CareQuality Commission

The state of health care and adult social care in England

Key themes and quality of services in 2009

Care Quality Commission

The state of health care and adult social care in England
Key themes and quality of services in 2009

About the Care Quality Commission

The Care Quality Commission is the independent regulator of health care and adult social care services in England. We also protect the interests of people whose rights are restricted under the Mental Health Act.

Whether services are provided by the NHS, local authorities or by private or voluntary organisations, we make sure that people get better care by:

• Driving improvement across health and social care.*

• Putting people first and championing their rights.

• Acting swiftly to remedy bad practice.

• Gathering and using knowledge and expertise, and working with others.
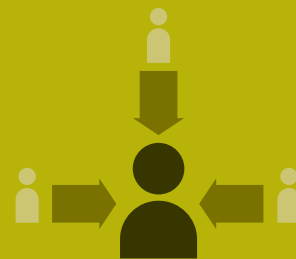
* When we use the term "social care" in this report, we mean adult social care for people of 18 years of age or older. Social care services for children and young people under 18 are regulated by Ofsted.
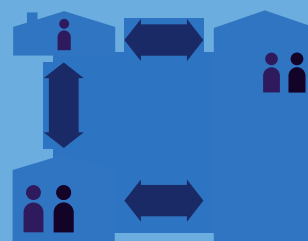
Contents

Summary

This report sets out how well health care and social care services in England performed in 2009, and the improvements leading up to 2009.

It is the Care Quality Commission's first yearly report to Parliament on the state of health care and adult social care in England. We have taken a broad view across health and social care, drawing on the wide range of evidence gathered through our regulation and performance assessment activities, which are currently different for health care and social care. This includes, as much as possible, information on the experiences of people who use services and what happens to them. Our analysis highlights key areas of progress to build on, and those areas where further attention is needed to improve people's care.

The *State of health care and adult social care in England* covers the services that we regulate, which are:

- Adult social care services (care homes and home care agencies)

- NHS and independent health care services

- Primary care trusts (PCTs) and councils, which provide and purchase (commission) health care and adult social care services for their communities.

Overview of health and social care in 2009

Great improvements have been made over recent years. Increasing numbers of health and social care services, councils and PCTs have been assessed as "good" or "excellent". The proportion of adult social care services (such as care homes and home care agencies) rated as good or excellent rose from 69% in 2008 to 77% in 2009; the proportion of NHS trusts scoring good or excellent for quality of services has remained high at 63%, an increase from 61% in 2008.

There have been great successes in reducing waiting times for NHS non-emergency care and waiting times in A&E; in reducing rates of healthcare-associated infections; and in supporting more people to live independently at home. This is clearly cause for celebration.

There remains unacceptable variation, and a small number of services or organisations do not meet minimum* standards of safety and quality. Five per cent of NHS trusts are rated "weak" and 2% of adult social care services (such as care homes and home care agencies) are "poor". In the independent health care sector, across all services and all minimum standards, there are major shortfalls from the standards in 10% of cases. In particular, good practice relating to

---

* In this report we refer to core 'Standards for Better Health' set out for the NHS in 2004 as minimum standards. We also refer to National Minimum Standards that are set out in the Care Standards Act for independent health care providers and adult social care providers, as minimum standards.

safety, safeguarding arrangements and workforce training needs to be implemented more widely.

The future presents a major challenge. The Government expects that, in 20 years' time, 1.7 million more adults in England will have a care and support need. At the same time, we are entering a period when public finances will be stretched. And people are, rightly, coming to expect more choice and control over their care. To help meet these challenges, there needs to be real acceleration in joining up health and social care and centring it on people's needs. The changes needed are often cultural ones that could deliver major benefits.

- There is progress in joining up health and social care to meet people's needs but this must get faster, to improve people's experience of care and maintain their independence and health. Better joined-up care will help meet future demand and deliver greater value for money by reducing the reliance on high-cost hospital and residential care. For example, some older people are admitted to hospital as emergencies twice or more every year, and some of these admissions might not be necessary if people were cared for better in the community. If every local area could reduce the number of people admitted repeatedly as emergencies, and the length of time these people spend in hospital, to the low levels seen in the best performing areas of the country, this would result in an annual saving of around £2 billion to hospital budgets.

- A fundamental cultural shift needs to take place, so that people are able to shape their own care. As Lord Darzi identified for the NHS in *High Quality Care for All*, despite the improvements over the last decade, "convenience for the system too often takes precedence over convenience for patients". This means giving people better access to timely, relevant and accurate information and allowing them to make decisions about their care, so that they have more control and are treated with dignity and respect. Such person-centred care can be more effective because the focus is on an individual's needs and maintaining their independence and health, as opposed to a one-size-fits-all approach which could involve providing the wrong care at the wrong time.

Improvements in health and social care

Assessments show that there has been great improvement in performance over recent years, and that some services or aspects of care have improved significantly.

Overall improvements in performance

- There has been a steady increase in the number of councils which are performing "well" or "excellently". This is the sixth year running where no councils have been assessed as "poor".

- In adult social care, the proportion of services (such as care homes and home care services) rated as "good" or "excellent" rose from 69% to 77% between 2008 and 2009.

- Over four years of NHS performance ratings, the proportion of trusts scoring excellent or good for the quality of their services has risen from 41% in 2005/06 to 63% in 2008/09.

- Over the same time period, the proportion of NHS trusts scoring excellent or good for financial management has improved markedly, from 16% in 2005/06 to 71% in 2008/09.

- Independent health care providers such as independent hospitals, hospices and private doctors meet 64% of minimum standards and almost meet* a further 26%.

Examples of progress

- The NHS has greatly improved access to, and the experience of, people waiting for acute care. For example in 2008/09, 70% (109) of trusts met the target to ensure that (in 98% of cases) people spend no more than four hours in accident and emergency (A&E) departments.

- In 2008/09, 89% of (151) acute trusts achieved the demanding target of ensuring a maximum waiting time of 18 weeks from referral to start of non-emergency treatment.** In 2007/08, 44% (75) of trusts achieved the measures that examined progress towards meeting the target. There has been huge improvement, particularly as the number of patients waiting longer than 18 months was still being measured in 2001/02.

- There was a 34% fall in reported MRSA (Methicillin-resistant *Staphylococcus aureus*) cases and a 35% fall in *Clostridium difficile* cases between 2007/08 and 2008/09.

---

*   Not met with minor shortfalls

** For 90% of admitted patients and 95% of non-admitted patients

Care Quality Commission

- More than 78% of PCTs meet indicators relating to the management of long-term conditions.

- There are signs of more people being supported to live independently at home: 2.1% of people (208,530) aged 65 and above were living in care homes (supported by their council) in 2009, compared to 2.5% (241,200) in 2005.

- In 2009, 148,000 people had access to council-funded services that help prevent unnecessary admission to hospital, compared to 80,000 five years ago.

- In 2009, 157,000 people had access to council-funded services that help prevent delays in discharge from hospital, compared to 112,000 five years ago. The average number of people experiencing delays has fallen from 3,600 a week in 2003/04 to 2,200 a week in 2008/09.

- Things sometimes go wrong when people receive care. It is crucial that organisations report their mistakes and near misses (called 'incidents'). This is so that they can learn and put things right, which creates a culture of improvement in safety, rather than one of blame. The number of safety incidents reported by the NHS to the National Patient Safety Agency (NPSA) has improved greatly, from 922,552 incidents in 2007/08 to 1,061,934 in 2008/09.*

---

* Figures relate to incidents that are reported between each July and the following June

Variations in performance and in meeting minimum standards of safety and quality

At a local level there is unacceptable variation in the performance of services. A small proportion are falling below minimum standards of quality and safety. Some are persistently failing to improve.

- 426 social care services (2%) are overall rated "poor", with a further 17% rated "adequate".

- Of the 392 trusts assessed in 2009, 20 trusts (5%) were rated "weak" and 32 (8%) have never scored higher than "fair" over the past four years.

- Service providers within the independent health care sector are required to meet different sets of minimum standards. Across all services and all minimum standards, there were major shortfalls from the standards in 10% of cases.

Our analysis has highlighted safety, safeguarding, and workforce training as particular areas of concern.

Safety

Safe care, delivered in a way that gives continual attention to reducing avoidable harm, is fundamental to ensuring that people have good outcomes after treatment. The NHS has made considerable progress in this area but unacceptable variations persist. A number of organisations need to adopt accepted good practice.

- **Reporting incidents.** As we said above, it is crucial that organisations report their mistakes and near misses so that they can learn and put things right. The number of incidents reported to the NPSA has improved greatly. However, the reporting rate continues to vary across organisations: for example, reporting from primary care trusts with hospital beds varies over twenty-fold. A number of organisations must improve their awareness of safety, reporting of incidents, and learning from things that have gone wrong. In particular, reporting from general practice needs to improve: even though 90% of patient contact with the NHS takes place within general practices, only 3,417 incidents were reported from general practice, compared to 693,700 incidents from hospitals.

- **Infection control.** The NHS has made excellent overall progress in tackling MRSA and *Clostridium difficile*. Yet this picture varies across organisations and 48 acute trusts (28%) did not meet at least one of three infection control minimum standards in 2008/09.

Safeguarding

Everyone, including health and social care staff, has a responsibility to keep children and adults safe from abusive and criminal behaviour. This is called "safeguarding". In both health and adult social care, concerns have been raised about the effectiveness of safeguarding arrangements across and between different organisations.

• NHS organisations should have been meeting minimum standards of quality since they were established in 2004. In 2008/09, 9% of NHS organisations did not comply with the minimum standard on child safeguarding, which is worse than the previous year (4%).

• Improvements in adult safeguarding procedures were needed in 10% of councils, and over a third had to make further improvements in their safeguarding training.

