANNUAL AVERAGE	**11,254**	**11,296**	**11,744**	⌃ **4.4%**

as the highest number of people limited in their day-to-day activity. However the East had the highest number of people per NHS community healthcare location overall.

NHS BED NUMBERS

Between 2010/11 and 2012/13, the number of available overnight beds under the care of consultants for all NHS wards in England fell by 4% (5,671 beds) (table 3).[8] Beds specifically for people with learning disabilities saw the greatest fall of 18.6% (or 408). In contrast, there was a rise of 4.4% (or 490) in the number of daycase beds for all ward types between 2010/11 and 2012/13 (table 4).

Overall, apart from in maternity wards, there has been a general decline in the availability and use of overnight hospital beds and a corresponding increase in daycases since 2010/11. It is worth noting that while there was little change in the proportion of overnight beds that were occupied, there was an increase in occupancy rates for daycase beds (from 82.1% occupancy to 86.0%).

COMPLEX CONDITIONS

With an ageing population, there are more and more older people in hospital. Between 2006/07 and 2012/13, the proportion of all adult patients aged 75 and over slowly but steadily increased for both elective (19.4% to 20.8%) and emergency admissions (31.7% to 34.5%) – with more of an increase among emergency admissions.[6]

And people going into hospital increasingly have complex conditions and comorbidities (that is, more than one illness or condition at the same time). The 'Charlson score' is a measure of comorbidity - it gives an indication of how complex a patient's condition is. Between 2006/07 and 2012/13 the mean Charlson score increased for patients in all age groups admitted both in an emergency and for elective procedures. It should be noted that at least some of this increase will have been due to improvements in coding practices. The increase was steeper for those in the older age groups, particularly for people aged 75 and over. Figure 21 shows the figures for emergency admissions.

FIGURE 21: Mean Charlson score for emergency admissions, by age group.

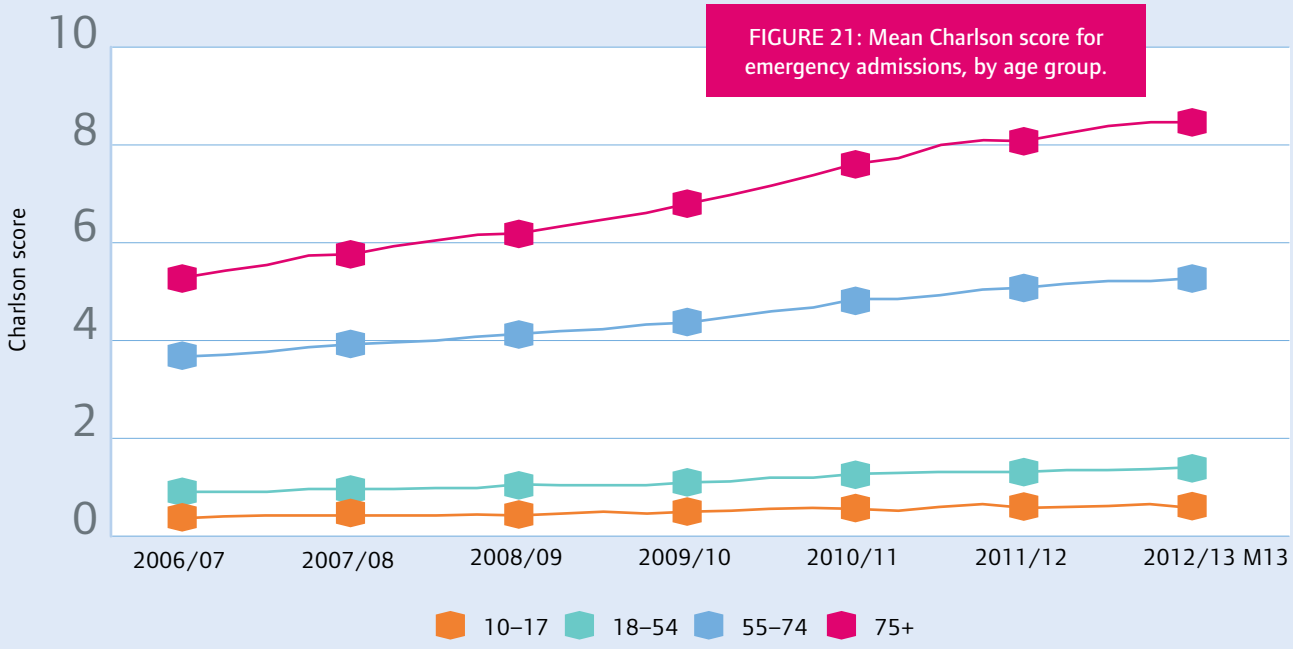
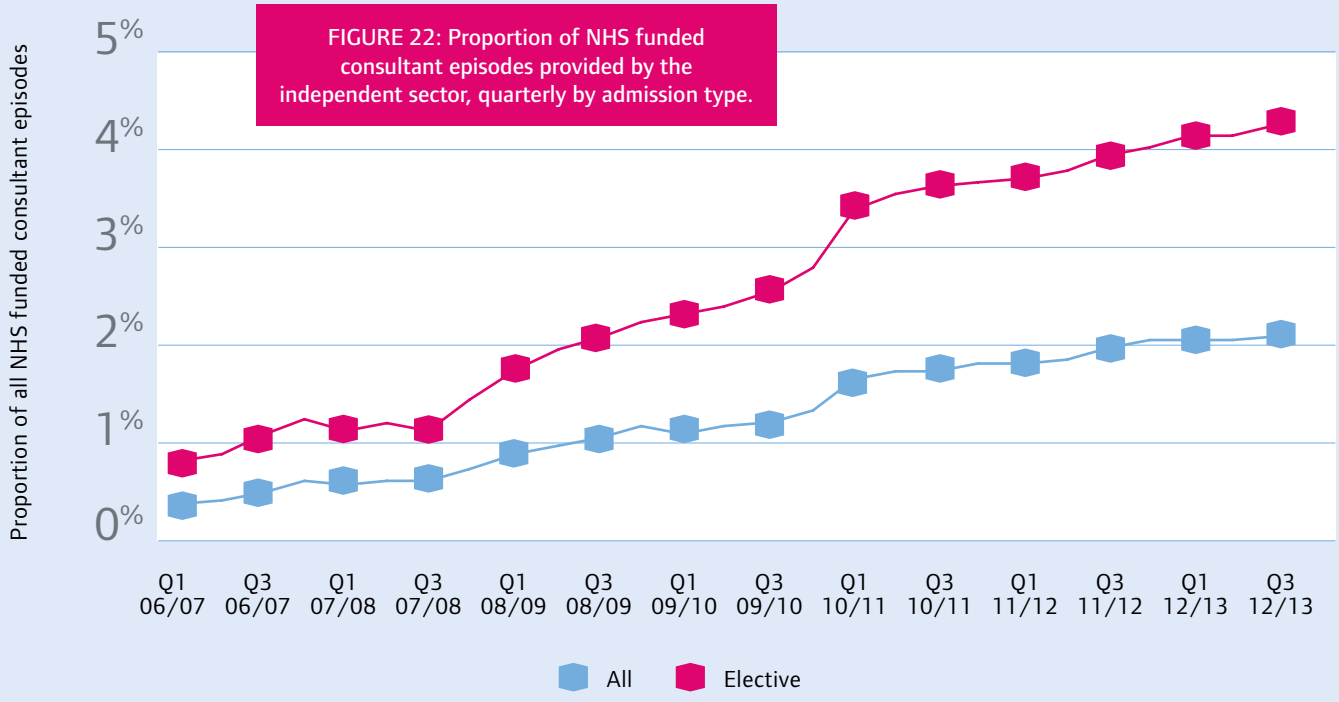


FIGURE 22: Proportion of NHS funded consultant episodes provided by the independent sector, quarterly by admission type.



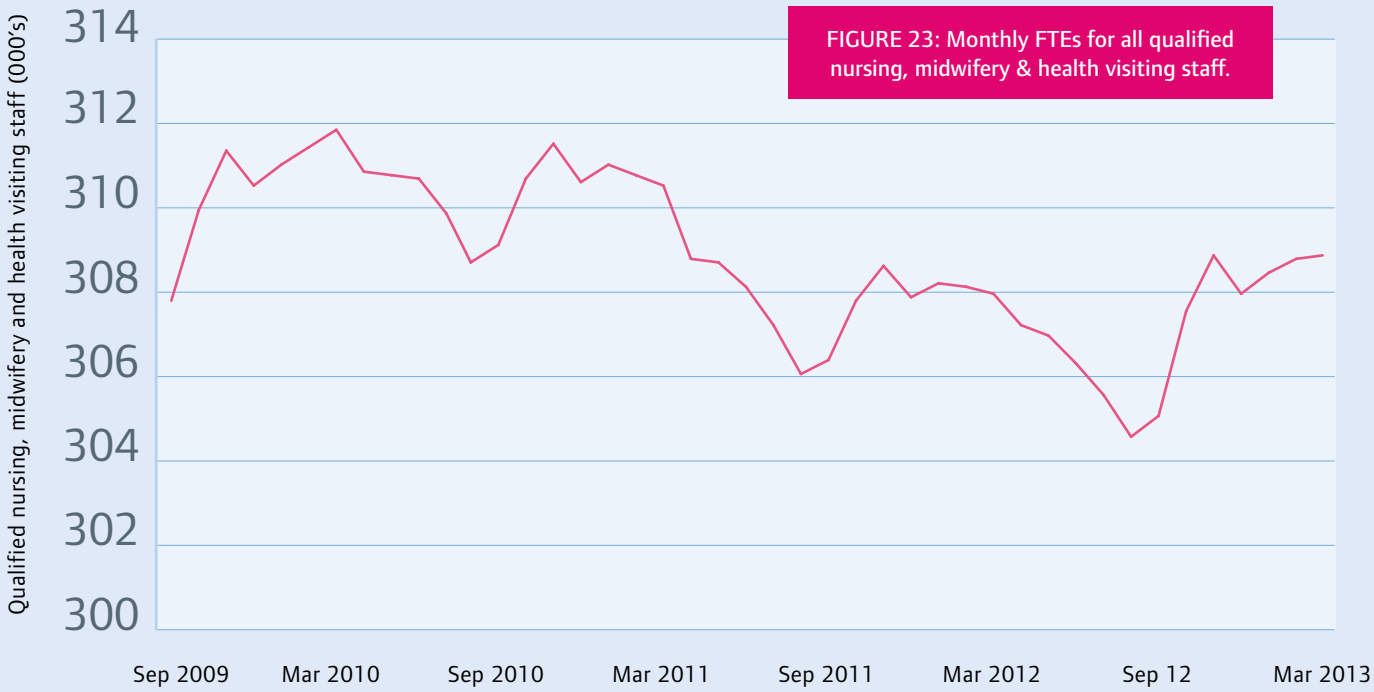


FIGURE 23: Monthly FTEs for all qualified nursing, midwifery & health visiting staff.

However, the impact on emergency departments is that much greater – the Charlson scores among the emergency admissions increased more between 2006/07 and 2012/13 than the scores for elective admissions. This is most notable for people aged 75 and over, in which the mean Charlson score increased by 3.65 among emergency admissions compared with 1.45 among elective admissions between 2006 and 2013.

There was a further knock-on effect on emergency departments – the number of people returning to A&E in the same year rose noticeably. The proportion of patients admitted more than twice a year as a proportion of all those admitted in an emergency rose from 7.6% in 2006/07 to 9.1% in 2012/13.

In addition, in 2012/13 mothers having babies were on average older – the mean age of mothers having babies increased from 28.9 years to 29.4 – and the complexity of maternity admissions (as measured by the Charlson score) also increased.

Between 2006/07 and 2012/13 the total number of NHS-funded consultant episodes increased from 15.8 million to 19.0 million. Emergency consultant-led episodes increased by 21% and elective admissions increased by 25%.

Some of the extra burden on elective procedures has been taken up by private health care providers. The proportion of elective NHS-funded episodes provided in the independent sector increased from 1% in 2006/07 to 4.3% in 2012/13 (figure 22). However this may, in part, be due to improved recording practices for these procedures.

STAFFING IN THE NHS

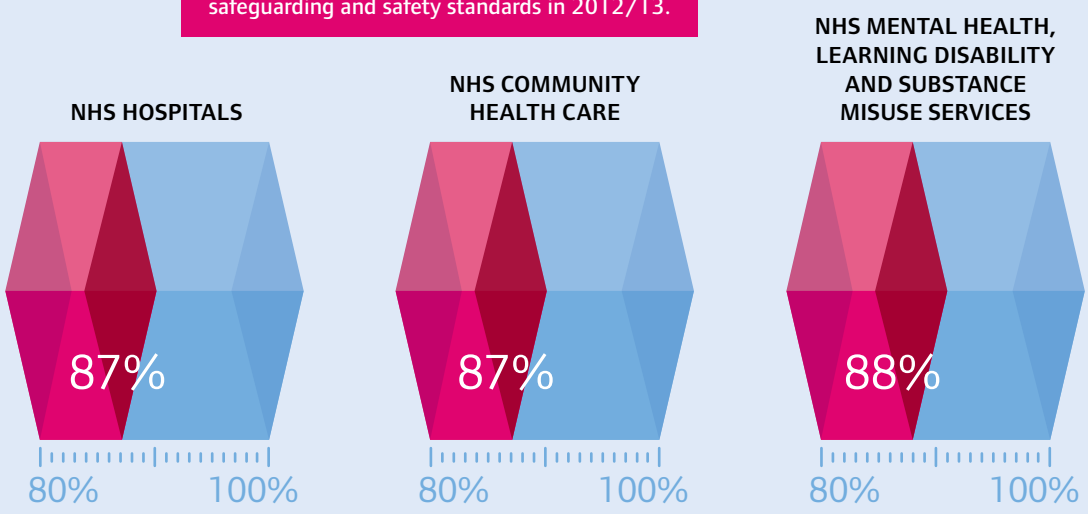
Following falls in the total numbers of all NHS staff in 2010/11 and 2011/12, there was an overall increase of 0.5% in 2012/13.[9]

But not all types of staff have experienced the same trend in total full time equivalents (FTEs). Total numbers of doctors have been on a steady rise, with an increase of almost 5% over the last three years, and there has also been an increase in numbers of 'other qualified' staff (although this group did show a fall in numbers during 2011/12).

Nursing and support staff (the two largest staff groups) showed a similar trend to the national picture with numbers falling during 2010/11 and 2011/12 before starting to rise in 2012/13 (figure 23).

However, there were increases in numbers of

FIGURE 24: Percentage of inspections that met safeguarding and safety standards in 2012/13.



midwives throughout each of the three years and the midwife to births ratio has gradually declined since 2010/11 (despite quarterly fluctuations) to a low of 1 to 32.37 in the last quarter of 2012/13.[6,9] Despite this, the birth to midwife ratio across England has remained well above that recommended by the Royal College of Midwives (one midwife to 28 births in order to ensure the delivery of one-to-one care during labour) throughout the last four years.

Safeguarding and safety

We found very little improvement in the safety of care across NHS hospitals, community healthcare services or mental health and learning disability services. Our inspectors found problems in around one in eight inspections across the three different types of service. Common problems

FIGURE 25: Rate of MRSA apportioned to acute trusts.