Staff training

Trained staff are essential to the quality and safety of services. But all types of services, as well as PCTs and councils that purchase care for people, find minimum training standards hardest to meet. These training standards cover a range of courses relevant to the services concerned, such as basic safeguarding, basic life support and fire safety.

• In 2009, the standard requiring NHS staff to participate in mandatory training programmes had the lowest overall compliance rate of all minimum standards, varying from 73% compliance in ambulance trusts to 90% in mental health trusts.

• 85% or less of adult social care services (care homes and home care agencies) meet minimum standards for training which were set out in 2000.

• Staff training and qualifications were a strength in only 16% of councils.

Joining up health and social care services

The future presents a major challenge. Public finances are tightening and the Government expects that, in 20 years' time, 1.7 million more adults in England will have a care and support need.

To help meet this challenge, there needs to be real acceleration in providing care that is coordinated around people's needs so that they can benefit from the very best possible outcomes. Approaches to joined-up care within and between health and social care can help make the system more efficient: for example, when hospitals work with councils to discharge people home from hospital quicker, the need for high-cost hospital and long-term residential care is reduced.

There have been encouraging improvements in joined-up care:

- There are signs of more people being supported to live independently at home – 2.1% of people aged 65 and above (208,530) were living in care homes (supported by their council) in 2009, compared to 2.5% (241,200) in 2005.

- In 2009, 148,000 people had access to council-funded services that helped them avoid being admitted to hospital as an emergency, compared to 80,000 five years ago.

- 157,000 people had access to services that helped them return home quickly from hospital, compared to 112,000 five years ago. The number of people experiencing delays has fallen from 3,600 a week in 2003/04 to 2,200 a week in 2008/09.

Local variations

The national picture of overall improvement masks considerable variation locally:

- There is a three-fold variation in the extent to which councils place older people in long-term residential care.

- There is a huge (over thirty-fold) variation in the proportion of people whose discharge from hospital is delayed. This means, that in some areas, expensive hospital-based care is over-used.

- Some older people are admitted to hospital as emergencies twice or more a year, and some of these admissions might not be necessary if people were cared for better in the community. If every local area could reduce the number of people admitted repeatedly as emergencies and the length of time these people spend in hospital to the low levels seen in the best performing five areas of the country, hospitals could make an annual saving of around £2 billion.

Sharing information between services

Good quality communication between professionals and between organisations makes for a more seamless experience for people moving within a service, or across health and social care services. Communication problems can have a negative impact on what happens to people.

- 95% of trusts said that they had protocols for sharing information on children's safeguarding concerns. However, 36% of acute trusts did not have a policy for joint working between maternity services and social services. Nineteen per cent of mental health trusts did not have agreements in place for communication between mental health and children's services.

- 17% of care homes had not received information about whether people had a healthcare-associated infection, when they were discharged from hospital.

- Only 53% of general practices reported that discharge summaries sent by acute trusts arrived in time to be useful.

Giving people choice and control, and protecting their rights

Centring care on people's individual needs and protecting their rights are important hallmarks of good quality health and social care.

People are, rightly, coming to expect more choice and control over their care. As Lord Darzi identified for the NHS in *High Quality Care for All*, despite the improvements over the last decade, "convenience for the system too often takes precedence over convenience for patients". Person-centred care can be more effective because the focus is on the individual's needs and maintaining their independence and health, as opposed to a one-size-fits-all approach. The Government has estimated that up to £2.7 billion per year could be saved by enabling people to manage their own conditions (such as diabetes) better, treating them closer to home and avoiding unnecessary hospital visits. Many services aim to give people as much independence as possible.

Sharing information with people

More people are now getting better information about their care and options. However, information is not always made available to people or communicated in a way that they can understand.

- Just under 99% of NHS trusts say they meet minimum standards on making information available.

- Over 80% of adult social care providers and between 48% and 75% of independent health care providers fully meet relevant minimum standards for sharing information with people.

- However, people's own views of whether they were well communicated with are not as positive. Twenty-one per cent of inpatients in hospital report that they were not given sufficient information about their condition or treatment, a picture which has remained unchanged over recent years. Twenty-nine per cent of people with disabilities using social care services thought that they were not communicated with in a way that helped them understand things properly.

Choice and control

People are being offered more choice and control, but progress is mixed.

- 47% of people recall being offered a choice of hospital for their first outpatient appointment, an improvement from 30% in 2006.

- Over 90% of adult social care services meet minimum standards on choice and control.

- Almost half of adult inpatients using an acute health care service were "definitely" not involved in decisions about their care as much as they wanted.

- In mental health services, 27% of people using acute mental health care were not as involved in their care as they wanted.

- In 2003, a system was introduced to enable councils to make direct payments to individuals so that they could choose and purchase their own social care. In 2008/09, 86,000 adults received such payments and spend equated to only 4% of the overall gross current expenditure on care. In 53 out of 141 councils, fewer than 5% of people receiving care use direct payments.

Access to care

People's options can be limited if access to care is restricted. PCTs and councils have to balance funding care for people with high levels of need with funding services that maintain people's independence and promote health and wellbeing.

- 72% of councils have chosen to focus their funding for social care solely on people whose needs are substantial or critical. As criteria are tightened, increasing numbers of people become ineligible for public funding. They have to fund their own care, if they are able to, otherwise the responsibility for providing care and support falls increasingly to carers and families. In such circumstances, it is particularly important to provide good support and information (for example, about voluntary sector services) to people and their carers and families. This is something that excellent-rated councils have done. As the population ages and financial pressures grow, we expect that access to publicly-funded care will become further restricted. We welcome the publication of the Government's green paper on reforming the system of care and support. Whatever funding system is adopted for a National Care Service, it needs to ensure that people have access to quality services, and to be sustainable in the face of future population changes.

- The NHS has greatly improved the experience of people waiting for acute care, both in terms of waits for non-emergency care and waits in A&E. In 2008/09, 89% of acute trusts (151) achieved the demanding target of ensuring a maximum waiting time of 18 weeks from referral to start of non-emergency treatment.* The percentage of people able to get an appointment with a general practitioner within 48 hours has improved to 85% on average, but varies from 76% to 92% across PCTs. And only half of trusts provide adequate access to out-of-hours support for people with mental health needs.

Equalities and human rights

We are concerned that services are not improving in challenging discrimination and promoting human rights fast enough. For example:

- 91% of NHS organisations are meeting the minimum standard for challenging discrimination, promoting equality and respecting human rights. But all organisations should have met this standard in 2004, and performance is low in comparison to most other minimum standards.

- Only 31% of councils were monitoring how well they were meeting targets on equalities.

- People from minority ethnic groups continue to be over-represented among those detained under the Mental Health Act.

---

* For 90% of admitted patients and 95% of non-admitted patients

Moving forward

Major improvements have been made in health and social care services in the years leading up to and during 2009. Yet there is variation in the quality of care, and we are concerned about a small number of organisations that do not meet current minimum standards or that persistently fail to improve.

Increased demand and tightened finances in the future mean that many organisations will need to fundamentally change the extent to which they join up services across traditional divides and give people more control and choice.

Those who provide services and those who purchase care on people's behalf are responsible for improving the quality of care, implementing essential improvements and learning from others. At CQC, we will play our part in helping to improve the quality of care through our regulatory activities. We are changing our approach to give more emphasis to people's experience and the outcomes of care.

We are committed to involving people who use health and adult social care services in our work and making sure that services involve people and respond to their views. We believe that this involvement is central to improving services for everyone.

We are introducing a registration system across health and adult social care, with a common set of new essential standards of quality and safety that all services have a legal responsibility to meet. We will set clear expectations of services that focus on outcomes and are centred on people. We will look at whether people who use services receive safe and coordinated care, and in particular we will look at the quality of treatment and support where people receive more than one service or are moved between services, because these are key points where the quality of care can break down.

The new registration system will work in real time. We will identify serious issues by vigilant assessment of risks to the quality and safety of care, and by responding quickly to concerns as they arise. We will act swiftly to bring about change that improves people's care. We are working as part of the National Quality Board to ensure that early warning signs of concerns are tackled and that it is clear who is responsible for this.

Where we find shortfalls in performance against essential standards, we will impose conditions of registration, and we will refuse to register services that fall below the standards. We will use our enforcement powers where needed. We will also focus on driving improvements through performance assessment and our special reviews and studies.

1

Giving people choice and control and protecting their rights

A fundamental cultural shift is needed, so that people are able to shape and control their own care. They need to be allowed to make decisions about different aspects of their care, and to have high-quality information to support their choices. Person-centred care can be more effective because the focus is on an individual's needs and maintaining their independence and health, instead of them having to fit into a 'one-size-fits-all' approach. The Government has estimated that up to £2.7 billion per year could be saved by enabling people to manage better their own conditions, such as diabetes, by treating them closer to home and avoiding unnecessary hospital visits.
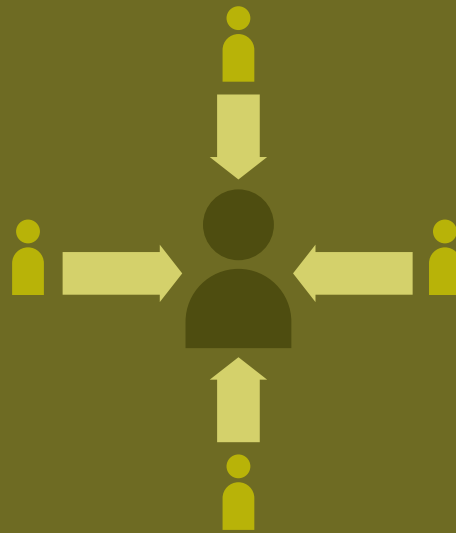
Here are some of our findings for 2009:

- Nearly 99% of NHS trusts said they met minimum standards on making information available. However, 21% of inpatients in hospital said that they were not given enough information about their condition or treatment.

- 29% of people with disabilities using social care services said they were not communicated with in a way that helped them understand things properly.

- 47% of people recall being offered a choice of hospital for their first outpatient appointment, an improvement from 30% in 2006.

- 27% of people using acute mental health care were not as involved in their care as they wanted. And only half of mental health trusts provided adequate access to out-of-hours support for people with mental health needs.

- Councils' spend on direct payments to people equated to only 4% of the overall gross expenditure on care.

- In 70% of councils, people's needs have to be substantial before they can get any publicly-funded social services support.

- The NHS has greatly improved waiting times for acute care.

- 91% of NHS trusts met the standard for challenging discrimination, promoting equality and respecting human rights, but this performance is lower than for most other minimum standards. Only 31% of councils were monitoring how well they were meeting targets on equalities.

Introduction

"Treat me with respect – involve me in decisions about my support."

Person who uses services

Putting people at the centre of their care

Centring care around people's individual needs and protecting their rights are important hallmarks of good quality health care and social care. By reflecting and addressing each person's unique needs, and enabling them to achieve as much independence as possible, person-centred care promotes wellbeing and upholds personal dignity.

Person-centred care is exactly that: it puts people at the centre of the design and delivery of the services they use. People should be able to make choices about different aspects of their care, maintain their independence and feel in control. To do so, they need high-quality, up-to-date information about their care, treatment and support and to be fully involved in decisions about it. It is equally important that people have fair and equal access to care and their dignity and human rights are respected.

We want everyone to be able to experience such care. However, we believe that this calls for a fundamental cultural shift in the health care and social care system. As Lord Darzi identified for the NHS in *High Quality Care for All*, despite the improvements over the last decade, "convenience for the system too often takes precedence over convenience for patients".[1]

Basing care around people's needs can achieve greater value for money than a 'one-size-fits-all' approach. In the years ahead, there are likely to be both increased demand for health care and social care and cuts in public spending. Services will have to work hard to improve their efficiency.

Person-centred care can improve the effectiveness of services, and services that are controlled by individuals can relieve pressure on the system. The Government has estimated that annual savings of up to £2.7 billion could be made by enabling people to better manage their own conditions, treating them closer to their own homes and avoiding unnecessary hospital visits.[2]

Jasmine's story

Jasmine was removed from her mother's care when she was 12 years old. She then lived in five different children's homes. She began self-harming as a result of the constant disruption to her life and left the homes on numerous occasions. During her time in care, Jasmine also developed a problem with illegal drugs. The problem grew worse when she experienced domestic violence. By her early 20s, Jasmine had been admitted to several refuges and her children had been taken into care.

A turning point for Jasmine was when she began treatment for her drug misuse. She was involved in developing her own care plan by people who "knew where I was coming from". Being given choices about the support she received – including the opportunity to say "no" – reduced the risk of her abandoning her care plan. This has helped her to achieve what she has planned to do.

"This time when I went for my assessments, I was listened to and actually felt like someone understood. I also agreed my care plan and had a big say as to what was in it and what suited me...I was involved at every stage."

*Jasmine took part in a workshop to share views and experiences of health care and social care. Her name has been changed to protect her confidentiality.

Setting the scene: the policy context

The Government is clear that public services should promote choice and opportunity and allow people to shape their own lives. This vision is reflected in a number of successive health care and social care policies that have sought to embed the principle of personalisation, using joined-up and connected care to achieve this.[1,2,3,4]

High Quality Care for All in 2008 emphasised the need for the NHS to be centred on people's needs and locally accountable.[1] The *NHS Constitution*, published in 2009, promotes the rights and responsibilities of people who use health services, as well as public and NHS staff.[5] The Government has allocated £520 million for councils to deliver the aspirations of *Putting People First* (2007).[6] While progress is being made, there are concerns about the rate of change – some councils are making substantial headway and others are just starting out.

In the 2006 white paper *Our health, our care, our say*, the Government made a commitment to improving access to information for people with health care and social care needs.[4] 'Information prescriptions', which signpost people to reliable sources of information and support tailored to their individual needs, help people with long-term needs to feel more in control and maintain their health and independence. They have been piloted and are now being rolled out nationally.[7] New plans for the NHS Choices website were laid out in *High Quality Care for All* in 2008 and represent the first step towards giving the public information about service quality in the NHS – including, for example, Care Quality Commission ratings and MRSA rates.

In its five-year plan, the Government set out its intentions for improving the NHS, which includes preventative and person-centred services and a health care system that works effectively and in a joined-up way.[2]

To increase people's control over their own care, *Putting People First* set out a vision for 'self-directed support' – based on more use of personal budgets and direct payments to people who are eligible for publicly-funded social care. These give individuals an allocation of money and the ability to choose how this is spent on their own care. Health care is moving in the same direction. *High Quality Care for All* sets out ideas for piloting of personal health budgets and direct payments for health care. The aim is to give people as much control over their health care as possible. There will be 70 pilot sites across England and 20 of these will take part in an evaluation study.[8] The Government is also consulting on proposals for regulations and guidance relating to direct payments for health care.[9]

This drive towards increased choice and control requires reform across all areas, including the planning, commissioning and delivery of services. These overarching aspirations have also been translated into the strategies for particular groups, such as people with learning disabilities[10], disabled people[11], carers[12], people with dementia[13] and people with mental health needs.[14] Together, these seek to drive forward personalised care and devolve power and decision making to local people.

Elements of person-centred care

Health and social care organisations are subject to different sets of regulation and approaches to inspection. We gather a wide range of information when we look at the quality of services. This includes drawing on the views and experiences of people who use services, which will be an increasingly important part or our regulatory model.

The assessment framework for councils is mostly built around the outcomes for people set out in *Our health, our care, our say*. We assess adult social care services against national minimum standards. A similar approach applies to independent health care providers (although we do not make a judgement on overall quality). NHS trusts are assessed against core and developmental standards.

Using our regulatory evidence, and feedback from people who use services and those who provide or commission them, we have identified four key elements of person-centred health care and social care:

- Giving people choice and control over their own care, treatment and support.

- Ensuring that people have fair and equal access to care.

- Promoting equality and respecting human rights.

- Involving people in shaping services for their local community.

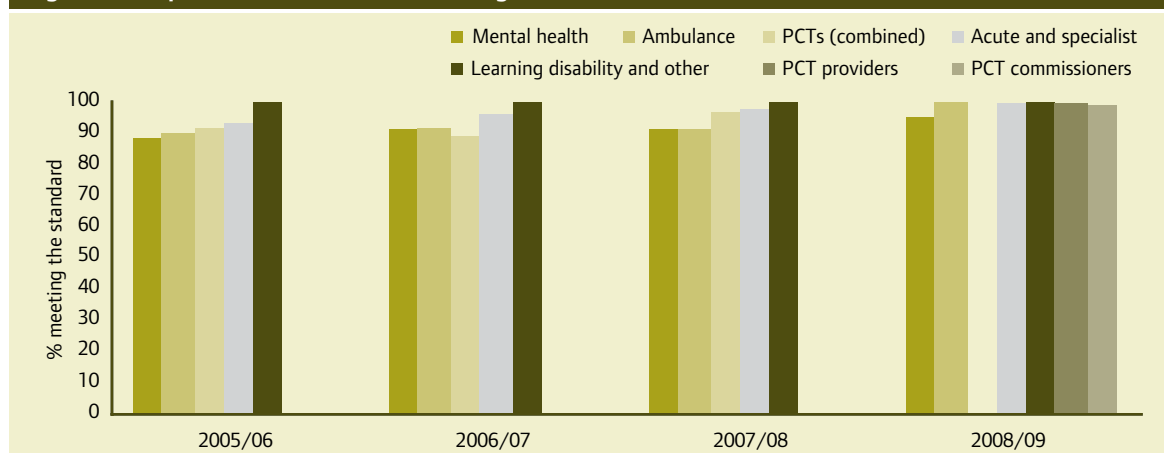# Giving people choice and control over their care, treatment and support

Health care and social care services have made good progress in meeting minimum standards when it comes to providing information to people. However, people still do not receive enough information to make choices or exercise control. For example, we found that information was often not shared at all, or not available in a format that made it understandable to the individual.

There have been improvements in some of the choice and control that people have, such as choosing which hospital they want to be treated in, but people are still not involved enough in ongoing decisions about their own care. Similarly, in social care, much more needs to be done to increase the levels of self-directed support.

Providing the right kind of information

Since 2004, NHS trusts have had to meet a minimum standard that requires them to make information about services and treatment available to the public. Trusts have improved noticeably in recent years and just under 99% of them have now met the standard (see figure 1).* Adult social care services have also improved in recent years, for example in providing users' guide to services, and more than 80% of adult care providers now meet minimum standards, as shown in figure 2. The performance of independent health care providers was more mixed. Of all services inspected, there were lower levels of compliance overall (see figure 3).