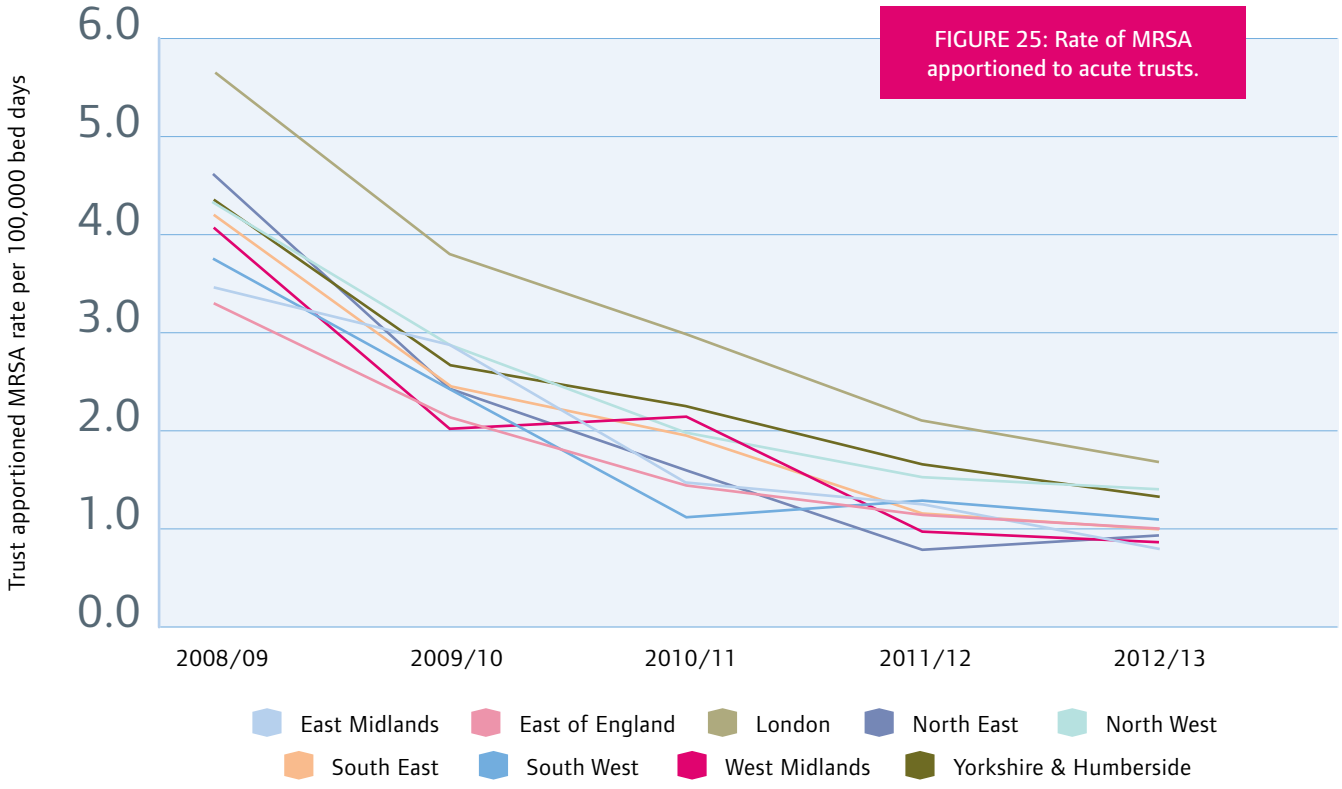
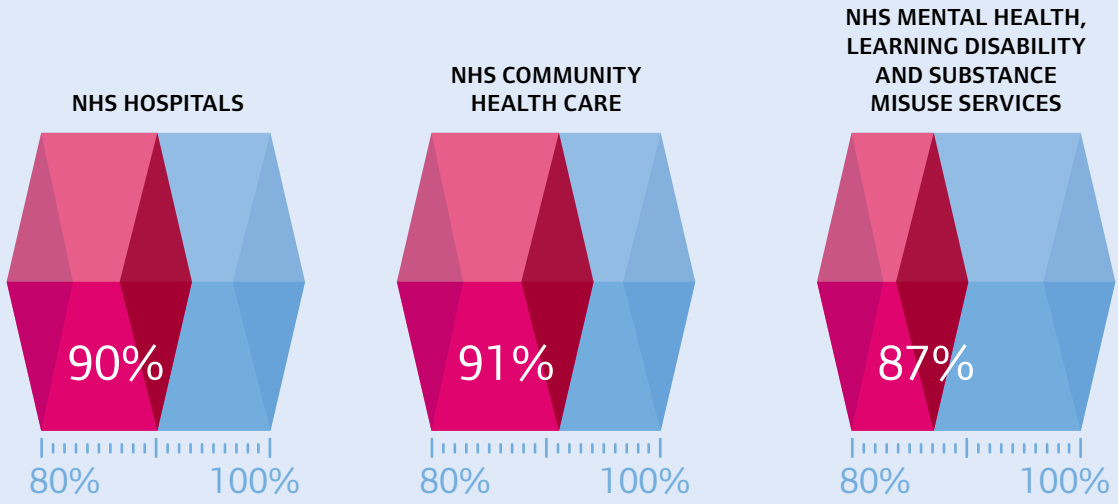


FIGURE 26: Percentage of inspections that met care and welfare standards in 2012/13.



were poor medicines management and failing to carry out and record checks on vital equipment.

There were 275 'never events' in NHS-funded care in 2012/13 – these are serious and largely preventable safety incidents that should not occur if healthcare providers put the available preventative measures in place.[10] Monitoring never events can indicate the safety of an organisation and its patient safety culture. The 2012/13 figure equated to 1.4 never events per 100,000 finished consultant episodes in England – the same as in 2011/12.[6]

The NHS deserves real praise in its continued successful clampdown on healthcare-associated infections.[11] This shows what can be done with the focus, effort and determination of all staff. The rate of MRSA bacteraemia apportioned to acute hospital trusts has continuously fallen year-on-year for the last five years, from 4.3 cases per 100,000 bed days in 2008/09 to 1.2 in 2012/13 (figure 25). This is a 72% reduction in rates since 2008/09.

Similarly the acute hospital rate of *Clostridium difficile* infection has continuously fallen, from 52.9 cases per 100,000 bed days in 2008/09 to 17.3 in 2012/13. This is a decrease in rates of 67% since 2008/09.

Care and welfare

Our inspectors recorded an improvement in terms of delivering effective care and treatment. Overall, 89% of all NHS inspections met the required standards, up from 83% in 2011/12, and every type of service improved.

However, this still means that patients were not being cared for effectively in one in 10 inspections. NHS hospitals and community services performed slightly better than mental health and learning disability services.

CQC's outliers programme monitors a set of indicators about mortality, maternity and hip and knee operations in the NHS.[6] This is to identify unusual patterns of outcomes that could reflect serious concerns about the provision of care.

We analysed the 129 alerts between 1 June 2012 and 31 May 2013 that were either closed as a concern or passed over to our inspection teams for ongoing monitoring.

Some of the more common themes for the mortality alerts, and the areas for improvement, are summarised in table 5. The learning from these has fed into our new Intelligent Monitoring

tool that we launched in October 2013.

NHS hospitals have become much more adept at treating patients as 'day cases', so that people can return home without the need for an overnight stay. We looked at a range of common procedures including appendectomies, cataract replacement, hip replacements, hernia repairs and neck of femur repairs over a number of years.[6]

Between 2006/07 and 2012/13, the proportion of episodes carried out as day cases has increased from 30% (4.4 million out of 14.8 million) to 34% (6.1 million out of 17.7 million). This helps to explain the decrease in the average length of stay in hospital over that time, from 10.1 to 7.6 days. This is a real achievement in ensuring patients spend as little time in hospital as is necessary.

The number of day cases that turned into hospital stays increased by 56% between 2006/07 and 2012/13. This was more than the percentage rise in day cases themselves. However, much of this increase took place earlier, between 2006/07 and 2007/08. More recently, between 2011/12 and 2012/13, NHS hospitals have been successful in reducing the number of day cases that became hospital stays. There is some noticeable regional variation in these figures – day cases that turned into hospital stays were most likely in the North West and least likely in the South West.

Readmission rates were relatively stable for these conditions over that time. The proportion of readmissions per discharge increased only very slightly, from 0.18% to 0.19%.

We have reported previously on the huge impact that dementia has on hospital services. In our Care Update published in March 2013, we found that between July 2011 and June 2012 people with dementia, once in hospital, were more likely to stay there longer, to be readmitted, and to die there. We re-ran our analysis to include data for 2012/13 and found that hospitals have made some gradual progress in caring for people with dementia. For example, the higher death rate for patients with dementia has been

GOOD PRACTICE EXAMPLE

MANCHESTER ROYAL INFIRMARY

ACUTE HOSPITAL STAFF PROUD OF THEIR FOCUS ON GOOD INFECTION CONTROL

A large acute hospital in Manchester that we inspected in November 2012 had very good infection control procedures.

Personal protective equipment was available to staff on all of the wards we visited. We saw staff wearing aprons and using protective gloves when assisting with personal care and at other times such as mealtimes. Housekeeping staff wore aprons and gloves when they were mopping floors and wiping down surfaces.

There were hand washing instructions, gel and paper towels in the patient bathrooms and toilets and in the ward areas used by staff. There were anti-bacterial hand gels at the entrances to wards and in the visitor day rooms. We saw both staff and visitors use the gel when entering and leaving wards. Each patient had a bottle of anti-bacterial gel on a cupboard by the side of their bed.

All parts of the hospital we saw during our visit were clean and we saw staff complying with good practice for the prevention and control of infection. Ward staff performed regular cleaning audits.

We talked to a housekeeper for one ward and they described in detail some of the daily checks they carried out to maintain good standards of cleanliness. We saw a list of weekly tasks for housekeeping staff including dusting high walls and ceilings, cleaning out the fridge in the patient and visitor area, and removing shower curtains for washing. Staff signed to say when the task had been completed.

Staff we spoke with understood the importance of infection prevention and control. One patient said of the housekeeping staff, "There're always cleaning the ward, there's always someone with a mop in their hand" and "They even clean at night".

TABLE 5: Common themes from CQC's monitoring of mortality outliers.

Theme	Areas where improvement was needed
Assessing and monitoring the quality of service	• Improving how trusts monitor their mortality rates and investigate any unusual results • Improving how trusts respond to alerts raised externally
Integrated working across local health services and partners	• Improving end of life care • Making better links with GPs and primary care • Reviewing admissions from care homes • Creating integrated programmes to reduce mortality rates
Recording of information	• Making sure diagnoses are recorded accurately • Making sure coding of data is accurate • Ensuring effective links between clinicians and those whose job it is to record information • Improving how palliative care is coded • Understanding the consequences of inaccurate or imprecise records
Pathways of care	• Improving how to spot early warning signs when a patient's condition starts to deteriorate • Improving the escalation process for managing worsening health
Other clinical issues	• Reducing delays in diagnosis and treatment • Monitoring weekend admissions • Improving patient handovers between clinical teams • Reviewing the staffing of high risk area

declining slowly (figure 27). However, the high numbers are still huge issues of concern. In 2012/13:

- Deaths in hospital among those with dementia were over a third higher (36%) than matched patients without dementia (figure 21).
- Emergency readmissions were over a fifth higher (21%).
- And the length of stay in hospital was over a quarter higher (27%).

Respect and dignity

Our inspectors saw improvements in NHS mental health and learning disability services treating people with respect and dignity. Ninety-three per cent of inspections met the standard, up from 91% the previous year.

These findings were supported by the 2012 survey, commissioned by CQC, of people who use community mental health services.[12] This canvassed the opinions of more than 15,000 service users at 61 NHS trusts, including combined mental health and social care trusts, foundation trusts and primary care trusts that provide mental health services.

When asked "Did the most recent NHS health

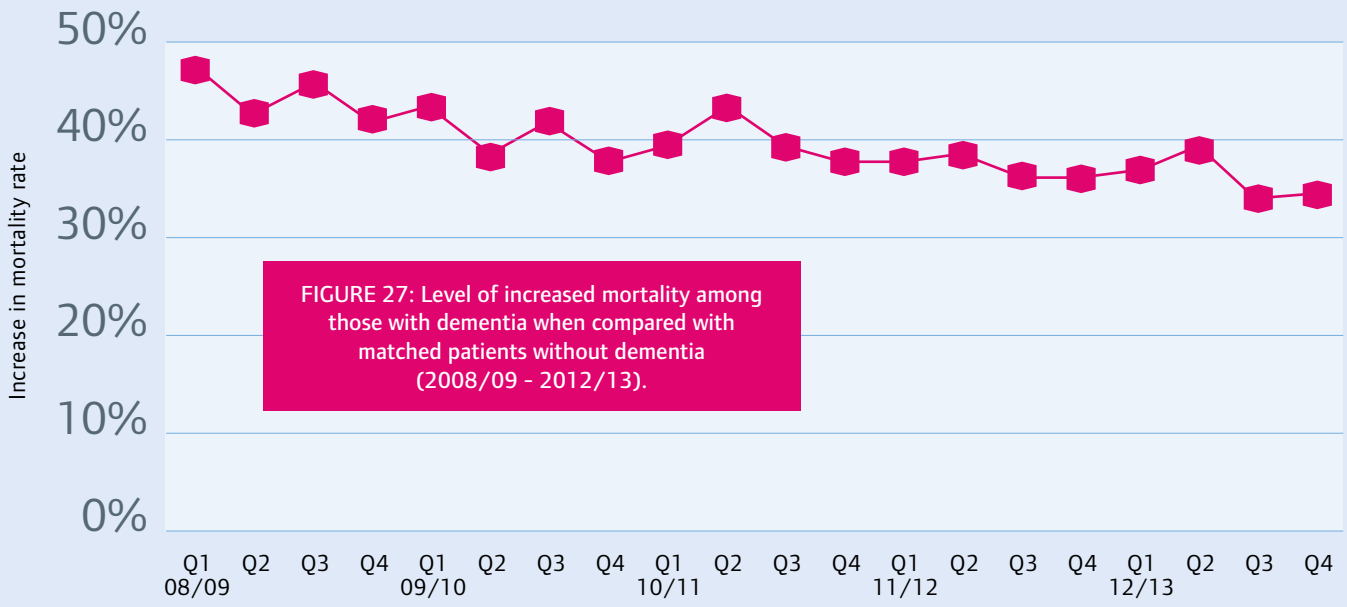


FIGURE 27: Level of increased mortality among those with dementia when compared with matched patients without dementia (2008/09 - 2012/13).

or social care worker you saw for your mental health condition treat you with respect and dignity?", the overall response was very positive. Men and women reported similar levels of being treated with respect and dignity, although younger people reported lower levels than older people.

However, there was no improvement in NHS hospitals in treating people with dignity and respect. We carried out themed inspections in acute hospitals to look at the care provided to older patients. The inspections focused on dignity and nutrition at 50 NHS trusts and followed inspections of 100 hospitals in the previous year looking at the same broad themes.

Comparing these findings with the 2011 review, we

CONTINUING POOR CARE

WARD STRETCHED TO BREAKING POINT

We received a number of concerns from members of the public regarding their experience, or that of other patients, at the acute assessment unit (AAU) of a hospital in Humberside. When we visited, we talked to more than 30 patients and various staff from nursing, medical and the mental health teams.

One person said, "I have been in bed on a drip, I was then put in this chair an hour ago and don't know what's happening. I have a rash, I have told the nurse but I am still waiting".