Figure 1: Proportion of NHS trusts meeting the core information standard, 2005/06–2008/09

Legend: Mental health, Ambulance, PCTs (combined), Acute and specialist, Learning disability and other, PCT providers, PCT commissioners
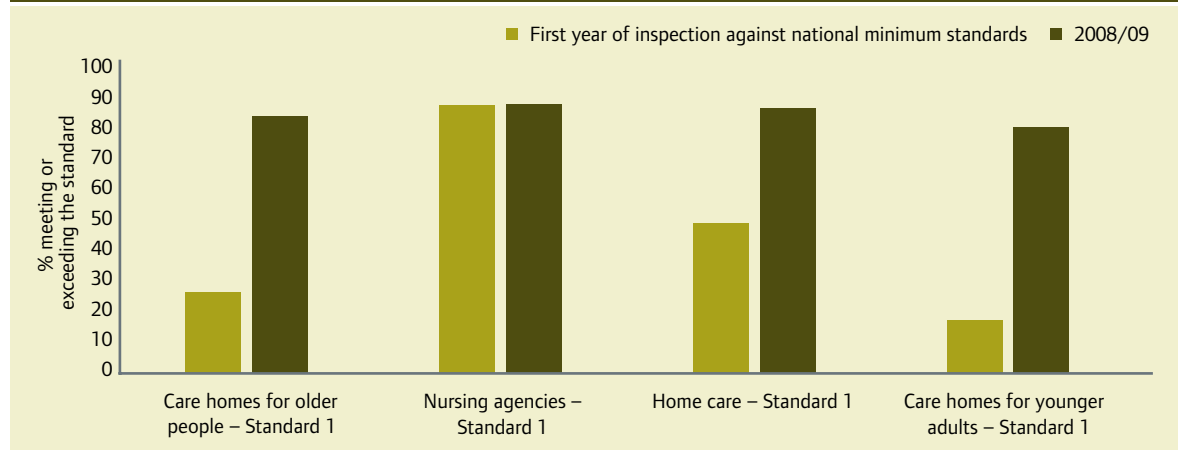
Source: Care Quality Commission.

---

*   Unless otherwise indicated, we use performance data for the NHS as at October 2009. See Care Quality Commission, *NHS performance ratings 2008/09: An overview of the performance of NHS trusts in England*, October 2009.

"Since being transferred from a maximum-secure unit to a medium-secure unit,
I have been able to put together my care plan with my primary nurse and be part of contributing to my care and future."

Person who has been detained under the Mental Health Act

Figure 2: Proportion of adult social care services meeting relevant information standards, comparison of first year of inspection with 2008/09

Source: Care Quality Commission.

Note: The first year of national minimum standards for care homes for younger adults and older people was 2002/03, for nursing agencies 2003/04 and for home care 2004/05. We have not included a Shared Lives standard, as the scheme does not have a broadly equivalent standard on information.

10% of youth offending teams were not providing enough suitable health care for children and young people who had been released from a secure setting.

When we took into account the views of people who use services, and looked beyond performance on the minimum standards, we saw room for improvement. Twenty-one per cent of inpatients said that they were not given enough information about their condition or treatment, a picture that has remained unchanged over a number of years.[15] Nationally, the proportion of people within trusts who said that they were not given enough information about their medicine on leaving hospital ranged from 11% to 34%.[16] In addition, our review of medicines management found that only seven of the 12 PCTs, with varying characteristics, that we visited gave people copies of their discharge letters, and only 55% of general practices replied "most of the time" when asked if people were present when their medicines were reviewed.

Our inspections of youth offending teams found that 10% of teams did not provide enough suitable health care to young people following their release from a secure setting.[17] A lack of involvement and communication by local health staff appeared to reduce the likelihood that young people would engage with services after they had been released.

In social care services, we found, for example, that 58% of older people using home care services were extremely or very satisfied with the service that they received. However, 30% said that their home care service provider hardly ever or never told them in advance about changes in the care they received.[18] We found shortfalls elsewhere in providers' communication with people who use services.[19,20,21] One study of disabled people found that 29% were not given information about the service in a way that they could understand. And in a sample

Figure 3: Proportion of independent health care providers meeting the core information standard, 31 March 2009
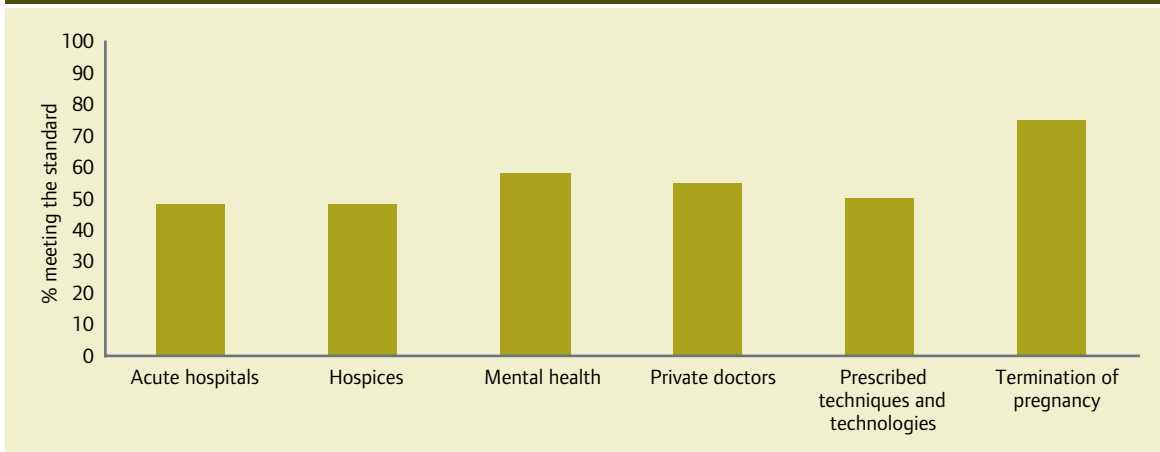
Source: Care Quality Commission.

Note: We have excluded maternity hospitals due to the low numbers of services inspected. Detailed descriptions of each of the standards are contained within Department of Health, *Independent Health Care: National Minimum Standards Regulations*, February 2002.

of 400 providers, only 9% said that they had made information more accessible for disabled people, for example by putting information into large print, audio format or easy words and pictures.[21]

We also found that many health care providers were not using the information they held about a person, which might be unrelated to their clinical needs, to make sure they communicated with them in a suitable way.[22] For example, people with a visual impairment who ask for correspondence in large print rarely got it in this format. Exceptions to this included some providers of mental health services, whose overall approach to communication focused more on the needs of individuals.

Failure to tailor communication to the individual often leads to a poorer experience of care and less positive outcomes. For example, it can lead to delays in people getting care if they missed appointments, and loss of privacy and independence because they need to have letters read to them or be accompanied to their appointments.

"No clear guidance about care and support, I feel like Alice in Wonderland – why can't I be sign posted to what I need to know or be able to access what I need to help me?"

Person who uses services

Marcella and Mitchell's story

Marcella's 19-year old son, Mitchell, has autism. It affects his communication and social skills, and he has been recognised as having 'challenging behaviour' since he was 14. Marcella thinks his behaviour becomes challenging because not many people understand how to help him when he's feeling anxious.

When Mitchell was 16, he and Marcella were chosen to take part in a pilot of a person-centred scheme for young people preparing to move to adult care services. Marcella developed Mitchell's care and support plan herself, around his individual needs. She says that "… the experience changed my life, because until then I had always thought that I would have to care for my son on my own for the rest of my life."

"At Mitchell's transition review meeting, many people came to support him and contribute to his future. I found it a 'transformation'… it taught me that my son worked differently with different people, depending very much on their characters. I was able to put this in his person-centred plan, to help avoid problems of 'challenging behaviour'." It was suggested at the meeting that Mitchell's communication would be helped by having a 'buddy' of a similar age to take him out to do things such as going to the cinema, ten-pin bowling, playing pool and football. This worked well for Mitchell, and he now also has a personal assistant to help him become more independent. This has also given Marcella the chance to develop her life, after 11 years as a full-time carer.

Mitchell's transition review meeting led to him having a buddy of a similar age and now a personal assistant, giving both him and Marcella the chance to develop their lives.

27% of people who used acute inpatient mental health services said that they were not involved as much as they wanted in decisions about their care and treatment.

47% of people surveyed recall being offered a choice of hospital for their first outpatient appointment.

Making choices and feeling in control

People are now given more choice about accessing NHS care, and there have been improvements in people being offered control over their own care. Commissioners and providers now need to take this further and ensure that all people feel fully involved throughout their care journey, no matter what type of care they use. In social care, most services reach the minimum standards, but councils are not doing enough to give people full control of their care through direct payments.

People referred by their GP for acute or outpatient care should be given a choice of hospital.[5,23] People's awareness of their right to choose has increased, as has the likelihood of them being offered and making a choice, and services meeting people's wishes. For example, in a survey conducted for the Department of Health in March 2009, 47% of people recently referred by a GP for their first hospital outpatient appointment said that they had been given a choice of hospital (up from 30% in May/June 2006). And of all people recently referred, 67% said that they were able to go to the hospital they wanted, 8% said that they were not, and 23% had had no preference.[24]

Involving people in decisions about their care and treatment is essential to creating a truly person-centred service. When we asked inpatients in NHS acute hospitals whether they were involved in decisions about their care as much as they wanted to be, we found that almost half (48%) of respondents said that they were not. This figure consisted of almost 11% who said "no", and 37% who were involved "to some extent". This means that only 52% of respondents said that they were "definitely" involved as much as they wanted. These results reflect little change over recent years, as shown in figure 4.[15]

In our 2009 survey of people who had recently received acute inpatient mental health services, we asked a similar question. A considerable minority (27%) said "no", 40% said "to some extent" and 34% said "definitely".[25]

There are positive findings from the 2009 GP Patient Survey commissioned by the Department of Health. Of all people with a long-standing health problem, disability or infirmity, 84% had had a discussion with their GP or a nurse about how best to deal with their problem. Of these, 88% said that the doctor or nurse took notice of their views. This means that 73% of people with these long-standing conditions had had this kind of discussion.[26]

In our inspections of adult social care services, we assess choice and control through distinct standards for each service type – for example, standards called "decision making" or "autonomy and choice". We have drawn these together in figure 5. The great majority of services meet minimum standards in this area.

Person using health services

"They [the pharmacist] make sure you know what tablets you're taking and why. … It's nice to think that they're thinking like that … now I can go to two people if I need any help – my GP and the chemist"

Figure 4: Proportion of NHS inpatients who were involved in decisions about their care and treatment, 2005 – 2008
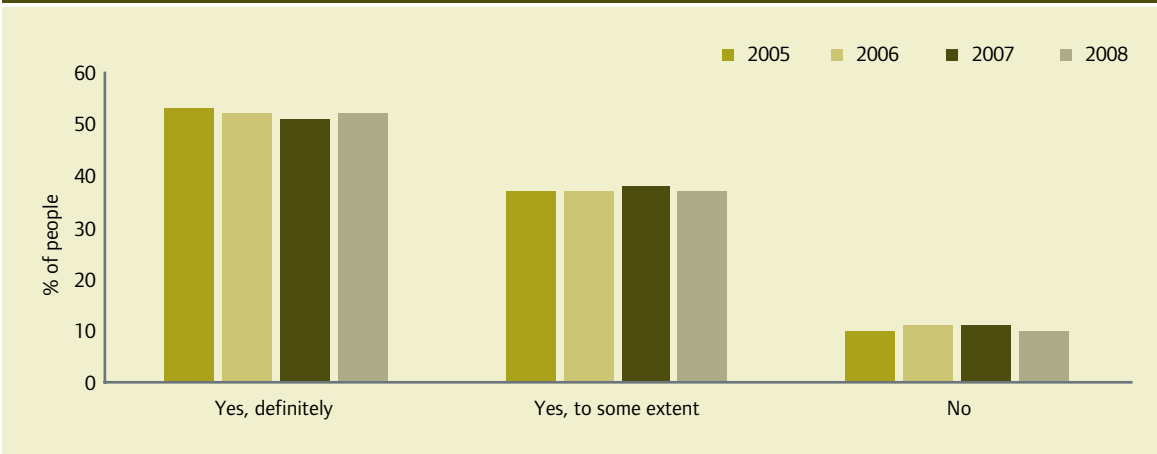
Source: Care Quality Commission, National NHS adult inpatient survey.

Figure 5: Proportion of adult social care services meeting the standards relating to choice and control, comparison of first year of inspection with 2008/09
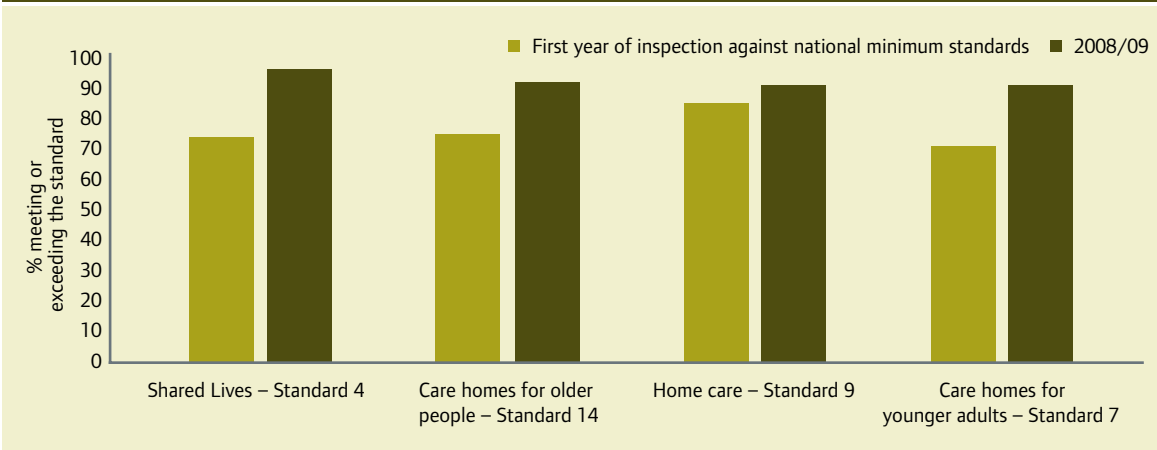
Source: Care Quality Commission.

Note: The first year of national minimum standards for care homes for younger adults and older people was 2002/03, for home care 2004/05 and for Shared Lives schemes 2005/06.

Figure 6: Levels of care funded by councils through direct payments, 2008/09

- 1 (1%)
- 22 (16%)
- 53 (38%)
- 65 (45%)

Legend:
- <5%
- 5 < 10%
- 10 < 20%
- 20 < 30%

Source: Information Centre for Health and Social Care, social care and mental health indicators from the National Indicator Set. Further analysis of provisional data for England 2008/09. No data for nine councils.

In 2008/09, spend on direct payments equated to only 4% of overall gross expenditure, with payments made to only 6.5% of people using services.

Enabling people to direct their own care

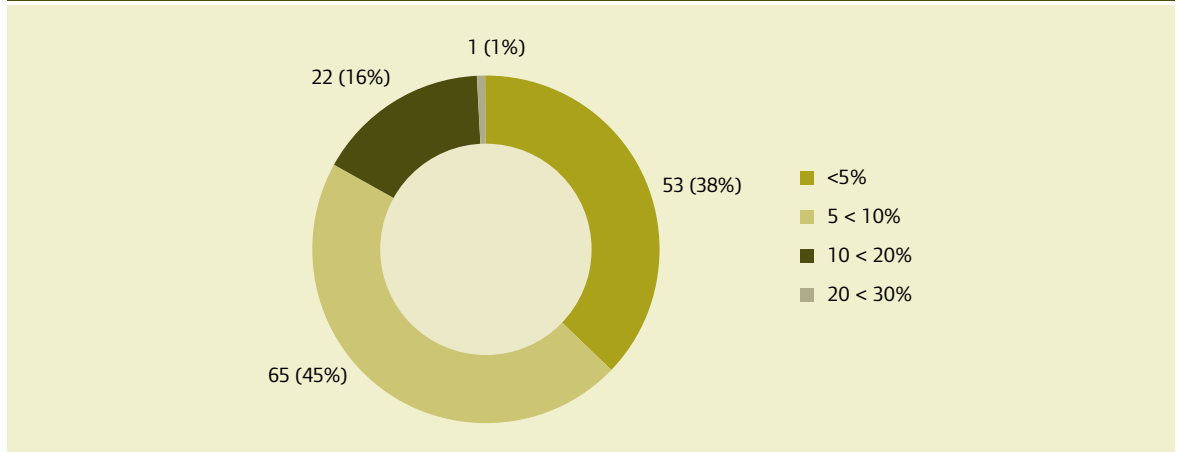Councils can significantly increase people's autonomy and independence by giving them a personal budget to buy their own care and support, and making direct payments to them from this budget. Since 2003, councils have had a duty to offer direct cash payments to people so that they can buy their own care, rather than automatically sending them to existing council-commissioned services. The Health and Social Care Act 2008 extended this right to those who lack capacity to consent and to those being treated in the community under the Mental Health Act.

In England, 115,000 adults aged 18 and over used direct payments during 2008/09 (including 29,000 carers who represented 25% of all direct payments users) – a total spend of £605 million. Direct payments are more likely to be used by adults of working age: 9.5% of all adults aged 18-64 receiving community-based or carers services and 3.6% of those aged 65 and over used a direct payment.

Expenditure on direct payments in 2008/09 increased by over 30% on the previous year, but this equates to only 4% of overall gross spend on adult care by councils. While across England direct payments were only made to 6.5% of all people using services, a minority of councils have promoted direct payments far more effectively, as shown in figure 6.

Our annual performance assessment of councils found that self-directed support and personal budgets to be a strength in nearly 30% of councils. However, 10% required further improvement and almost 40% needed to increase their level of self-directed support.

While more councils are promoting direct payments and starting to roll out personal budgets, our detailed review of arrangements for people with learning disabilities found few people or their family carers receiving such payments.[27] Although not a choice for everyone, we were told by many people that they would like to be able to get them.

> "It's changed my life. I get a set amount of money and I use it how I want for the care and support I need."

Roseann Pugh

Roseann has been a disabled person since the age of eight, when she was in a serious road traffic accident. At the age of 39 she had to have her hip replaced. Despite being told that she may not be able to walk afterwards, Roseann went on to work as a nurse for three years and with older people in their homes for 16 years. But three years ago she was diagnosed with a very rare respiratory condition that led to an emergency tracheostomy.

To enable her to manage after leaving hospital, Roseann received care at home. Then one day her council gave her the option of a personal budget for her care and support: "It's changed my life. I get a set amount of money and I use it how I want for the care and support I need. I still have freedom and I can do my house work my way, but with help. It's helping me with my independence."

Figure 7: Total direct payments received by different groups, 2008/09

Legend:
- █ £5000+ in year
- █ £2000<£5000 in year
- █ £1000<£2000 in year
- █ £500<£1000 in year
- █ £200<£500 in year
- █ <£200 in year

Categories (y-axis):
- Adults under 65 with physical disabilities
- Adults under 65 with learning disabilities
- Older people
- Adults under 65 with mental health problems
- Carers (all ages)

x-axis: % of recipients (0 to 100)
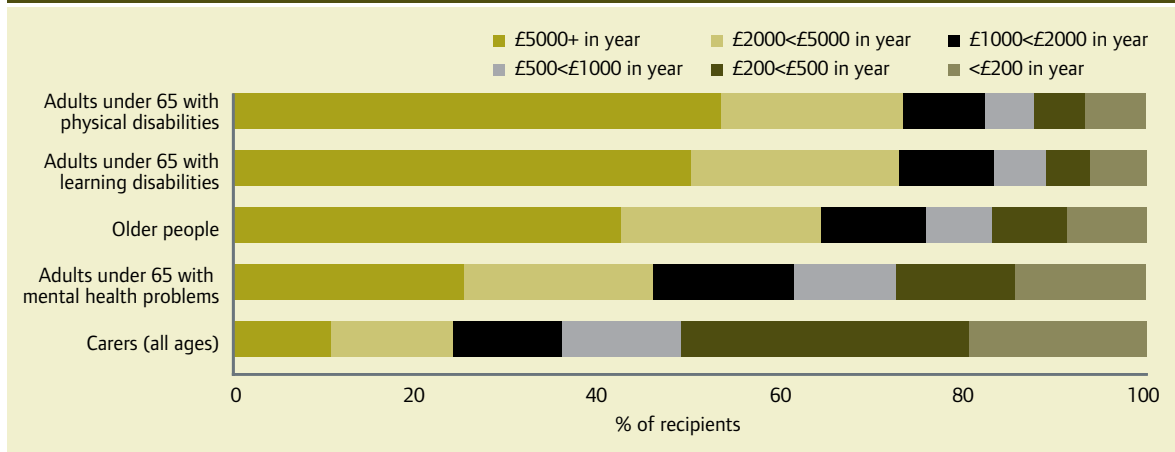
Source: Care Quality Commission.