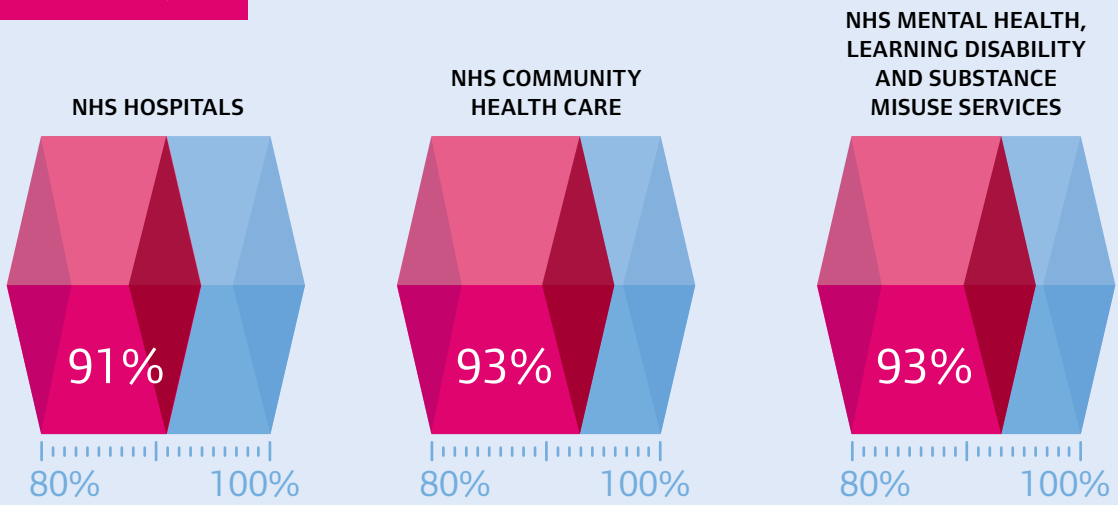
One person was unable to communicate so their relative had been with them since 9pm the previous evening. They had arrived on the AAU about 2am and they were told that the patient notes had gone missing so were still waiting to see the doctor. The patient had had breakfast but the relative had not been able to leave to eat. They did not want to leave in case the doctor appeared. They told us, "I am hungry, thirsty and tired, we have managed a cat nap but it is not easy in a chair". He did not know what was happening to his relative.

We spoke with patients who were awaiting consultation with the mental health team. One person had been waiting since 1.52am and when the mental health team visited the AAU to see another patient at 3.30pm, they did not know the person was waiting. A member of the mental health team told us "The system usually works well."

However, they also told us that AAU staff could not access mental health records and this sometimes led to difficulties. Also, we were told that patients had to be free from the influence of alcohol before a mental health assessment was made, but the three alcometers used to test this had gone missing, despite recent replacement purchases.

Staff we spoke with told us that busy times were "almost impossible" and that "something has to give".

FIGURE 28: Percentage of inspections that met respect and dignity standards in 2012/13.



were alarmed to see that there were fewer hospitals where patients were always treated with dignity and their privacy and independence respected. Out of 50 hospitals, 41 (82%) were meeting the standards for respecting patients' privacy and dignity and involving them in decisions about their care. This compared with 88% of hospitals in the 2011 review. It was clearly unacceptable that this position, poor to begin with, had deteriorated further.

Where we found problems, they included:

- Staff not involving patients enough in care planning, or recording their preferences and dislikes.
- Staff discussing confidential patient information in a public area.
- Patients not having anywhere to lock away their personal belongings.
- Staff 'talking over' patients as though they were not there.
- Patients not always being able to reach call bells, or staff not responding to them in a reasonable time.

In the 2012 inpatient survey, covering more than 64,000 people, most people responded positively when asked to rate their overall experience in hospital.[13] On a scale of 0 to 10, 69% of respondents scored their overall experiences as "8" or above. However, in what should be a caring environment, it is

CONTINUING POOR CARE

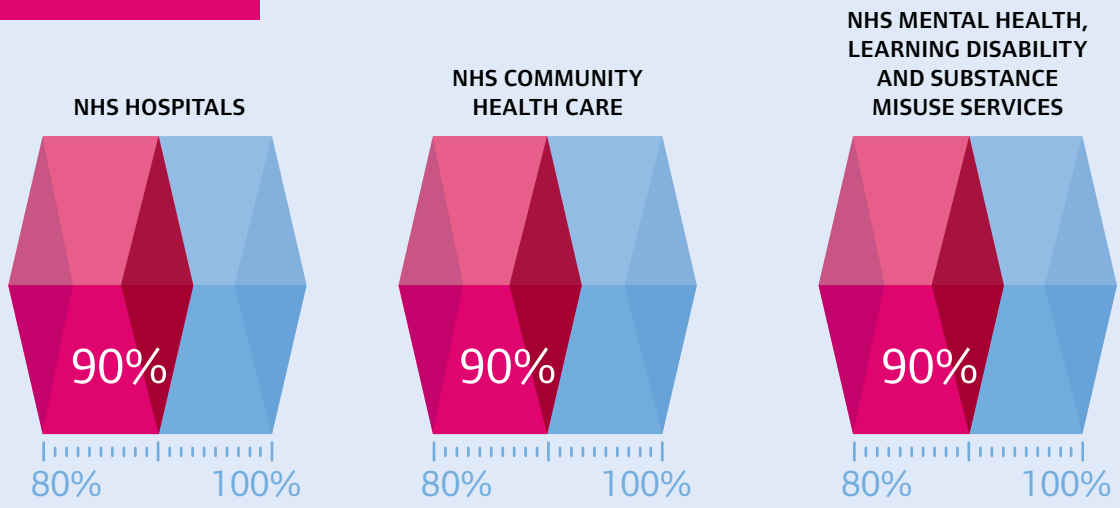
A LACK OF RESPECT AND DIGNITY

"The member of staff stood directly behind a patient and leant over them to cut up their food. They also called across to a colleague who was supporting a patient with eating, 'I think you've got a lost cause there', referring to the fact that the patient was falling asleep during the meal."

"One person said that a member of night staff had been annoyed when they had drawn their attention to a patient who was calling for assistance. The staff member told them not to interfere. This had made them feel frightened to call for help at night. "

"Staff made efforts to maintain patients' dignity by using gowns and drawing the curtains when providing personal care. However, on both wards some curtains did not always close and this did not give people full privacy. "

FIGURE 29: Percentage of inspections that met staffing suitability standards in 2012/13.



a concern that well under half of respondents (38%) "definitely" found someone on the hospital staff to talk to about their worries and fears, if they wanted to – down from 40% in 2011.

Suitability of staffing

We found staffing problems in around one in 10 services across all NHS services in 2012/13. This was despite improvements in both NHS hospitals and community services. The proportion of inspections where hospitals and community services met the relevant standards rose by 6% and 4% respectively, and suggests that these services were using their staff more flexibly and improving

EXAMPLE OF IMPROVING CARE

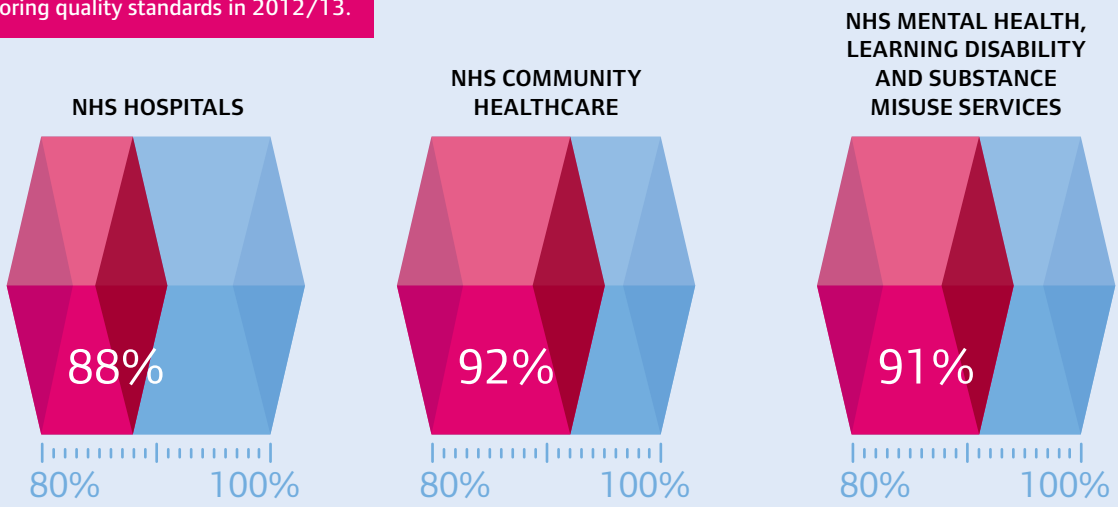
ASSESSMENT AND INTERVENTION SERVICE, KENT AND MEDWAY NHS AND SOCIAL CARE PARTNERSHIP TRUST

A BETTER FOCUS ON PEOPLE'S INDIVIDUAL NEEDS

We carried out an inspection of an NHS inpatient facility for people with learning disabilities who may also have a mental illness and severe challenging behaviour. We found that, although people who used the service had had their needs assessed and their healthcare needs met, the assessment information had not been used to plan care or manage people's behaviours in a way that focused on their individual needs. Also, some people had been in the unit for a long time, and the suitability of the service to meet their needs had not been assessed.

When we re-inspected the service, the care records were much clearer and more focused on people's individual needs. The manager told us that many of the people using the service had complex support needs, but they all had 'moving on' plans. We saw positive interactions between staff and people using the service. People were familiar and comfortable with the staff, and staff communicated with and responded to people in a way that was tailored to their needs. The staff we spoke with could all give examples of people's care and how they communicated, what they liked to do, and how to calm them if they became agitated. All of the care records we reviewed included a one page summary of people's likes and dislikes in an easy read format. All the care plans included people's views about their care.

FIGURE 30: Percentage of inspections that met monitoring quality standards in 2012/13.



the skill mix where it was needed. There were no improvements, though, in NHS mental health and learning disability services.

In acute trusts, the number of doctors, in particular consultants, went up over the last three years. So did the number of qualified nursing, midwifery and health visiting staff, as well as support, central functions and estates staff

Monitoring quality

Worryingly, particularly in the aftermath of the failures of care at Mid Staffordshire NHS Foundation Trust, our inspectors found that acute hospitals were poorer at assessing and monitoring the quality of care they provided. Almost one in 10 of all NHS inspections found a problem in this area, despite slight improvements in community and mental health/learning disability services.

Common issues included:

- Carrying out audits but failing to make sure the learning from these passes on to staff.
- Treating complaints as a reason to apportion blame, rather than an opportunity to learn and improve care.
- Boards not being fully updated on key risk assessment information.

In the 2012/13 NHS staff survey, only half agreed that managers were committed to patient care (see figure 31).[14] A third of staff said that communication between senior managers and staff was not effective. And one in six would not recommend their organisation as a place to work.

We have particular concerns about the reporting of data by providers in mental health services. This affects both NHS and independent services.

As part of our surveillance model development work, we have been examining patterns of reported adverse events and incidents for patients in mental health settings. The key source of data is the Mental Health Minimum Data Set (MHMDS) and it is mandatory for mental health providers to submit data to this.

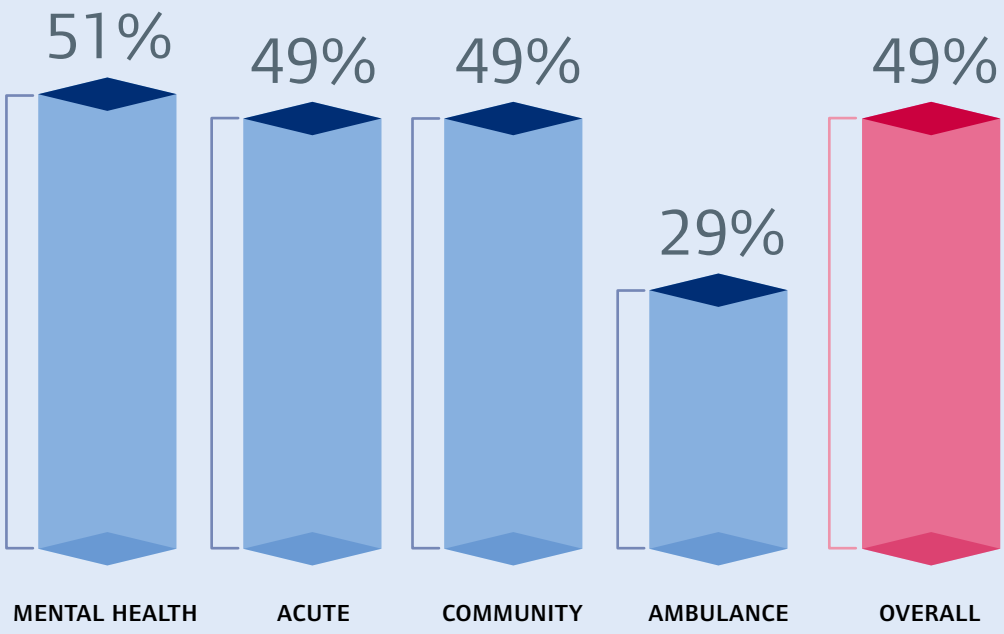
However, our analysis of quarterly MHMDS returns during 2012/13 highlights serious deficiencies in the quality and completeness of mental health data.

It would appear that, in some cases, mental health providers did not report any episodes of seclusion, restraint, assault and self-harm for the whole of 2012/13 – this despite reporting being mandatory.

In addition, for those providers that did report, there were wide variations in the reporting rates for these events, suggesting potential differences in interpretation.

We find it very difficult to understand how mental health providers can assess and monitor the quality of the care they provide if they are not able to accurately supply data about it. Providers must improve.

FIGURE 31: Percentage agreeing/ strongly agreeing that senior managers are committed to patient care.



CONTINUING POOR CARE

FAILURE TO LISTEN TO STAFF CONCERNS OR TO LEARN FROM PREVIOUS INCIDENTS

Following a review of two serious incidents at a major hospital in October 2012, we had significant concerns about the medical and nursing leadership in the children's department to support junior staff and protect children who may be at risk of inappropriate or unsafe care and treatment.

Eight staff we spoke with told us they had informally or formally raised concerns in the last few months regarding poor skill mix and numbers of staff on duty to provide a safe service.

Staff said their concerns had not been listened to by senior managers. We looked at five incident logs in June and July 2012, which showed staff concerns regarding the lack of senior cover, staff numbers and skill mix on the children's wards. We saw little evidence that the provider had taken account of concerns being raised by staff to monitor and manage risks to people who use the service.

One manager had noted on one incident form raised by staff in July 2012, "Despite the fact that the ward was so busy, four of the nurses found time to write incident reports." This does not demonstrate that managers on the paediatric wards were listening to staff to ensure that patient safety was at the heart of its remit. It also showed that staff were not being encouraged to contribute to the overall children's services to ensure the care and treatment provided was safe.

We were told that the head of paediatric nursing had not been working for several weeks and staff, including senior managers, stated that there were strained relationships among the senior medical and clinical staff, which resulted in poor communication and a lack of leadership. They said that this had a negative impact on staff learning from serious incidents, which could impact on the quality of service that people received.

PART TWO

INDEPENDENT HEALTH CARE

Although independent services generally perform better than NHS locations in terms of the safety and quality of care, our inspectors were concerned to see a slight deterioration in the way hospitals assessed and monitored the quality of care.