There is a wide variation in the value of direct payments that councils are making to people. The majority of older people, people with learning disabilities and people with physical and sensory impairments each received more than £2,000 in total in 2008/09. People with mental health needs frequently received less than £2,000 each in total (see figure 7).

Supporting people to make decisions

Good independent advocacy services play a crucial role in self-directed support, by helping people who use services to express their views and supporting them with decision-making.

We collect information about advocacy services for people with learning disabilities. There has been a year-on-year rise in average council spend between 2004/05 (£83,200) and 2008/09 (£136,800). It is now 60% higher than in 2004/05 and an extra 6.5% is planned for 2009/10. In total, more than £20 million has been spent across England in 2008/09 and this will rise to almost £22 million in 2009/10.

Despite the increase in funding, advocacy services to support people to make personal decisions, life choices and to promote equality and inclusion were identified as requiring improvement in 20% of councils in 2008/09.

Our national study to follow up specialist inpatient services for people with learning disabilities found that advocacy was in a poorer position in 2008/09 than in 2007. Just over a quarter of all services did not provide independent advocacy services in 2007. During 2008/09, this proportion increased to more than half (27 out of 43 services).[28]

"I have a direct payment for 24/7 care, including four hours out of the 24 when I have two care workers with me. I would not be able to survive, or lead a normal life without this. I can do what I want, when I want and how I want."

Disabled person using social care services

Ensuring people have fair and equal access to care

One of the big differences between health care and social care is that social care services are means tested, whereas health care is founded on a universal principle, free at the point of delivery. But, like local councils, the NHS still has to prioritise where resources will be spent, and there are issues of equal access to care across the country.

The financial challenges being experienced by the sector both now and in the longer term risk disrupting people's access to services. There is an ongoing tension between directing funding towards people with high levels of needs and investing in a wider range of services that help to maintain other people's independence and promote health and wellbeing.

We have found that, across both health care and social care, attention has tended to be focused on acute or more intensive needs, rather than on lower-intensity interventions. In times of financial downturn, and in response to increased demand, there is potential for the system to further reduce access to care – for example, by tightening up eligibility criteria, withdrawing services thought to be less critical, or extending those waiting times that are not subject to targets.

This brings considerable risks to the system. If less intensive needs are left unaddressed, they may become more complex and require more expensive packages of care in the medium to long term. It also places considerable additional pressure on individuals, families and carers.

Fair access to social care services

Excellent performance for access to social care is characterised by good support and information for people who fall outside the eligibility criteria, with good signposting to other services. This is particularly important for councils that only fund care for people with substantial and critical needs. However, we remain concerned that, in a large proportion of councils, people's needs have to be substantial before they can get support from social services.

The Fair Access to Care Services (FACS) framework was introduced in 2003 to address inconsistencies across England about who receives publicly-funded social care. The aim was to provide a fairer and more transparent system for the allocation of services.[29] FACS sets out four levels of need: low, moderate, substantial and critical. Councils decide at which level they will fund care. People whose needs fall below these levels receive no publicly-funded care and have to arrange and pay for their own care and support.

In recent years, financial pressures have encouraged local councils to shift their focus towards groups of people with the highest needs. Between 2005/06 and 2007/08, there was a marked reduction in the number of councils who would support people with low and moderate needs (see figure 8). However, there has been little change over the last two years. Only three councils raised their eligibility criteria in 2008/09 and three lowered them.

Of the 148 councils assessed in 2008/09, in three (2%) someone's needs have to be critical before they can get social services

70% of councils in England will not fund a person's social care unless their needs are "substantial".

The proportion of people who could get a GP appointment within 48 hours varied from 76% to 92%, depending on their primary care trust.

support; in 103 (70%) needs have to be substantial; in 39 (26%), moderate and in three (2%), low. Two councils were planning to raise their eligibility criteria for funding people's care in 2009/10.

A review in 2008 of eligibility criteria found problems for some people seeking support because their needs and circumstances were not explored sufficiently at their first contact with the council. Of the survey participants who did not meet eligibility thresholds, some complained that their financial means were assessed before their needs.[30] In addition, 62% said that they were not given any information about other help that might be available.

As noted above, this year 72% of councils chose to focus their funding for social care solely on people whose needs are substantial or critical. In such circumstances, it is particularly important to provide good support and information (for example, about voluntary sector services) to people who are not eligible for public funding, and their carers and families. This is something that excellent-rated councils have done. As the population ages and financial pressures grow, we expect that access to publicly-funded care will become further restricted. We welcome the publication of the Government's green paper on reforming the system of care and support.[40] Whatever funding system is adopted for a National Care Service, it needs to ensure that people have access to quality services, both now and to be sustainable in the face of future population changes.

Waiting times and access to health care

The NHS has greatly improved access and the experience of people waiting for acute care. For example, following unacceptable waiting times, the four-hour accident and emergency target was established as a longstanding commitment in the NHS. Trusts must ensure that, in 98% of cases, people spend no longer than four hours from when they arrive to when they are either discharged home, admitted to hospital or transferred elsewhere. In 2008/09, 109 trusts met this target (see figure 9).
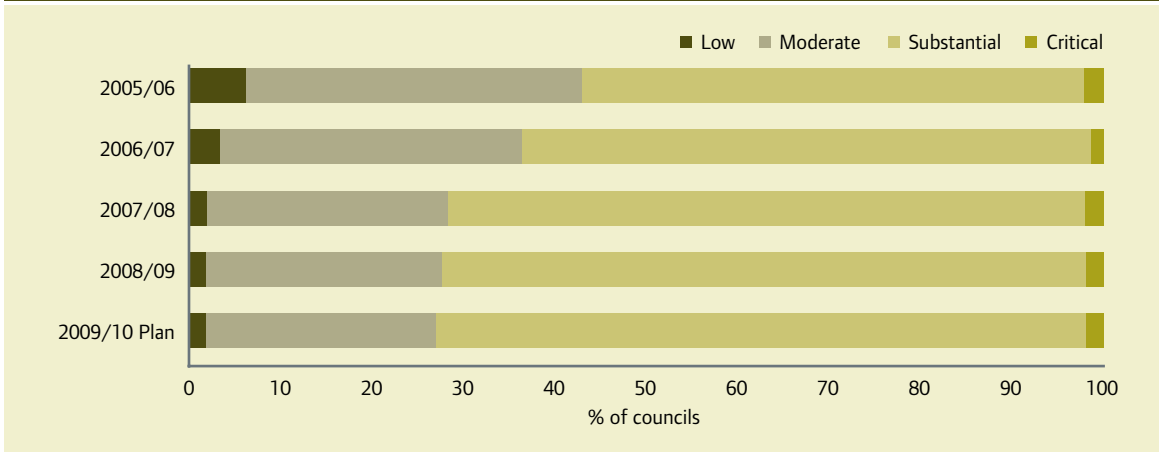
In 2008/09, 89% of acute trusts achieved the demanding target of ensuring a maximum waiting time of 18 weeks from referral to start of treatment. This compares with 2007/08, when 44% of trusts achieved the measures that examined progress towards meeting the target. There has been huge improvement – particularly when one considers that, in 2001/02, the number of people waiting longer than 18 months was still being measured.

People's access to their GP is variable. Across PCTs, the proportion of people able to get an appointment with a GP within 48 hours has improved to 85% on average, but varies from 76% to 92%.[26]

Access to some community services can also be a problem. Our review of specialist community mental health services found that only half of trusts provided adequate access to out-of-hours support for people with mental health needs.[31] And although there has been some improvement in the provision of out-of-hours support since 2005, performance by a small number of trusts (17%) was significantly lower than average.

In another review, of mental health services for older people, we found poor access to out-of-hours and crisis services, psychological therapies and alcohol services.[32] Many staff referred to chronic under-funding of services for older people compared with services for people aged under 65. In most trusts, older people were denied access to the full range of mental health services.

Figure 8: Levels of need at which councils will fund support for individuals, 2005/06 – 2009/10

Legend: ■ Low ■ Moderate ■ Substantial ■ Critical

Categories (y-axis): 2005/06, 2006/07, 2007/08, 2008/09, 2009/10 Plan

x-axis: % of councils (0 to 100)

Source: Care Quality Commission.

Figure 9: Performance of acute trusts in meeting the four-hour A&E target, 2008/09

y-axis: % of patients waiting four hours or less in A&E (93 to 100)

Source: Department of Health.