KEY FINDINGS

In 2012/13 we found:

INDEPENDENT COMMUNITY HEALTH CARE:

- Services performed very well in treating patients effectively, and with dignity and respect.
- Safeguarding and safety was still a concern, with almost one in 10 inspections raising concerns for our inspectors.

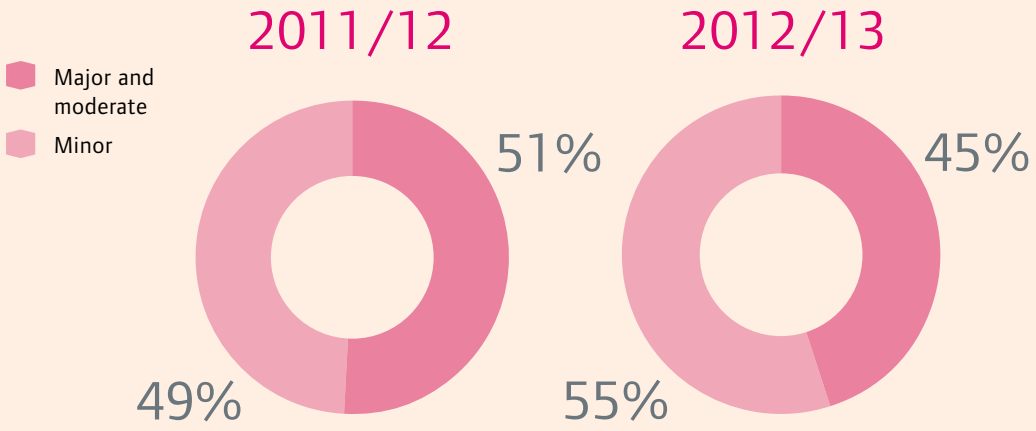
INDEPENDENT MENTAL HEALTH, LEARNING DISABILITY AND SUBSTANCE MISUSE SERVICES:

- These services improved in all five of our main areas of focus, and independent services almost matched the performance of their NHS counterparts in 2012/13.
- However, problems still remained in a number of areas, with safeguarding and safety the biggest concern.

INDEPENDENT HOSPITALS:

- Standards of care in 2012/13 were on the whole good.
- However, overall, hospitals did not improve their performance in terms of monitoring quality.

FIGURE 32: When we found a problem in independent health care, what effect did this have on people who use services?



Overall, safeguarding and safety remained the biggest issue for hospitals, with almost one in 12 inspections not meeting standards.

Independent hospital and community services generally provided effective care and treatment, in an environment where they treat patients with dignity and respect.

The quality of care in mental health and learning disability services lags behind that of other independent services. These services did make improvements in 2012/13, but there is still some way to go.

Private ambulance services showed significant variations in care – while performing well in treating people effectively and with respect and dignity, one in seven private ambulance inspections raised problems around safeguarding and safety, having enough staff to respond to people's needs, or monitoring the quality of service provision.

In almost half (45%) of cases where we found problems, we judged them to have a 'major' or 'moderate' impact on people (figure 32). This was similar to the previous year, although it did represent an improvement.

INDEPENDENT AMBULANCE SERVICES:

- 2012/13 was the first year we inspected all private ambulance services, so this sets a benchmark for the sector going forward.
- Our inspectors found that services provide effective care and treatment and in every case we looked at treated people with dignity and respect.
- But there were concerns about safeguarding and safety, staffing and assessing and monitoring the quality of the service, where around one in eight inspections uncovered problems.

TABLE 6: Independent healthcare locations registered with CQC.

TOTAL INDEPENDENT HEALTHCARE LOCATIONS	**2,764**	**3,020**
*CONSISTING OF**		
INDEPENDENT HOSPITALS	1,542	1,210
INDEPENDENT COMMUNITY HEALTHCARE SERVICES	1,543	1,510
INDEPENDENT MENTAL HEALTH, LEARNING DISABILITY AND SUBSTANCE MISUSE SERVICES	451	446
INDEPENDENT AMBULANCE SERVICES	243	305

* Locations may offer more than one type of service. Therefore there is overlap within these location figures.

Independent healthcare provision

The ongoing growth in independent health care continued in 2012/13, with the number of registered locations increasing from 2,764 to 3,020, a rise of 9% (table 6).

We have put tables in appendix 2 showing the number of registered locations in the different regions of England, and the average population (based on the 2011 census) per location for:

- People overall
- Older people aged 65 and over
- People with bad or very bad health
- People who are limited in their day-to-day activity.

Unsurprisingly, London and the South East have the highest concentrations of independent hospitals per head of population; the lowest are in the North East, closely followed by the North West and East Midlands.

Safeguarding and safety

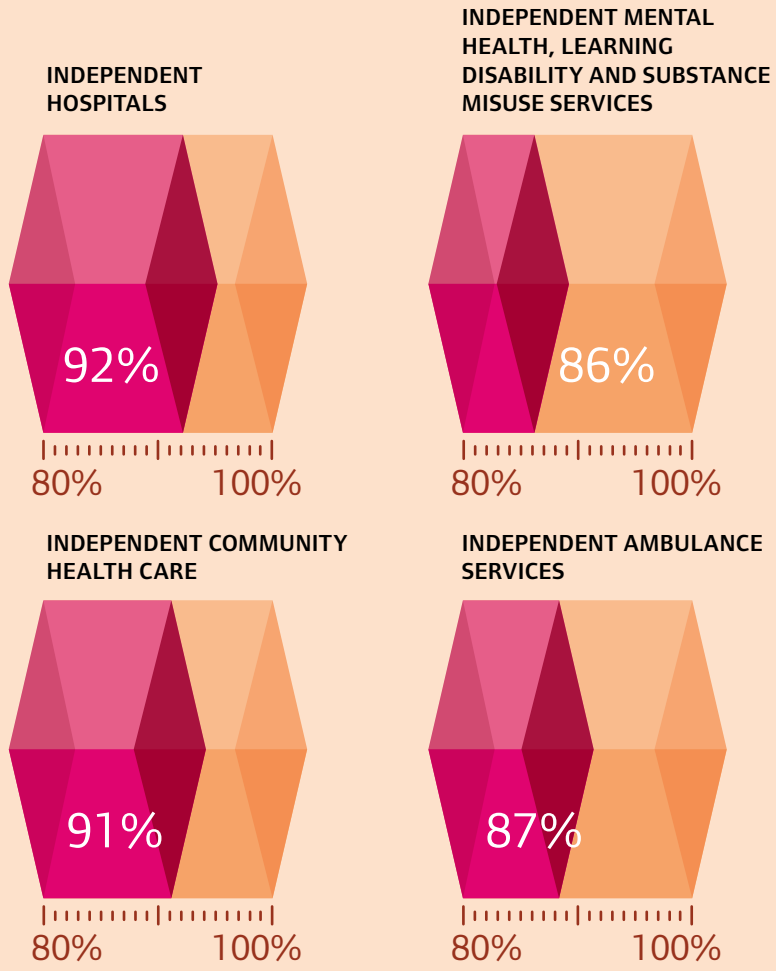
Our inspectors saw some improvements in safeguarding and safety in both independent mental health and learning disability services, and independent ambulance services. There was very slight improvement in hospitals and community services.

However, overall, almost one in 10 inspections found a problem with safety, with the biggest shortfalls in mental health and learning disability services and in independent ambulance services.

1 in 10

inspections overall found a problem with safety, with the biggest shortfalls in mental health and learning disability services and in independent ambulance services.

FIGURE 33: Percentage of inspections that met safeguarding and safety standards in 2012/13.



There was improvement in the way independent hospitals assess patients for the risk of blood clots. Venous thromboembolism (VTE) is a significant patient safety issue and since June 2010 all independent providers of NHS services have had to submit data on the numbers of adult patients who are risk assessed for VTE.[15]

Nationally, the proportion of total admissions receiving a VTE assessment has improved from 92% in 2011/12 to 98% in 2012/13.

EXAMPLE OF IMPROVING CARE

AMBULINE LEICESTERSHIRE

PRIVATE AMBULANCE SERVICE TURNS THINGS AROUND

In December 2012, we re-inspected an independent ambulance service operating from six stations across Leicestershire. This followed a previous inspection in September, in which we had found problems across a range of issues, including the care and welfare of patients, cleanliness and infection control, staffing and monitoring the quality of service.

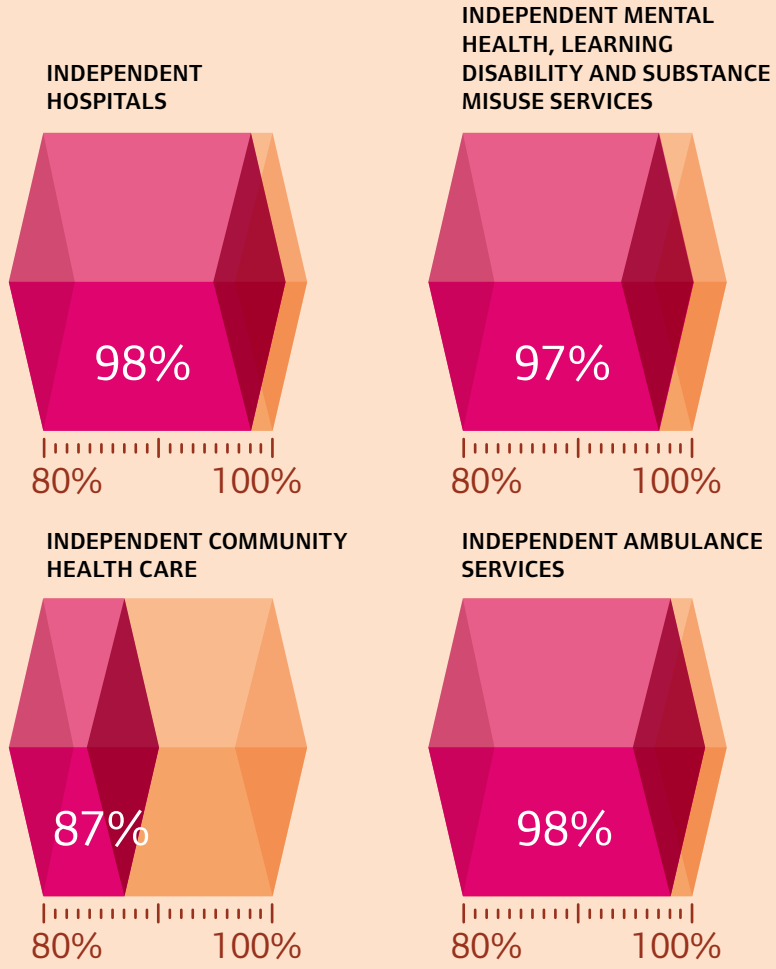
Previously, we had found that data was being lost or incorrectly entered into the mobile phones used by the ambulance drivers. This meant they often went to the wrong bookings. When we returned, a new telephone application had been installed on the drivers' mobiles. This had resulted in a 10% improvement on data being transferred through to drivers. The service had also implemented a dedicated "driver line". This made it easier for drivers to report any issues about the safety and welfare of the patients.

The service had appointed a dedicated training coordinator. The coordinator showed us detailed and comprehensive training schedules that covered key areas of delivering safe and appropriate care. This included safeguarding vulnerable adults, infection control and moving and handling techniques. We visited the new dedicated training area and found that this was well resourced.

The service has initiated a number of audits following our visit in September. These quality checks were now being carried out at each ambulance station in relation to infection control, staff practice, health and safety and security.

We looked at the induction programme for new staff starting with the service and found that infection control formed a significant part of this schedule. Staff told us that the service was now monitoring the cleanliness of both the stations in which they worked and the vehicles being used to transfer patients.

FIGURE 34: Percentage of inspections that met care and welfare standards in 2012/13.



Care and welfare

Our inspectors recorded substantial improvements in the effectiveness of care delivered in all types of independent healthcare setting. The most progress was made by mental health and learning disability providers, with 87% of inspections meeting the relevant standards, compared with 73% in 2011/12. However, these services still have a long way to go to match the other settings, where 97-98% of inspections met the standards.

EXAMPLE OF IMPROVING CARE

CHESWOLD PARK HOSPITAL, DONCASTER

HOSPITAL FOR PEOPLE WITH MENTAL HEALTH PROBLEMS ADDRESSES ITS POOR SECLUSION PRACTICE

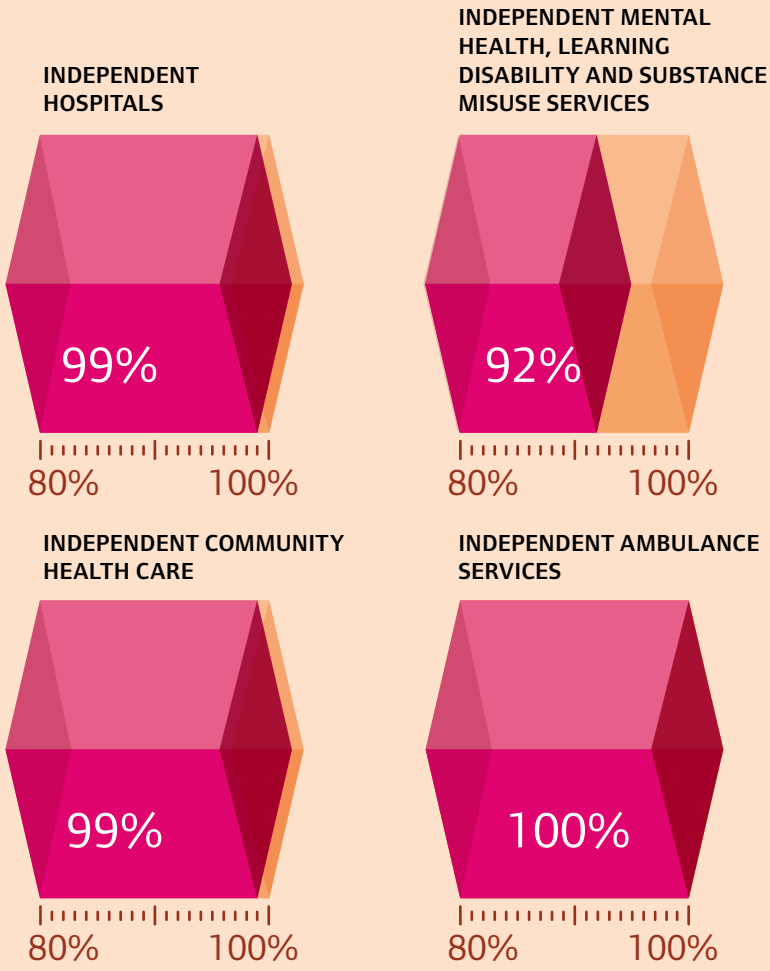
In August 2012 we inspected a secure psychiatric hospital that treats men with learning disabilities, personality disorders and other mental health needs. We found that there were significant gaps in some of the seclusion records and instances when the policy and practice in the hospital was not in line with the Mental Health Act Code of Practice or the National Institute for Health and Care Excellence guidance. We issued the provider with a warning notice.

When we followed up in September 2012, we found that the seclusion records were accurate and fit for purpose. They were clearly written and sufficiently detailed. The format had been improved to provide a clear picture of the care and treatment provided to patients while they were being nursed in seclusion. This included information about food and drinks offered and provided to patients.

The unit manager told us the seclusion policy had been reviewed and was part of the reading list for staff. We talked to a senior nursing assistant, who was able to explain the seclusion process to us. They told us they acted as a 'buddy' for new starters and agency staff, and they would ensure staff were confident to carry out observations of patients in seclusion.

There was evidence that the records were properly reviewed by the management team and any issues regarding the seclusion or the way it was recorded were followed up and addressed.

FIGURE 35: Percentage of inspections that met respect and dignity standards in 2012/13.

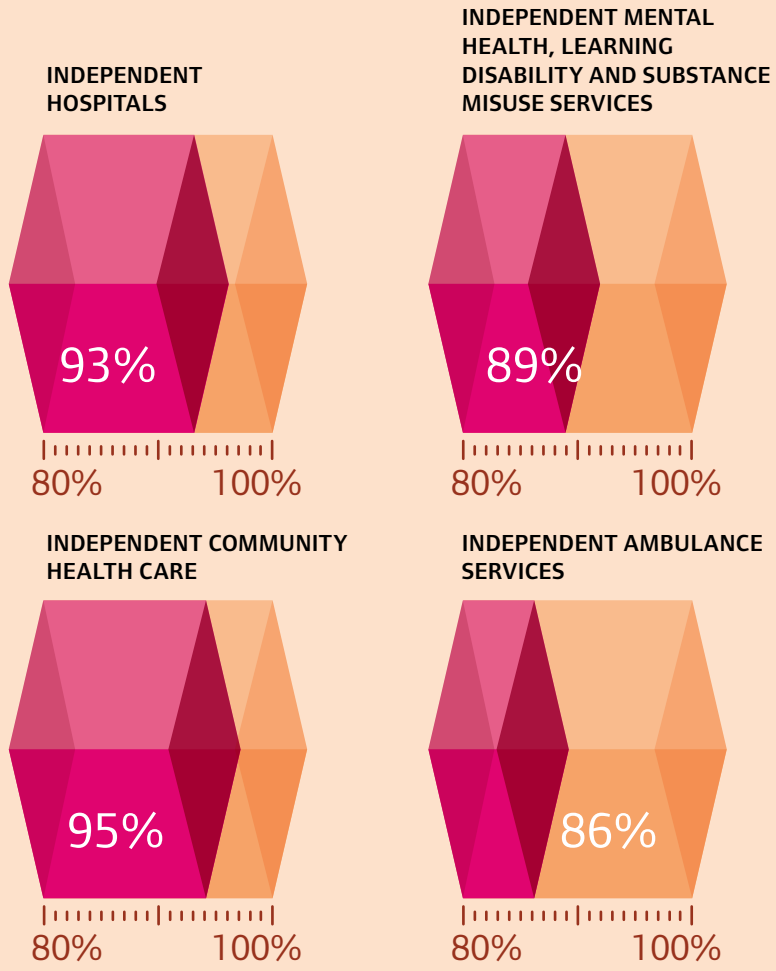


Respect and dignity

The independent sector performs well in treating patients with dignity and respect, and involving people in decisions about their care. Almost all hospitals, community services and private ambulance services met the standards required of them in 2012/13.

In mental health and learning disability services, there was improvement – with providers meeting standards in 92% of inspections, compared with 85% in 2011/12. This performance is now comparable to that achieved by similar services in the NHS. However, a recurring issue continues to be a lack of patients' involvement in their care plans, and patients not always having the opportunity to express their views about how they would like their care to be delivered.

FIGURE 36: Percentage of inspections that met staffing suitability standards in 2012/13.

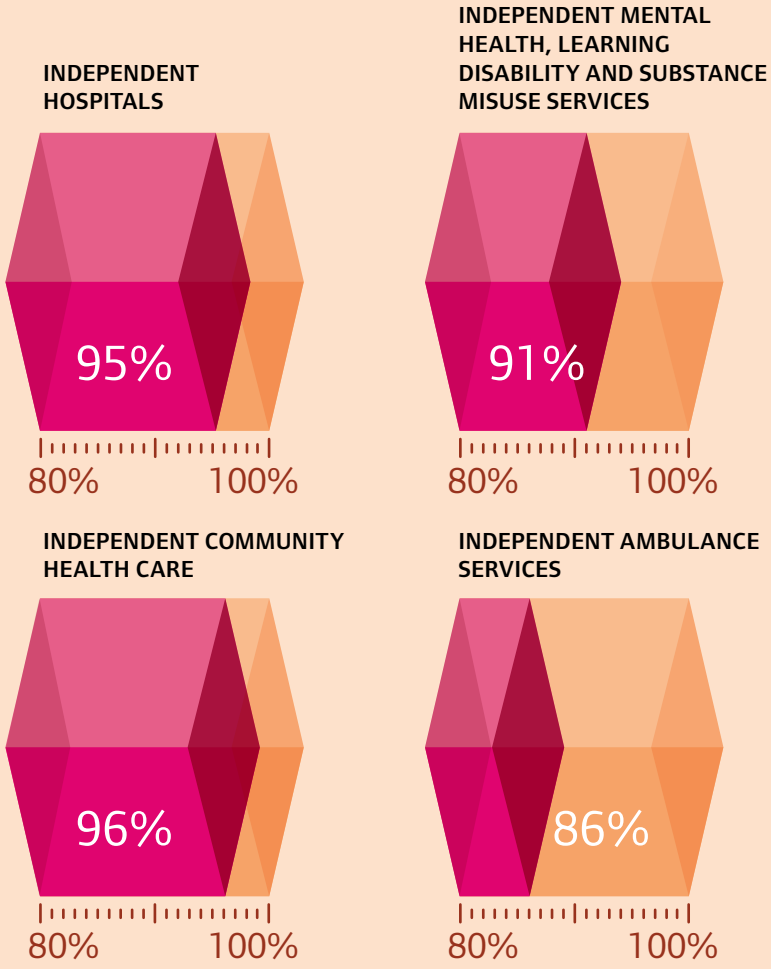


Suitability of staffing

There was some improvement in independent services having the right levels and mix of staff to make sure they can respond to the needs of patients. These were particularly notable in ambulance services and in mental health and learning disability services.

However, overall, around one in 12 inspections uncovered a problem in this area, so there is still significant room for improvement.

FIGURE 37: Percentage of inspections that met monitoring quality standards in 2012/13.



Monitoring quality

Leadership is an issue where, although there was slight improvement overall in 2012/13, there was a dip in performance among hospital services.

This is a concern to us given the similar findings in NHS hospitals, and something we will be looking at closely under our new regulatory model.

CONTINUING POOR CARE

REFUSAL TO PROPERLY MONITOR THE QUALITY OF SERVICE BEING PROVIDED

When we inspected a service in West Yorkshire that offered cosmetic surgical procedures, hair restoration and radio frequency assisted liposuction, we could not find any evidence of any audit or monitoring of the quality of care. There was no functioning process for reporting incidents, or any sign that the service has carried out any kind of patient survey.

The clinic manager confirmed that this was the case, and in fact there was no evidence of any kind of governance activity or meetings taking place. We issued the provider with a compliance action.

When we re-inspected in June 2012, we spoke again to the manager of the service. She explained that seven patient survey records had been returned. But when we reviewed these, we found that they were undated and there was no evidence that the information had been used to inform the development of services. We asked the manager if there was any other monitoring or audit of activity or quality taking place. She confirmed that there was none.

We issued the provider with a warning notice and it took until another inspection in September 2012 before our concerns were properly addressed.

PART TWO

PRIMARY DENTAL CARE

We have fewer overall concerns with the quality and safety of dental care providers. The performance of the sector is very good compared to other parts of the health and social care system.

KEY FINDINGS

In 2012/13 we found:

Almost all dental practices provided effective care and treatment, and treated patients with dignity and respect.

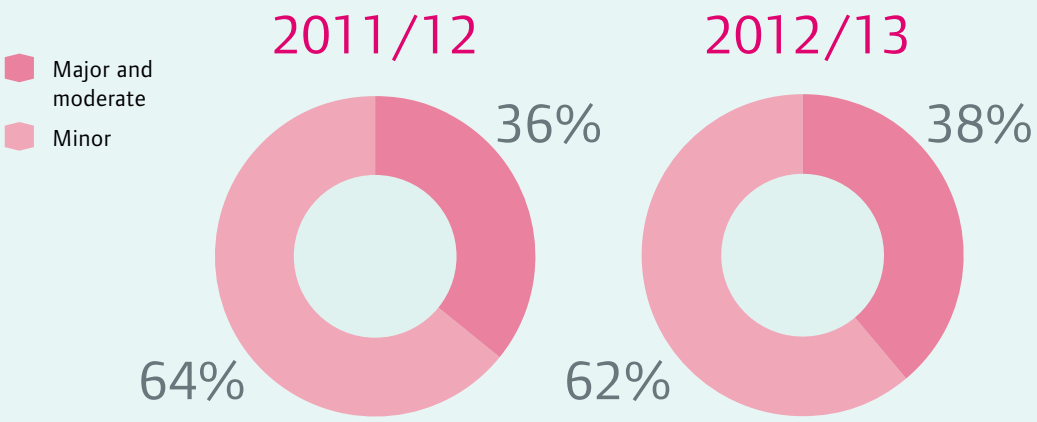
There was no overall improvement in the safety of the care provided, with 7% of inspections finding a problem.

Where we did find problems, just under 40% of them had a 'major' or 'moderate' impact on patients.

Dental care services generally provide effective care and treatment and treat patients with dignity and respect.

What concerns we do have relate to safety. On the whole surgeries are clean, with good infection control procedures, and staff know how to protect patients from the risk of abuse. However, we did uncover problems in these areas in 7% of inspections. This is the same as last year, so there is still some work to be done by the sector to embed safe practices in all dental surgeries.

FIGURE 38: When we found a problem, what effect did this have on patients?



Dental care provision

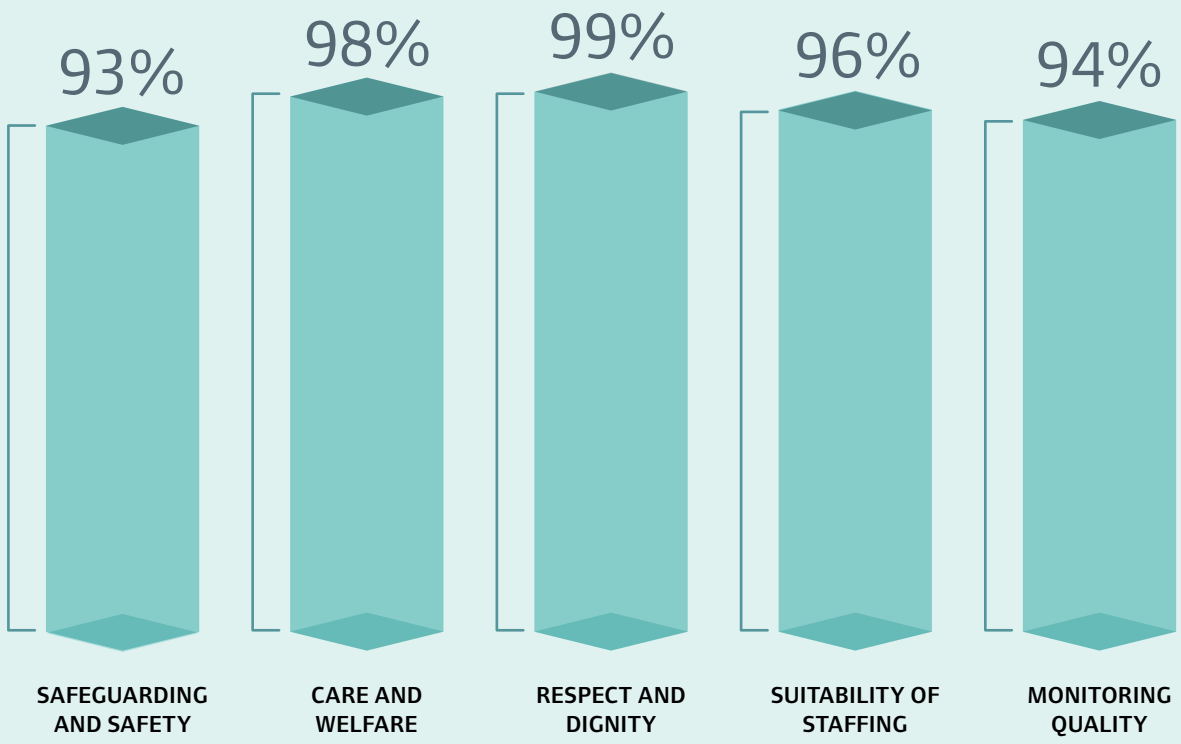
The number of dental care providers registered with CQC changed very little in 2012/13, going from 8,112 to 8,064. The number of registered locations also fell very slightly from 10,130 to 10,105. London and the South East have the highest concentrations of dental locations per head of population while the East Midlands and North East have the lowest (see appendix 2).

Over the last few years there has been a gradual rise in the number of adults having been seen by a dentist within the preceding two years, although little change in this figure for children.[16]

Between 2006/07 and 2011/12 there were gradual increases in the average weekly hours of dentists. Over the same time period, there was also a gradual increase in the proportion of time spent on non-clinical work (including administration). This means that despite the increase in average weekly hours, the average weekly time spent on clinical work by dentists changed little between 2006/07 and 2011/12.

In 2011/12, there were 5,099 Providing Performer dentists (those who held a contract with a primary care trust or local health board and also performed dental services) making up 22.2% of all dentists. This proportion has been decreasing in each year and compares to 2006/07 when 37.6% of dentists were Providing Performers. The shift to a greater percentage of Performer only dentists (those who performed dental services but did not hold such a contract) continues. In 2006/07, the proportion of dentists who operated as a Performer only stood at 62.4%. By 2011/12 this had increased to 77.8%.

FIGURE 39: Judgements made by CQC's inspectors: proportion meeting standards in 2012/13.



Safeguarding and safety

Dental care services are generally safe: most surgeries are clean, with good infection control procedures, and staff know how to protect patients from the risk of abuse.

However, we uncovered problems in these areas in around 7% of inspections, and this has not changed since last year. Dental care providers need to make sure they embed safe practices in all their surgeries.

Care and welfare

Our inspectors found that almost everywhere people received effective dental care, with practices meeting the relevant standards in 98% of inspections.

Respect and dignity

Dental practices were also very good at treating people with respect, listening to them and involving them in decisions about their treatment. Almost all (99%) of inspections found that practices were meeting standards.

EXAMPLE OF IMPROVING CARE

MY DENTAL SMILE, BIRMINGHAM

DENTAL PRACTICE THAT HAS IMPROVED ITS INFECTION CONTROL PROCEDURES

A dental practice that we inspected in January 2013 had a new, purpose-built decontamination room. It did not comply with minimum requirements under national guidelines, as it did not have two hand wash basins. The dentist told us that the room had been built just before the guidelines had been implemented, but they had acknowledged the shortfall when they carried out an audit to check if they were meeting the guidelines.

We also saw that domestic gloves were being used in the decontamination room to clean dirty instruments. Domestic gloves should be changed weekly or more frequently if worn or torn. However, there was no date on the gloves, which meant the provider could not be confident that they were being changed frequently enough.

When we went back to follow up, the practice had started to use a separate rinsing bowl for decontamination, and it had also developed an action plan to install a new sink. The domestic gloves being used in the decontamination room were now being dated and changed weekly.