Figure 10: Proportion of people able to book a GP appointment on the same day or within the next two working days, by PCT, April – September 2009

y-axis: % of people (60 to 100)
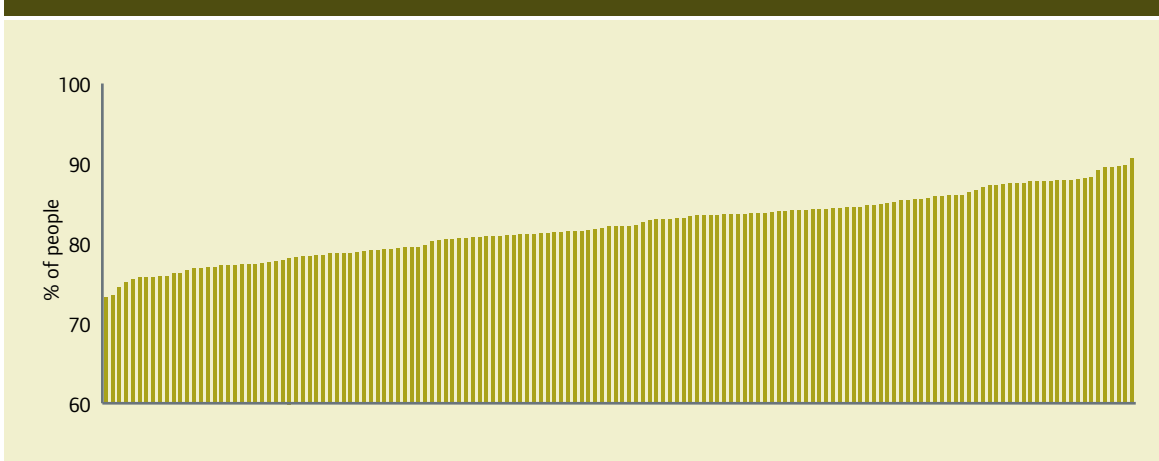
Source: GP Patient Survey 2009/10, quarters 1+2 (combined).

Note: Unweighted results, excluding people who had not tried to make an advance appointment or who could not remember whether they were able to get an appointment more than two full weekdays in advance.

Denise's story

When Denise was 10, her parents noticed that she was moving awkwardly and falling over a lot. Three years later, she was diagnosed with limb girdle muscular dystrophy.

Denise is now in her 40s. She has been using a wheelchair for more than 10 years and a ventilator for about eight years. At first this was difficult for her to terms with: "… during the first few years of my disability I found it really hard to accept."

Four years ago Denise started receiving a care package from the local council for 24 hours a day, 7 days a week. She needs someone with her at all times, especially during the night, in case one of her ventilation tubes comes out and she stops breathing. If Denise catches a cold or the flu, she becomes seriously ill and it takes her longer to recover.

"I found that my care package was quite limiting. So I made my views known to Social Services, as I'm quite a vocal person." Denise now has a care package which she manages herself. "My direct payments have been brilliant. It enables me to receive assistance with all the daily tasks that I'm unable to do for myself. I have a personal assistant with me at all times, including on holiday. Person-centred care enables me to do what everyone else does. However, there is some controversy between Social Services and the Primary Care Trust as to who will continue to fund my care package." Denise's care package has been scrutinised excessively over the past year, which has caused her stress and anxiety – "I'm never 100% certain who will be funding my care package from one yearly quarter to the next."

Denise has been closely involved with Barking and Dagenham Centre for Independent, Integrated, Inclusive Living Consortium for 10 years and is now its Chair. The centre enables people with a disability or learning difficulties, or older people, to obtain the level of care to which they are entitled.
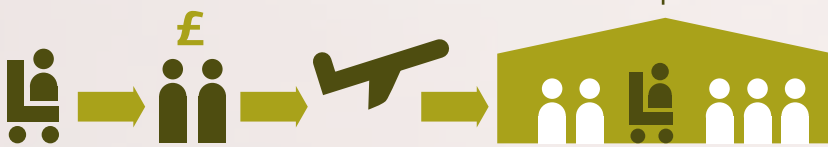
Denise now receives direct payments that enable her to manage her own care package, so it's much more tailored to her individual needs than before.

Promoting equality and respecting human rights

"People know they have rights, but
they don't know how far they go."

Person using a homeless service

The life
expectancy and
health of the
population is
improving, but
the differences
between
the most
deprived and
least deprived
areas persist.

Health care and social care services can play a key role in challenging discrimination and promoting human rights. But inequalities are growing and sometimes the people who are most in need of services are least likely to receive them. Performance is low when compared with the achievements of these two sectors against many of the other minimum standards.

Tackling health inequalities

There are significant health inequalities between different social classes, men and women, ethnic groups, and for groups such as people with mental health needs or learning disabilities. It is a longstanding issue and the gaps are getting wider.[33]

The Place Survey, developed by the Department for Communities and Local Government, reports that 76% of people describe their health as good or very good.[34] The figure is higher in London and in the South East (both 79%), and lower in the North East (70%). As figure 11 shows, the life expectancy and health of the population is improving, but the differences between the most deprived and least deprived areas persist.

Looking at cardiovascular disease (CVD) in particular, there are stark variations across occupational groups and ethnic groups. Reducing smoking and increasing the use of statins (medicines that can lower cholesterol) are two key interventions that can cut the number of early deaths from CVD. In a study we found that the financial incentives to provide these services, offered as part of the quality and outcomes framework for primary care trusts, have greatly improved health outcomes.[35]

The study nevertheless raised a number of concerns – in particular, that the people who are most in need of services are least likely to receive them. For example, people living in more deprived areas are less likely to be prescribed nicotine replacement therapy by their GP, less likely to be referred to NHS stop smoking services, and are less likely to quit smoking using those services.

Tackling health inequalities is not the sole responsibility of trusts – rather, it is a joint challenge for health care services and local authorities. Of those councils that were delivering improved health and emotional wellbeing for people using social care, 91% were performing well or excellently; and information about healthy lifestyles and emotional wellbeing was identified as a

The council was providing "a wide range of information materials and initiatives that provide advice and raise awareness of the importance of maintaining a healthy lifestyle… a community magazine delivered to people's homes and coffee mornings that offer free health checks and information on managing long-term conditions"

CQC annual performance assessment report

Figure 11: Mortality rate for all causes and all ages, by index of multiple deprivation, 2000 – 2008
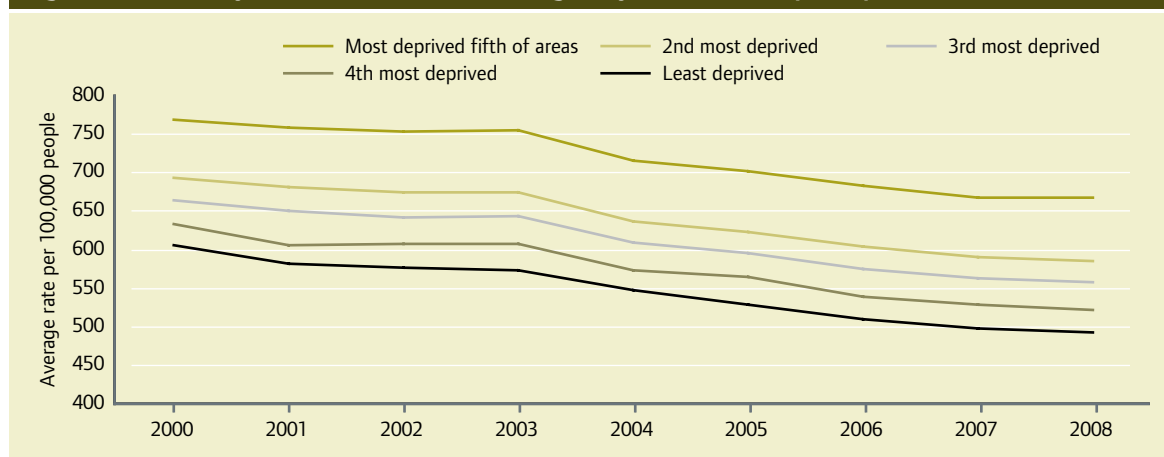
Source: Department for Communities and Local Government.

Note: Local councils in England were divided into five groups according to their relative positioning in the index of multiple deprivation.

strength in just over 11% of these councils. The 29% of councils that were assessed as excellent were reducing local health inequalities and providing a wider range of advice services. These councils use a variety of approaches to promote healthier lifestyles: information prescriptions, DVDs for people with learning disabilities, community magazines and health checks.

The comprehensive area assessment (CAA) of the performance of local public services identified health 'red flags' in 18 areas. These indicate concerns about issues such

as health inequalities (including among children), high death rates in deprived areas, teenage conception rates and harm associated with alcohol and smoking. There were 'green flags' for the commendable progress being made in improving infant mortality rates and reducing teenage pregnancy.* For more information about the CAA, visit http://oneplace.direct.gov.uk.

---

* The CAA uses a red flag to highlight where there are major concerns about problems in the area and local partners need to do something more or different to make improvements. A green flag shows outstanding achievements or improvements, or an innovation that is likely to be successful. This will help other areas to learn from them.

Challenging discrimination and promoting human rights

In our performance assessment of NHS trusts, we looked at whether they were meeting the minimum standard for challenging discrimination, promoting equality and respecting human rights. Ninety-one per cent of trusts met the standard in 2008/09, an improvement from the previous year's score of 83%. However, this is the minimum standard that should have been met since 2004. Performance against it continued to be low in comparison with other minimum standards, where rates of compliance varied from 88% to 100% in 2008/09.

Ninety per cent of councils performed excellently or well in ensuring that there is freedom from discrimination and harassment, continuing the improvement of recent years. Only 3% performed worse than in the previous year. However, tackling the causes of discrimination and harassment for people who use services, or who are in vulnerable circumstances, or from hard-to-reach groups or ethnically diverse communities, was judged a strength in just over 13% of councils only.

Councils must also meet a standard that ensures that they consider gender, race and disability equality issues at all levels within all of their departments. Although more than eight out of 10 councils were implementing many important aspects of this standard, there is still considerable work to do to achieve robust information systems and monitoring against targets as well as steps to achieve and review outcomes (see table 1). Our performance assessment highlighted how some councils were not doing enough to ensure that the needs of the whole population were sufficiently met.