CONTINUING POOR CARE

PRACTICE THAT HAS NOT MADE THE IMPROVEMENTS NEEDED DESPITE WARNINGS

When we inspected a dental surgery in Northampton, we found that their infection control policy was unsatisfactory. It did not include the management of needles or the disposal of clinical waste.

When we followed up in May 2012, the provider had introduced a new policy for the safe management of needles but had not addressed the issue of clinical waste. When we spoke to the surgery staff, they gave us different descriptions of how they would dispose of clinical waste.

At our previous inspection, there had been no written schedules for cleaning the premises, including the treatment rooms. At this re-inspection, the provider produced written cleaning schedules, which he had signed to confirm he had checked the cleanliness every day. However, written guidance for staff outlining the cleaning procedures was still not available.

We also followed up on the fact that there had been no written audits for cleanliness. The provider told us he planned to introduce a new system of infection control audit. But this had not yet been started, so we were not assured that infection control policies and instructions were followed by staff, or that they were effective.

Suitability of staffing

Our inspectors found that almost everywhere staffing levels and support for staff was good. This is a particular area of improvement for dental practices. Last year, they met the standards in only 91% of inspections. In 2012/13, this had risen to 96% of inspections.

Monitoring quality

Our inspectors found that most dental care providers were monitoring the quality of their service, although there is room for improvement. Ninety-four per cent of inspections uncovered problems with monitoring the quality of services and handling complaints. This compared with 92% of inspections in 2011/12.

96%

of inspections found that almost all practices were meeting standards for staffing levels and support for staff was good.

EXAMPLE OF IMPROVING CARE

ASHURST DENTAL SURGERY, SKELMERSDALE

DENTAL SURGERY UNDERSTANDS THE IMPORTANCE OF TRAINING

A dental surgery we inspected in July 2012 employed three dental nurses. These nurses were also responsible for carrying out the decontamination process, covering the reception desk and cleaning the premises.

We found there was nothing to show that staff were appraised or formally supervised. There were also no records relating to training on safeguarding vulnerable adults, child protection and infection control procedures. The staff confirmed they had not received this type of training while working at the practice. We insisted that the provider took action to correct this.

When we followed up a few months later, we were pleased to see that staff had undergone training in disinfection, decontamination, life support and medical emergencies. Training in safeguarding children and protecting vulnerable adults was scheduled in.

The provider also sent us the notes of monthly staff meetings, which incorporated group supervision for those working at the surgery, and copies of staff appraisals that had taken place since our inspection. Plans were now in place for appraisals to be carried out every year.

APPENDIX 1

CARING FOR AN AGEING POPULATION

There were 53 million people in England living in 22.1 million households in 2011, up from 49.1 million people in 2001 (an increase of 7.9%). The population is getting older and one in six people is aged 65 and over.

The areas with higher percentages of people aged 65 and over are particularly concentrated along the coast in the South West, South East and East regions. In 11 local and unitary authorities, more than a quarter of the population was aged 65 and over in 2011; most of these were in the East and South West.

Large urban concentrations tend to have relatively fewer older people. In 13 local and unitary authorities, less than 10% of the population was aged 65 and over. All of these were in London, except Manchester and Slough. Other areas with low proportions of older people included Cambridge, Oxford, Leicester and Nottingham.

Despite predictions to the contrary, the number of older people living alone has actually gone down, from 2.9 million people 65 and over in 2001 (14.4% of all households) to 2.7 million in 2011 (12.4%). This decrease is linked to the fact that people are living longer: there has been a fall in the proportions of people who are widowed.

A fifth of respondents to the 2011 census said that they were not White British; this compared with 13% in 2001. In London this figure was 55%, up from 40% in 2001. The changes in the ethnic profile of the population are likely to have an impact on population health due to the different rates of disease in different ethnic groups. For example, people from the Asian and Black groups have higher rates of diabetes than others, and many minority ethnic groups have lower rates of cancer.

The health of the nation

The majority of people, 81% (43.1 million), described themselves as being in good or very good health in 2011. It was not possible to make a direct comparison of this figure with 2001, as the structure of the census question changed. The Office for National Statistics was able to provide some comparisons that showed a variable picture across the country. Those with the lowest percentages of people with 'good' health in 2001 saw their rates fall in the following decade and vice versa. The North East, North West, East Midlands and West Midlands experienced falls, but in other regions the rate increased, most notably in London and the south.

The percentage of people in England with a long-term illness that limits their day-to-day activity has changed little over the last 10 years – 18% (9.4 million) in 2011, compared to 18% (8.8 million) in 2001.

The most common conditions seen by GPs and covering all ages were hypertension (7.6 million patients) and asthma (3.3 million).[17] In relation to mental health, the UK Household Longitudinal Survey (2010/11) published in June 2013 showed that around a fifth (19%) of individuals had some indication of anxiety or depression. Women were more likely than men to have these mental health problems. Mental ill-health was more likely to affect people aged 40 to 59, and 80 and over. There was also some evidence of anxiety and depression being more common among people who were either divorced, not in paid work, caring for someone else in their household, or living on their own.

Unpaid care

The number of people providing unpaid care has increased from 4.9 million (9.9% of the population) to 5.4 million (10.2%). The greatest rise has been among those providing over 20 hours a week, which is the point at which caring starts to significantly impact on the health and wellbeing of the carer and their ability to hold down paid employment. The number of people providing the most care – more than 50 hours a week – has risen from just under one million to almost 1.3 million.

The North East region had the highest percentage of residents who are providing care, although the unitary authority where most unpaid care was provided was North East Derbyshire in the East Midlands.

The highest percentage increases in provision of unpaid care since 2001 were in Fenland in Cambridgeshire with a 30% increase (2,435 people providing care), and the Isles of Scilly with a 28% increase (48 people). North Kevesten in Lincolnshire and East Northamptonshire both had a 27% increase (2,581 and 1,911 people respectively).

GP provision

During 2012/13 CQC registered 7,634 GP and primary medical services. We started to inspect these services in 2013/14, and we will report in next year's State of Care report on our findings.

The annual GP census was published by the Health and Social Care Information Centre in September 2012.[18] This showed that, on average, a GP practice has 6,891 patients. However, this reflects huge variations in census returns, ranging from zero registered patients to just under 45,000.

Nationally there is approximately one full-time equivalent GP for every 1,569 people. Regional variations range from 1,373 in the South West to 1,653 in the East Midlands.

In terms of changes in the numbers of GPs, there were 40,265 headcount GPs in England, an increase of 485 (1%) since 2011. This equated to 35,871 full-time equivalent GPs, a rise of 552 (2%) since 2011.

APPENDIX 2

REGISTERED PROVIDERS AND LOCATIONS

TABLE A2.1

ACTIVE ADULT SOCIAL CARE LOCATIONS ACROSS DIFFERENT TYPES OF PROVIDER, 31 MARCH 2012 AND 31 MARCH 2013

	31 March 2012				31 March 2013			
REGION	Nursing homes	Residential homes	Home care agencies	Community social care	Nursing homes	Residential homes	Home care agencies	Community social care
EAST	382	1,515	724	232	389	1,466	789	233
EAST MIDLANDS	458	1,163	570	141	452	1,143	635	149
LONDON	418	1,411	925	284	414	1,330	1,010	280
NORTH EAST	316	610	288	106	310	592	302	111
NORTH WEST	660	1,495	914	329	648	1,463	981	304
SOUTH EAST	871	2,522	1,215	338	881	2,489	1,325	360
SOUTH WEST	603	1,847	780	223	599	1,805	847	225
WEST MIDLANDS	484	1,389	822	230	484	1,387	856	228
YORKSHIRE AND THE HUMBER	480	1,182	592	151	485	1,169	654	147
UNSPECIFIED					2	4	21	6
TOTAL	**4,672**	**13,134**	**6,830**	**2,034**	**4,664**	**12,848**	**7,420**	**2,043**
PROPORTION OF SECTOR	17.5%	49.3%	25.6%	7.6%	17.3%	47.6%	27.5%	7.6%

TABLE A2.2

CARE HOME BED PROVISION BY REGION, 31 MARCH 2012 AND 31 MARCH 2013

	31 March 2012			31 March 2013				
REGION	Nursing home beds 2012	Residential home beds 2012	Total beds	Nursing home beds 2013	Residential home beds 2013	Total beds	Change in bed numbers	% change in bed numbers
EAST	18,854	32,416	51,270	19,603	31,826	51,429	159	0.31%
EAST MIDLANDS	18,734	24,292	43,026	18,826	23,909	42,735	-291	-0.68%
LONDON	20,745	18,710	39,455	20,654	17,633	38,287	-1168	-2.96%
NORTH EAST	15,097	13,288	28,385	14,866	12,998	27,864	-521	-1.84%
NORTH WEST	31,712	31,916	63,628	31,814	31,700	63,514	-114	-0.18%
SOUTH EAST	40,127	43,925	84,052	41,281	43,674	84,955	903	1.07%
SOUTH WEST	25,540	32,166	57,706	26,217	31,560	57,777	71	0.12%
WEST MIDLANDS	22,105	24,039	46,144	22,530	24,107	46,637	493	1.07%
YORKSHIRE AND THE HUMBER	22,549	27,072	49,621	22,755	26,718	49,473	-148	-0.30%
UNSPECIFIED				132	107	239	239	
TOTAL	**215,463**	**247,824**	**463,287**	**218,678**	**244,232**	**462,910**	**-377**	**-0.08%**

TABLE A2.3

CARE HOME BED PROVISION BY REGIONAL POPULATION, 31 MARCH 2012 AND 31 MARCH 2013

REGION	Number of people per care home bed	Proportion of all over 65s	Proportion of all care home beds	Number of people over 65 per care home bed	Number of people with very bad or bad health per care home bed	Number of people with limitation in day to day activity per care home bed
EAST	113.69	11.83%	11.11%	19.91	5.31	18.99
EAST MIDLANDS	106.08	8.92%	9.23%	18.09	5.90	19.76
LONDON	213.49	10.45%	8.27%	23.63	10.59	30.22
NORTH EAST	93.20	5.19%	6.02%	16.13	6.94	20.18
NORTH WEST	111.03	13.52%	13.72%	18.44	7.54	22.46
SOUTH EAST	101.64	17.11%	18.35%	17.44	4.41	15.96
SOUTH WEST	91.54	11.96%	12.48%	17.92	4.72	16.85
WEST MIDLANDS	120.12	10.92%	10.07%	20.28	7.34	22.77
YORKSHIRE AND THE HUMBER	106.80	10.10%	10.69%	17.68	6.44	20.08

TABLE A2.4

HOME CARE AGENCIES BY REGION AND REGIONAL POPULATION, 31 MARCH 2012 AND 31 MARCH 2013

	31 March 2012		31 March 2013					
REGION	Number of agencies	65+ population per agency	Number of agencies	65+ population per agency	Change in number of agencies	% change in number of agencies	Change in 65+ population per agency	% change in 65+ population per agency
EAST	724	1,414	789	1,298	65	9%	-116	-8%
EAST MIDLANDS	570	1,356	635	1,217	65	11%	-139	-10%
LONDON	925	978	1,010	896	85	9%	-82	-8%
NORTH EAST	288	1,563	302	1,488	14	5%	-75	-5%
NORTH WEST	914	1,281	981	1,194	67	7%	-87	-7%
SOUTH EAST	1,215	1,220	1,325	1,119	110	9%	-101	-8%
SOUTH WEST	780	1,327	847	1,222	67	9%	-105	-8%
WEST MIDLANDS	822	1,151	856	1,105	34	4%	-46	-4%
YORKSHIRE AND THE HUMBER	592	1,478	654	1,337	62	10%	-141	-10%

TABLE A2.5

HEALTHCARE LOCATIONS, 31 MARCH 2013

REGION	NHS hospitals	NHS community health care	NHS mental health, learning disability and substance misuse services	Independent hospitals	Independent community health care	Independent mental health, learning disability and substance misuse services	Independent ambulance services	Out-of-hours doctors services	Dental care
EAST	109	91	90	124	153	74	45	12	1,055
EAST MIDLANDS	83	88	50	78	78	44	29	12	696
LONDON	125	136	76	250	445	69	35	28	1,936
NORTH EAST	58	66	34	43	39	19	10	4	402
NORTH WEST	128	173	94	124	150	53	24	39	1,252
SOUTH EAST	141	150	123	252	252	66	66	28	1,899
SOUTH WEST	159	86	72	126	123	30	48	15	1,037
WEST MIDLANDS	95	95	91	102	111	31	25	13	950
YORKSHIRE AND THE HUMBER	77	104	77	108	158	58	23	15	875
UNSPECIFIED	1	2	2	3	1	2			3
TOTAL	976	991	709	1,210	1,510	446	305	166	10,105

TABLE A2.6

NHS HOSPITAL LOCATIONS BY POPULATION, 31 MARCH 2013

REGION	1,000 people per location	1,000 people over 65 per location	1,000 people with very bad or bad health per location	1,000 people with limitation in day to day activity per location
EAST	53.64	9.40	2.51	8.96
EAST MIDLANDS	54.62	9.31	3.04	10.17
LONDON	65.39	7.24	3.24	9.26
NORTH EAST	44.77	7.75	3.34	9.69
NORTH WEST	55.10	9.15	3.74	11.15
SOUTH EAST	61.24	10.51	2.66	9.62
SOUTH WEST	33.26	6.51	1.71	6.12
WEST MIDLANDS	58.97	9.96	3.60	11.18
YORKSHIRE AND THE HUMBER	68.62	11.36	4.14	12.90
NATIONAL	**54.32**	**8.87**	**2.98**	**9.58**

TABLE A2.7

NHS COMMUNITY HEALTHCARE LOCATIONS BY POPULATION, 31 MARCH 2013

REGION	1,000 people per location	1,000 people over 65 per location	1,000 people with very bad or bad health per location	1,000 people with limitation in day to day activity per location
EAST	64.25	11.25	3.00	10.73
EAST MIDLANDS	51.51	8.78	2.87	9.59
LONDON	60.10	6.65	2.98	8.51
NORTH EAST	39.35	6.81	2.93	8.52
NORTH WEST	40.76	6.77	2.77	8.25
SOUTH EAST	57.57	9.88	2.50	9.04
SOUTH WEST	61.50	12.04	3.17	11.32
WEST MIDLANDS	58.97	9.96	3.60	11.18
YORKSHIRE AND THE HUMBER	50.81	8.41	3.06	9.55
NATIONAL	**53.49**	**8.74**	**2.94**	**9.44**

TABLE A2.8

NHS MENTAL HEALTH, LEARNING DISABILITY AND SUBSTANCE MISUSE SERVICES BY POPULATION, 31 MARCH 2013

REGION	1,000 people per location	1,000 people over 65 per location	1,000 people with very bad or bad health per location	1,000 people with limitation in day to day activity per location
EAST	64.97	11.38	3.04	10.85
EAST MIDLANDS	90.66	15.46	5.05	16.89
LONDON	107.55	11.90	5.34	15.23
NORTH EAST	76.38	13.22	5.69	16.54
NORTH WEST	75.02	12.46	5.09	15.18
SOUTH EAST	70.20	12.05	3.04	11.03
SOUTH WEST	73.46	14.38	3.78	13.52
WEST MIDLANDS	61.56	10.40	3.76	11.67
YORKSHIRE AND THE HUMBER	68.62	11.36	4.14	12.90
NATIONAL	**74.77**	**12.22**	**4.11**	**13.19**

TABLE A2.9

INDEPENDENT HOSPITALS BY POPULATION, 31 MARCH 2013

REGION	1,000 people per location	1,000 people over 65 per location	1,000 people with very bad or bad health per location	1,000 people with limitation in day to day activity per location
EAST	47.15	8.26	2.20	7.88
EAST MIDLANDS	58.12	9.91	3.23	10.82
LONDON	32.70	3.62	1.62	4.63
NORTH EAST	60.39	10.45	4.50	13.07
NORTH WEST	56.87	9.44	3.86	11.51
SOUTH EAST	34.26	5.88	1.49	5.38
SOUTH WEST	41.98	8.22	2.16	7.73
WEST MIDLANDS	54.92	9.27	3.36	10.41
YORKSHIRE AND THE HUMBER	48.92	8.10	2.95	9.20
NATIONAL	**43.81**	**7.16**	**2.41**	**7.73**

TABLE A2.10

INDEPENDENT COMMUNITY HEALTHCARE LOCATIONS BY POPULATION, 31 MARCH 2013

REGION	1,000 people per location	1,000 people over 65 per location	1,000 people with very bad or bad health per location	1,000 people with limitation in day to day activity per location
EAST	38.22	6.69	1.79	6.38
EAST MIDLANDS	58.12	9.91	3.23	10.82
LONDON	18.37	2.03	0.91	2.60
NORTH EAST	66.59	11.53	4.96	14.42
NORTH WEST	47.01	7.81	3.19	9.51
SOUTH EAST	34.26	5.88	1.49	5.38
SOUTH WEST	43.00	8.42	2.22	7.92
WEST MIDLANDS	50.47	8.52	3.09	9.57
YORKSHIRE AND THE HUMBER	33.44	5.54	2.02	6.29
NATIONAL	**35.11**	**5.74**	**1.93**	**6.19**

TABLE A2.11

INDEPENDENT MENTAL HEALTH, LEARNING DISABILITY AND SUBSTANCE MISUSE LOCATIONS BY POPULATION, 31 MARCH 2013

REGION	1,000 people per location	1,000 people 65 and over per location	1,000 people with very bad or bad health per location	1,000 people with limitation in day to day activity per location
EAST	79.01	13.84	3.69	13.20
EAST MIDLANDS	103.03	17.57	5.73	19.19
LONDON	118.46	13.11	5.88	16.77
NORTH EAST	136.68	23.66	10.18	29.59
NORTH WEST	133.06	22.10	9.03	26.92
SOUTH EAST	130.83	22.45	5.67	20.55
SOUTH WEST	176.30	34.51	9.08	32.46
WEST MIDLANDS	180.70	30.52	11.05	34.26
YORKSHIRE AND THE HUMBER	91.10	15.08	5.49	17.13
NATIONAL	**118.86**	**19.42**	**6.53**	**20.97**

TABLE A2.12

DENTAL CARE LOCATIONS BY POPULATION, 31 MARCH 2013

REGION	1,000 people per location
EAST	5.54
EAST MIDLANDS	6.51
LONDON	4.22
NORTH EAST	6.46
NORTH WEST	5.63
SOUTH EAST	4.55
SOUTH WEST	5.10
WEST MIDLANDS	5.90
YORKSHIRE AND THE HUMBER	6.04
NATIONAL	**5.25**

APPENDIX 3

SECTOR PERFORMANCE TABLES:

Adult social care

TABLE A3.1: SAFEGUARDING AND SAFETY

PROPORTION OF JUDGEMENTS WHERE STANDARDS MET FOR OUTCOMES 7, 8, 9 AND 10

	JUDGEMENTS 2012/13				2011/12		PERCENTAGE POINT CHANGE
	Standards met	Standards not met	Total Judgements	% standards met	Total Judgements	% standards met	
RESIDENTIAL HOMES	14172	2162	16334	87%	14690	82%	+5%
NURSING HOMES	5536	1214	6750	82%	7078	76%	+6%
HOME CARE AGENCIES	5250	491	5741	91%	3387	88%	+3%
COMMUNITY SOCIAL CARE	1576	128	1704	92%	1073	88%	+4%

	2012/13					2011/12
	Major impact	Moderate impact	Minor impact	Total	% Major and Moderate	% Major and Moderate out of all concerns
RESIDENTIAL CARE HOMES	110	1078	974	2162	55%	50%
NURSING HOMES	105	603	506	1214	58%	55%
HOME CARE AGENCIES	17	243	231	491	53%	46%
OTHER COMMUNITY SOCIAL CARE	4	55	69	128	46%	50%

	Residential care homes	Nursing homes	Home care services	Other community social care
EAST	89%	82%	91%	93%
EAST MIDLANDS	84%	78%	88%	88%
LONDON	89%	85%	92%	93%
NORTH EAST	89%	84%	95%	96%
NORTH WEST	86%	80%	93%	95%
SOUTH EAST	89%	84%	90%	90%
SOUTH WEST	83%	83%	90%	91%
WEST MIDLANDS	83%	79%	90%	90%
YORKSHIRE AND THE HUMBER	89%	83%	96%	98%

TABLE A3.2: CARE AND WELFARE

PROPORTION OF JUDGEMENTS WHERE STANDARDS MET FOR OUTCOMES 4 AND 5

	JUDGEMENTS 2012/13				2011/12		PERCENTAGE POINT CHANGE
	Standards met	Standards not met	Total Judgements	% standards met	Total Judgements	% standards met	
RESIDENTIAL HOMES	12126	1457	13583	89%	9731	83%	+6%
NURSING HOMES	4789	1002	5791	83%	4906	74%	+9%
HOME CARE AGENCIES	4804	534	5338	90%	2492	87%	+3%
COMMUNITY SOCIAL CARE	1460	123	1583	92%	789	86%	+6%

	2012/13					2011/12
	Major impact	Moderate impact	Minor impact	Total	% Major and Moderate	% Major and Moderate out of all concerns
RESIDENTIAL CARE HOMES	79	737	641	1457	56%	48%
NURSING HOMES	98	557	347	1002	65%	55%
HOME CARE AGENCIES	22	257	255	534	52%	42%
OTHER COMMUNITY SOCIAL CARE	5	62	56	123	54%	45%

	Residential care homes	Nursing homes	Home care services	Other community social care
EAST	87%	83%	91%	95%
EAST MIDLANDS	82%	74%	82%	84%
LONDON	90%	83%	90%	91%
NORTH EAST	95%	90%	94%	97%
NORTH WEST	91%	85%	94%	97%
SOUTH EAST	91%	85%	88%	89%
SOUTH WEST	88%	82%	89%	90%
WEST MIDLANDS	88%	77%	89%	91%
YORKSHIRE AND THE HUMBER	93%	87%	95%	96%

TABLE A3.3: RESPECT AND DIGNITY

PROPORTION OF JUDGEMENTS WHERE STANDARDS MET FOR OUTCOME 1

	JUDGEMENTS 2012/13				2011/12		PERCENTAGE POINT CHANGE
	Standards met	Standards not met	Total Judgements	% standards met	Total Judgements	% standards met	
RESIDENTIAL HOMES	8583	457	9040	95%	5984	93%	+2%
NURSING HOMES	3264	430	3694	88%	2502	85%	+3%
HOME CARE AGENCIES	4225	125	4350	97%	1680	95%	+2%
COMMUNITY SOCIAL CARE	1240	37	1277	97%	524	94%	+3%

	2012/13					2011/12
	Major impact	Moderate impact	Minor impact	Total	% Major and Moderate	% Major and Moderate out of all concerns
RESIDENTIAL CARE HOMES	9	195	253	457	45%	37%
NURSING HOMES	13	183	234	430	46%	45%
HOME CARE AGENCIES	1	44	80	125	36%	36%
OTHER COMMUNITY SOCIAL CARE	1	9	27	37	27%	30%

	Residential care homes	Nursing homes	Home care services	Other community social care
EAST	95%	86%	97%	99%
EAST MIDLANDS	94%	85%	94%	92%
LONDON	95%	90%	97%	96%
NORTH EAST	98%	95%	100%	99%
NORTH WEST	95%	89%	99%	99%
SOUTH EAST	96%	90%	97%	96%
SOUTH WEST	93%	85%	96%	96%
WEST MIDLANDS	94%	86%	98%	98%
YORKSHIRE AND THE HUMBER	96%	90%	99%	98%

TABLE A3.4: SUITABILITY OF STAFFING

PROPORTION OF JUDGEMENTS WHERE STANDARDS MET FOR OUTCOMES 13 AND 14

	JUDGEMENTS 2012/13				2011/12		PERCENTAGE POINT CHANGE
	Standards met	Standards not met	Total Judgements	% standards met	Total Judgements	% standards met	
RESIDENTIAL HOMES	10026	1374	11400	88%	8715	84%	+4%
NURSING HOMES	4087	923	5010	82%	4314	76%	+6%
HOME CARE AGENCIES	3828	512	4340	88%	2439	86%	+2%
COMMUNITY SOCIAL CARE	1141	158	1299	88%	754	86%	+2%

	2012/13					2011/12
	Major impact	Moderate impact	Minor impact	Total	% Major and Moderate	% Major and Moderate out of all concerns
RESIDENTIAL CARE HOMES	44	640	690	1374	50%	50%
NURSING HOMES	39	487	397	923	57%	55%
HOME CARE AGENCIES	15	231	266	512	48%	46%
OTHER COMMUNITY SOCIAL CARE	4	63	91	158	42%	44%

	Residential care homes	Nursing homes	Home care services	Other community social care
EAST	87%	82%	88%	86%
EAST MIDLANDS	82%	74%	85%	84%
LONDON	89%	83%	85%	84%
NORTH EAST	90%	83%	91%	95%
NORTH WEST	90%	85%	91%	92%
SOUTH EAST	89%	83%	86%	85%
SOUTH WEST	87%	78%	87%	88%
WEST MIDLANDS	87%	79%	90%	87%
YORKSHIRE AND THE HUMBER	93%	87%	92%	94%

TABLE A3.5: MONITORING QUALITY

PROPORTION OF JUDGEMENTS WHERE STANDARDS MET FOR OUTCOMES 16 AND 17

	JUDGEMENTS 2012/13				2011/12		PERCENTAGE POINT CHANGE
	Standards met	Standards not met	Total Judgements	% standards met	Total Judgements	% standards met	
RESIDENTIAL HOMES	9548	1158	10706	89%	8024	86%	+3%
NURSING HOMES	3602	556	4158	87%	3541	83%	+4%
HOME CARE AGENCIES	4619	561	5180	89%	2505	88%	+1%
COMMUNITY SOCIAL CARE	1375	144	1519	91%	779	88%	+3%

	2012/13					2011/12
	Major impact	Moderate impact	Minor impact	Total	% Major and Moderate	% Major and Moderate out of all concerns
RESIDENTIAL CARE HOMES	53	507	598	1158	48%	45%
NURSING HOMES	34	293	229	556	59%	50%
HOME CARE AGENCIES	27	210	324	561	42%	44%
OTHER COMMUNITY SOCIAL CARE	5	50	89	144	38%	43%

	Residential care homes	Nursing homes	Home care services	Other community social care
EAST	90%	90%	90%	93%
EAST MIDLANDS	84%	80%	85%	87%
LONDON	92%	88%	90%	88%
NORTH EAST	95%	94%	93%	97%
NORTH WEST	90%	86%	90%	91%
SOUTH EAST	91%	90%	89%	91%
SOUTH WEST	84%	84%	86%	88%
WEST MIDLANDS	85%	82%	87%	90%
YORKSHIRE AND THE HUMBER	95%	91%	94%	92%

SECTOR PERFORMANCE TABLES:

NHS services

TABLE A3.6: SAFEGUARDING AND SAFETY

PROPORTION OF JUDGEMENTS WHERE STANDARDS MET FOR OUTCOMES 7, 8, 9 AND 10

	JUDGEMENTS 2012/13				2011/12		PERCENTAGE POINT CHANGE
	Standards met	Standards not met	Total Judgements	% standards met	Total Judgements	% standards met	
NHS HOSPITAL	351	53	404	87%	702	87%	No change
NHS COMMUNITY HEALTHCARE	283	44	327	87%	536	86%	+1%
NHS MENTAL HEALTH, LEARNING DISABILITY AND SUBSTANCE MISUSE SERVICES	205	27	232	88%	503	86%	+2%

	2012/13					2011/12
	Major impact	Moderate impact	Minor impact	Total	% Major and Moderate	% Major and Moderate out of all concerns
NHS HOSPITAL	3	20	30	53	43%	41%
NHS COMMUNITY HEALTHCARE	2	16	26	44	41%	44%
NHS MENTAL HEALTH, LEARNING DISABILITY AND SUBSTANCE MISUSE SERVICES	1	17	9	27	67%	44%

	NHS hospital	NHS community health care	NHS MH/LD/SM
EAST	86%	100%	93%
EAST MIDLANDS	88%	83%	90%
LONDON	89%	88%	92%
NORTH EAST	88%	89%	70%
NORTH WEST	81%	80%	88%
SOUTH EAST	87%	87%	83%
SOUTH WEST	86%	86%	84%
WEST MIDLANDS	92%	89%	94%
YORKSHIRE AND THE HUMBER	90%	89%	91%

TABLE A3.7: CARE AND WELFARE

PROPORTION OF JUDGEMENTS WHERE STANDARDS MET FOR OUTCOMES 4 AND 5

	JUDGEMENTS 2012/13				2011/12		PERCENTAGE POINT CHANGE
	Standards met	Standards not met	Total Judgements	% standards met	Total Judgements	% standards met	
NHS HOSPITAL	377	44	421	90%	613	83%	+7%
NHS COMMUNITY HEALTHCARE	285	27	312	91%	428	84%	+7%
NHS MENTAL HEALTH, LEARNING DISABILITY AND SUBSTANCE MISUSE SERVICES	186	28	214	87%	341	82%	+5%

	2012/13					2011/12
	Major impact	Moderate impact	Minor impact	Total	% Major and Moderate	% Major and Moderate out of all concerns
NHS HOSPITAL	4	21	19	44	57%	42%
NHS COMMUNITY HEALTHCARE	1	14	12	27	56%	44%
NHS MENTAL HEALTH, LEARNING DISABILITY AND SUBSTANCE MISUSE SERVICES	1	11	16	28	43%	48%

	NHS hospital	NHS community health care	NHS MH/LD/SM
EAST	67%	80%	69%
EAST MIDLANDS	89%	95%	85%
LONDON	95%	97%	94%
NORTH EAST	100%	100%	100%
NORTH WEST	93%	90%	83%
SOUTH EAST	87%	83%	89%
SOUTH WEST	88%	84%	79%
WEST MIDLANDS	96%	94%	88%
YORKSHIRE AND THE HUMBER	91%	91%	95%

TABLE A3.8: RESPECT AND DIGNITY

PROPORTION OF JUDGEMENTS WHERE STANDARDS MET FOR OUTCOME 1

	JUDGEMENTS 2012/13				2011/12		PERCENTAGE POINT CHANGE
	Standards met	Standards not met	Total Judgements	% standards met	Total Judgements	% standards met	
NHS HOSPITAL	221	21	242	91%	350	91%	No change
NHS COMMUNITY HEALTHCARE	169	13	182	93%	243	91%	+2%
NHS MENTAL HEALTH, LEARNING DISABILITY AND SUBSTANCE MISUSE SERVICES	125	9	134	93%	160	86%	+7%

	2012/13					2011/12
	Major impact	Moderate impact	Minor impact	Total	% Major and Moderate	% Major and Moderate out of all concerns
NHS HOSPITAL	1	11	9	21	57%	26%
NHS COMMUNITY HEALTHCARE	1	7	5	13	62%	30%
NHS MENTAL HEALTH, LEARNING DISABILITY AND SUBSTANCE MISUSE SERVICES	0	5	4	9	56%	37%

	NHS hospital	NHS community health care	NHS MH/LD/SM
EAST	80%	67%	86%
EAST MIDLANDS	95%	100%	88%
LONDON	92%	100%	94%
NORTH EAST	94%	95%	88%
NORTH WEST	97%	94%	100%
SOUTH EAST	94%	95%	93%
SOUTH WEST	88%	90%	86%
WEST MIDLANDS	92%	87%	100%
YORKSHIRE AND THE HUMBER	86%	86%	100%

TABLE A3.9: SUITABILITY OF STAFFING

PROPORTION OF JUDGEMENTS WHERE STANDARDS MET FOR OUTCOMES 13 AND 14

	JUDGEMENTS 2012/13				2011/12		PERCENTAGE POINT CHANGE
	Standards met	Standards not met	Total Judgements	% standards met	Total Judgements	% standards met	
NHS HOSPITAL	334	37	371	90%	497	84%	+6%
NHS COMMUNITY HEALTHCARE	247	28	275	90%	355	87%	+3%
NHS MENTAL HEALTH, LEARNING DISABILITY AND SUBSTANCE MISUSE SERVICES	157	17	174	90%	273	90%	No change

	2012/13					2011/12
	Major impact	Moderate impact	Minor impact	Total	% Major and Moderate	% Major and Moderate out of all concerns
NHS HOSPITAL	1	20	16	37	57%	38%
NHS COMMUNITY HEALTHCARE	0	15	13	28	54%	36%
NHS MENTAL HEALTH, LEARNING DISABILITY AND SUBSTANCE MISUSE SERVICES	0	9	8	17	53%	36%

	NHS hospital	NHS community health care	NHS MH/LD/SM
EAST	97%	93%	91%
EAST MIDLANDS	81%	70%	85%
LONDON	90%	94%	91%
NORTH EAST	94%	94%	86%
NORTH WEST	94%	90%	91%
SOUTH EAST	88%	86%	95%
SOUTH WEST	80%	91%	88%
WEST MIDLANDS	94%	91%	83%
YORKSHIRE AND THE HUMBER	94%	93%	100%

TABLE A3.10: MONITORING QUALITY

PROPORTION OF JUDGEMENTS WHERE STANDARDS MET FOR OUTCOMES 16 AND 17

	JUDGEMENTS 2012/13				2011/12		PERCENTAGE POINT CHANGE
	Standards met	Standards not met	Total Judgements	% standards met	Total Judgements	% standards met	
NHS HOSPITAL	245	32	277	88%	372	91%	- 3%
NHS COMMUNITY HEALTHCARE	197	17	214	92%	271	90%	+2%
NHS MENTAL HEALTH, LEARNING DISABILITY AND SUBSTANCE MISUSE SERVICES	119	12	131	91%	235	89%	+2%

	2012/13					2011/12
	Major impact	Moderate impact	Minor impact	Total	% Major and Moderate	% Major and Moderate out of all concerns
NHS HOSPITAL	2	13	17	32	47%	38%
NHS COMMUNITY HEALTHCARE	0	6	11	17	35%	38%
NHS MENTAL HEALTH, LEARNING DISABILITY AND SUBSTANCE MISUSE SERVICES	0	10	2	12	83%	38%

	NHS hospital	NHS community health care	NHS MH/LD/SM
EAST	67%	86%	82%
EAST MIDLANDS	88%	76%	75%
LONDON	94%	98%	100%
NORTH EAST	100%	100%	100%
NORTH WEST	92%	93%	91%
SOUTH EAST	91%	92%	92%
SOUTH WEST	88%	90%	80%
WEST MIDLANDS	86%	92%	94%
YORKSHIRE AND THE HUMBER	90%	89%	100%

SECTOR PERFORMANCE TABLES:

Independent health care

TABLE A3.11: SAFEGUARDING AND SAFETY

PROPORTION OF JUDGEMENTS WHERE STANDARDS MET FOR OUTCOMES 7, 8, 9 AND 10

	JUDGEMENTS 2012/13				2011/12		PERCENTAGE POINT CHANGE
	Standards met	Standards not met	Total Judgements	% standards met	Total Judgements	% standards met	
INDEPENDENT HOSPITAL	766	65	831	92%	750	91%	+1%
INDEPENDENT COMMUNITY	910	85	995	91%	814	89%	+2%
INDEPENDENT MENTAL HEALTH, LEARNING DISABILITY AND SUBSTANCE MISUSE	413	65	478	86%	401	77%	+9%
INDEPENDENT AMBULANCES	235	36	271	87%	34	71%	+16%

	2012/13					2011/12
	Major impact	Moderate impact	Minor impact	Total	% Major and Moderate	% Major and Moderate out of all concerns
INDEPENDENT HOSPITAL	2	23	40	65	38%	41%
INDEPENDENT COMMUNITY HEALTH CARE	5	36	44	85	48%	45%
INDEPENDENT MENTAL HEALTH, LEARNING DISABILITY AND SUBSTANCE MISUSE SERVICES	10	29	26	65	60%	53%
INDEPENDENT AMBULANCES	1	13	22	36	39%	75%

	Independent hospital	Independent community health care	Independent MH/LD/SM	Independent ambulance
EAST	92%	86%	83%	85%
EAST MIDLANDS	83%	91%	87%	79%
LONDON	97%	94%	86%	94%
NORTH EAST	89%	97%	96%	100%
NORTH WEST	92%	95%	88%	67%
SOUTH EAST	89%	88%	89%	88%
SOUTH WEST	93%	85%	74%	83%
WEST MIDLANDS	92%	89%	80%	100%
YORKSHIRE AND THE HUMBER	96%	96%	95%	94%

TABLE A3.12: CARE AND WELFARE

PROPORTION OF JUDGEMENTS WHERE STANDARDS MET FOR OUTCOMES 4 AND 5

	JUDGEMENTS 2012/13				2011/12		PERCENTAGE POINT CHANGE
	Standards met	Standards not met	Total Judgements	% standards met	Total Judgements	% standards met	
INDEPENDENT HOSPITAL	738	17	755	98%	541	94%	+4%
INDEPENDENT COMMUNITY	820	26	846	97%	545	89%	+8%
INDEPENDENT MENTAL HEALTH, LEARNING DISABILITY AND SUBSTANCE MISUSE	324	49	373	87%	265	73%	+14%
INDEPENDENT AMBULANCES	167	4	171	98%	20	80%	+18%

	2012/13					2011/12
	Major impact	Moderate impact	Minor impact	Total	% Major and Moderate	% Major and Moderate out of all concerns
INDEPENDENT HOSPITAL	1	6	10	17	41%	49%
INDEPENDENT COMMUNITY HEALTH CARE	1	13	12	26	54%	56%
INDEPENDENT MENTAL HEALTH, LEARNING DISABILITY AND SUBSTANCE MISUSE SERVICES	5	26	18	49	63%	58%
INDEPENDENT AMBULANCES	0	4	0	4	100%	80%

	Independent hospital	Independent community health care	Independent MH/LD/SM	Independent ambulance
EAST	98%	93%	82%	100%
EAST MIDLANDS	95%	98%	84%	93%
LONDON	98%	97%	83%	100%
NORTH EAST	100%	100%	100%	100%
NORTH WEST	99%	99%	94%	93%
SOUTH EAST	97%	96%	93%	100%
SOUTH WEST	98%	95%	76%	93%
WEST MIDLANDS	97%	100%	86%	100%
YORKSHIRE AND THE HUMBER	97%	96%	87%	100%

TABLE A3.13: RESPECT AND DIGNITY

PROPORTION OF JUDGEMENTS WHERE STANDARDS MET FOR OUTCOME 1

	JUDGEMENTS 2012/13				2011/12		PERCENTAGE POINT CHANGE
	Standards met	Standards not met	Total Judgements	% standards met	Total Judgements	% standards met	
INDEPENDENT HOSPITAL	451	6	457	99%	365	98%	+1%
INDEPENDENT COMMUNITY	551	8	559	99%	380	96%	+3%
INDEPENDENT MENTAL HEALTH, LEARNING DISABILITY AND SUBSTANCE MISUSE	241	20	261	92%	148	85%	+7%
INDEPENDENT AMBULANCES	92	0	92	100%	8	100%	–

	2012/13					2011/12
	Major impact	Moderate impact	Minor impact	Total	% Major and Moderate	% Major and Moderate out of all concerns
INDEPENDENT HOSPITAL	0	0	6	6	0%	36%
INDEPENDENT COMMUNITY HEALTH CARE	0	4	4	8	50%	50%
INDEPENDENT MENTAL HEALTH, LEARNING DISABILITY AND SUBSTANCE MISUSE SERVICES	1	8	11	20	45%	53%
INDEPENDENT AMBULANCES	0	0	0	0	n/a	0%

	Independent hospital	Independent community health care	Independent MH/LD/SM	Independent ambulance
EAST	96%	94%	85%	100%
EAST MIDLANDS	96%	100%	90%	100%
LONDON	100%	99%	93%	100%
NORTH EAST	100%	100%	100%	100%
NORTH WEST	98%	98%	92%	100%
SOUTH EAST	99%	97%	97%	100%
SOUTH WEST	100%	100%	91%	100%
WEST MIDLANDS	98%	100%	89%	100%
YORKSHIRE AND THE HUMBER	100%	100%	100%	100%

TABLE A3.14: SUITABILITY OF STAFFING

PROPORTION OF JUDGEMENTS WHERE STANDARDS MET FOR OUTCOMES 13 AND 14

	JUDGEMENTS 2012/13				2011/12		PERCENTAGE POINT CHANGE
	Standards met	Standards not met	Total Judgements	% standards met	Total Judgements	% standards met	
INDEPENDENT HOSPITAL	565	44	609	93%	470	93%	–
INDEPENDENT COMMUNITY	617	33	650	95%	481	93%	+2%
INDEPENDENT MENTAL HEALTH, LEARNING DISABILITY AND SUBSTANCE MISUSE	298	37	335	89%	256	81%	+8%
INDEPENDENT AMBULANCES	115	18	133	86%	14	64%	+22%

	2012/13					2011/12
	Major impact	Moderate impact	Minor impact	Total	% Major and Moderate	% Major and Moderate out of all concerns
INDEPENDENT HOSPITAL	0	12	32	44	27%	40%
INDEPENDENT COMMUNITY HEALTH CARE	1	11	21	33	36%	49%
INDEPENDENT MENTAL HEALTH, LEARNING DISABILITY AND SUBSTANCE MISUSE SERVICES	2	20	15	37	59%	55%
INDEPENDENT AMBULANCES	0	11	7	18	61%	60%

	Independent hospital	Independent community health care	Independent MH/LD/SM	Independent ambulance
EAST	92%	93%	91%	62%
EAST MIDLANDS	79%	91%	85%	80%
LONDON	96%	98%	83%	95%
NORTH EAST	90%	91%	95%	100%
NORTH WEST	94%	95%	89%	87%
SOUTH EAST	92%	92%	90%	84%
SOUTH WEST	90%	85%	88%	94%
WEST MIDLANDS	91%	98%	89%	100%
YORKSHIRE AND THE HUMBER	100%	100%	94%	100%

TABLE A3.15: MONITORING QUALITY

PROPORTION OF JUDGEMENTS WHERE STANDARDS MET FOR OUTCOMES 13 AND 14

	JUDGEMENTS 2012/13				2011/12		PERCENTAGE POINT CHANGE
	Standards met	Standards not met	Total Judgements	% standards met	Total Judgements	% standards met	
INDEPENDENT HOSPITAL	677	38	715	95%	558	96%	-1%
INDEPENDENT COMMUNITY	735	34	769	96%	549	95%	+1%
INDEPENDENT MENTAL HEALTH, LEARNING DISABILITY AND SUBSTANCE MISUSE	287	29	316	91%	203	84%	+7%
INDEPENDENT AMBULANCES	137	23	160	86%	18	83%	+3%

	2012/13					2011/12
	Major impact	Moderate impact	Minor impact	Total	% Major and Moderate	% Major and Moderate out of all concerns
INDEPENDENT HOSPITAL	0	20	18	38	53%	28%
INDEPENDENT COMMUNITY HEALTH CARE	0	15	19	34	44%	37%
INDEPENDENT MENTAL HEALTH, LEARNING DISABILITY AND SUBSTANCE MISUSE SERVICES	3	17	9	29	69%	53%
INDEPENDENT AMBULANCES	2	7	14	23	39%	75%

	Independent hospital	Independent community health care	Independent MH/LD/SM	Independent ambulance
EAST	93%	95%	92%	70%
EAST MIDLANDS	95%	95%	88%	82%
LONDON	99%	98%	77%	92%
NORTH EAST	97%	100%	100%	100%
NORTH WEST	97%	98%	95%	83%
SOUTH EAST	96%	97%	100%	84%
SOUTH WEST	80%	86%	79%	86%
WEST MIDLANDS	88%	89%	94%	92%
YORKSHIRE AND THE HUMBER	99%	96%	92%	100%

SECTOR PERFORMANCE TABLES:

Primary dental care

TABLE A3.16

PROPORTION OF JUDGEMENTS WHERE STANDARDS MET

	JUDGEMENTS 2012/13				2011/12		PERCENTAGE POINT CHANGE
	Standards met	Standards not met	Total Judgements	% standards met	Total Judgements	% standards met	
SAFEGUARDING AND SAFETY	4798	376	5174	93%	1393	93%	No change
CARE AND WELFARE	2994	72	3066	98%	729	98%	No change
RESPECT AND DIGNITY	2514	17	2531	99%	584	100%	-1%
SUITABILITY OF STAFFING	1564	67	1631	96%	119	91%	+5%
MONITORING QUALITY	2128	141	2269	94%	84	92%	+2%

	2012/13					2011/12
	Major impact	Moderate impact	Minor impact	Total	% Major and Moderate	% Major and Moderate out of all concerns
SAFEGUARDING AND SAFETY	18	143	215	376	43%	30%
CARE AND WELFARE	2	30	40	72	44%	32%
RESPECT AND DIGNITY	0	3	14	17	18%	20%
SUITABILITY OF STAFFING	2	16	49	67	27%	61%
MONITORING QUALITY	5	46	90	141	36%	31%

	Safeguarding and safety	Care and welfare	Respect and dignity	Suitability of staffing	Monitoring quality
EAST	91%	97%	98%	93%	89%
EAST MIDLANDS	89%	95%	99%	94%	93%
LONDON	93%	99%	100%	97%	93%
NORTH EAST	94%	99%	99%	97%	96%
NORTH WEST	97%	99%	100%	98%	98%
SOUTH EAST	92%	97%	100%	93%	92%
SOUTH WEST	87%	97%	99%	95%	91%
WEST MIDLANDS	93%	98%	99%	96%	92%
YORKSHIRE AND THE HUMBER	96%	98%	100%	98%	99%

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Published as separate annexes

Technical Annex 1: Avoidable admissions

Technical Annex 2: ASC funding data collection

Technical Annex 3: Dementia thematic review

Technical Annex 4: Adult social care statistical analysis

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