Comprehensive recording of the ethnicity of people receiving and asking for care is a must for monitoring equality of access to services. In councils, recording of ethnicity at the assessment stage deteriorated since 2007/08: 2.9% of people who were assessed did not have their ethnicity stated.* For those already receiving services, recording of ethnicity remained static at 2% of adults. Between 82% and 92% of acute and specialist trusts, PCTs and mental health trusts achieved a performance indicator that requires them to monitor information on ethnic group. However, a number of trusts did not achieve the indicator in 2008/09 (see figure 12), which is again cause for concern given the high level of standards met.
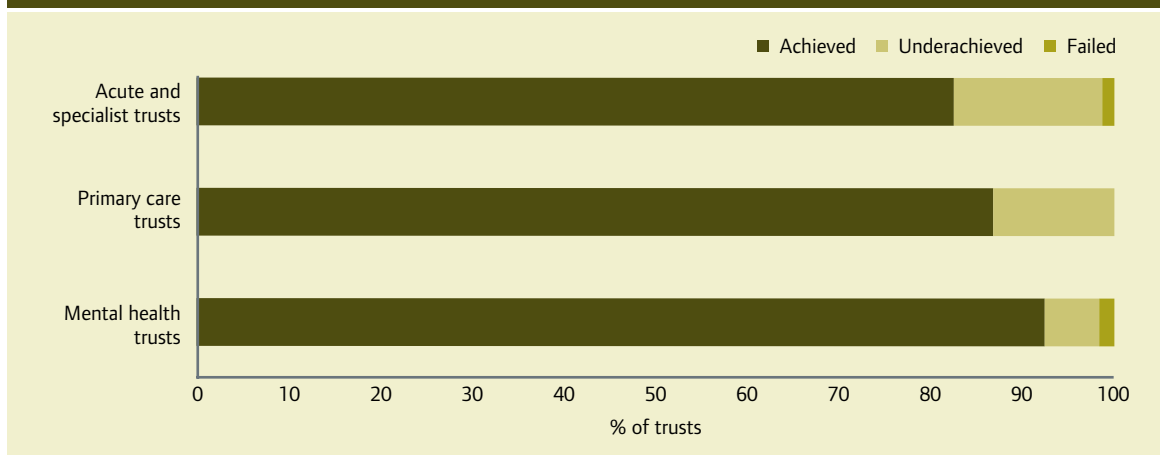
"The council should ensure that its diverse communities are effectively involved in commissioning processes, at both strategic and individual levels."

CQC annual performance assessment report

Table 1: Performance of councils in implementing the equality standard, 2008/09	
Level	**Proportion of councils**
Level 1: commitment to a comprehensive equality policy	91%
Level 2: assessment and consultation	91%
Level 3: setting quality objectives and targets	85%
Level 4: information systems and monitoring against targets	31%
Level 5: achieving and reviewing outcomes	4%

* Since councils cannot demand this information, some shortfalls in data are legitimate. Councils are now being asked to record the numbers of people who declined to give their ethnicity and other cases where no ethnicity data is present.

Figure 12: Performance of NHS trusts in meeting the indicator for quality of data on ethnic groups, 2008/09

Legend: ■ Achieved ■ Underachieved ■ Failed

Categories (y-axis): Acute and specialist trusts, Primary care trusts, Mental health trusts

x-axis: % of trusts (0 to 100)

Source: Care Quality Commission.

Promoting dignity and respect

Dignity and respect are at the heart of all high-quality care. Across the NHS, there was a high level of compliance for the minimum standard relating to dignity and respect (91% of all trusts). However, our more detailed review of how well trusts were meeting their race equality duties and promoting equalities, which took people's views into account, showed that generally progress was patchy.[36]

Findings from our recent patient surveys show a range of variations between ethnic groups and their White British counterparts.[37] Where differences exist, most are negative, indicating that these groups are less likely to report positive experiences. In particular, ethnic groups have tended to be less positive about questions relating to "access and waiting" or to "better information and more choice". However, many areas show no difference, and some show a positive difference. These findings suggest areas of NHS service provision where experience of the service looks different to people from different ethnic groups.

Councils' performance in promoting dignity and respect has fallen. In 2008/09, only 12 councils were assessed as excellent, down from 17 in 2007/08.

We carried out a joint review across health care and social care of how people with learning disabilities and complex needs were being supported to live their lives fully, through the commissioning of health care and social care. We found that those from ethnically diverse communities need to receive services that are better tailored to their particular requirements.[27] Some local areas needed to improve their involvement with people from diverse communities in the planning of services and tackling staff attitudes. Too often, the prevailing view was "…well, they look after their own". But, in contrast, some areas had worked hard to raise awareness of disability and to promote diversity, such as introducing dedicated community development staff to improve engagement with diverse communities.

90% of councils performed excellently or well in making sure people using their social care services do not experience discrimination and harassment.

Giving people choice and control and protecting their rights

Involving people in shaping services for their local community

A genuine commitment to working with local communities needs to be much more firmly embedded in the planning and commissioning of health care and social care services

Across councils, nearly half were judged to be strong in engaging with people who use social care services.

Health care and social care services have a responsibility to engage with their communities and ensure that local people are helping to shape and develop local services. *The NHS Constitution* makes it clear that people have a right to be involved.[5]

We expect services to involve people proactively, genuinely and in ways that are meaningful to everyone. At first glance, commissioners of health care and social care appeared to be involving people in their work and meeting their responsibilities. But when we looked in more detail for positive practice across the sector, we found that some services were missing out particular groups or not acting on people's feedback.

How services are meeting the challenge

We asked trusts to tell us whether they were meeting the standard requiring them to seek local people's views about how they plan, design, deliver and improve their services, we found that 99% of trusts complied with the minimum standard (up from 97% in 2005/06).

Across councils, just under half were assessed as strong in engaging with people who use services. These councils use a variety of approaches: consultations, forums, surveys, focus groups, interviews, questionnaires, and partnership boards were among the methods used to encourage people to participate and feed back their views.

However, we found that people in the poorest health, in vulnerable circumstances or experiencing discrimination often find it more difficult than others to engage with health services.[38] For example, the full involvement of people in prison in helping to develop their health care services remains patchy and there is a need to ensure that all groups are included.[39]

Furthermore, not all trusts are consulting with, or seeking the views of, people from ethnically diverse communities[36], or people from all age ranges, such as children and young people. An in-depth look at how councils collect and act on information about the unmet needs of carers found that carers are represented on steering groups and boards at 43% of councils.* However, only 33% of councils said that they had commissioned additional services and just 15% provided examples of how they had changed services following feedback.

The need to involve people in the strategic development of services has long been entrenched in health care and social care policies. In the light of this, we see limited examples of strategic involvement in people using services and the public across both health care and social care: improvement is needed both in terms of the people involved in service development and the action taken as a result.

* We analysed responses from a representative sample of 40 councils.

2 Joining up health care and social care

Progress in joining up health care and social care to meet people's needs better must speed up, to improve people's experience of care and maintain their independence and health. Better joined-up care will also help meet increasing demand and deliver greater value-for-money by reducing reliance on high-cost hospital and residential care. For example, some older people are admitted to hospital as emergencies twice or more every year, and in some cases this might not be necessary if they were being cared for better in the community.
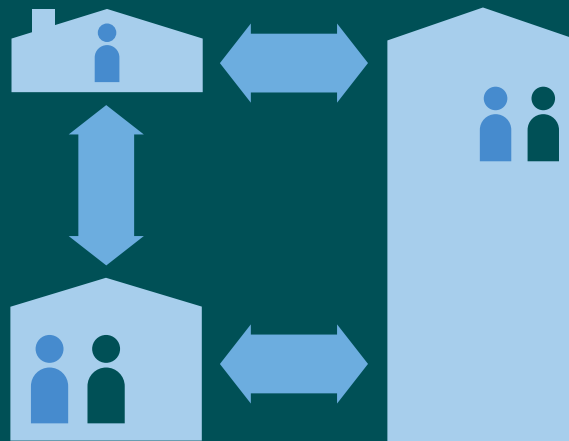
Here are some of our findings for 2009:

- More people aged 65 and above were being supported to live independently at home than in 2005.

- 148,000 people had access to services that helped them avoid being admitted to hospital as an emergency, compared to 80,000 in 2004.

- 157,000 people had access to services that helped them return home quickly from hospital, compared to 112,000 five years ago. The number of people whose discharge from hospital was delayed fell from 3,600 a week in 2003/04 to 2,200 a week in 2008/09.

- We found a three-fold variation in the extent to which different councils place older people in long-term residential care.

- 17% of care homes had not received information about people having infections when they arrive after discharge from hospital.

- Only 53% of general practices reported that discharge summaries sent by acute trusts arrived in time to be useful.

Introduction

"What works well is having the same people providing my support and care. And if there are times when they are not available, the people who step in need to be fully informed about my needs and care arrangements."

Person with a neurological condition who uses a range of services

As life expectancy increases, there will be a growing number of people with long-term and complex needs. In England, 570,000 people live with dementia, and this figure is set to double over the next 30 years.

Why joined-up care matters to people

Large numbers of people who use social care rarely need just one service and many are also receiving health care as well. It's vital that all of these services are joined up – in other words, fully coordinated – around the individual's needs. Services that work together efficiently to bridge boundaries within and between the two sectors help to improve people's experiences and outcomes, while promoting good health and independence. Joined-up care also makes it easier for people, and their families and carers, to find their way through what is often a complex system of health care and social care.

Good joined-up care responds seamlessly to people's needs. It reduces the likelihood of them being passed around the system before getting the care they need or short-term decisions being made about what kind of care is suitable for them. There must be a move away from the type of experience reported by a woman caring for her husband and son, who both had mental health needs: "I feel like I am in a circular room with lots of blank doors."

Joined-up care requires dedicated teamwork across agencies and disciplines. This is especially true when it comes to caring for people with mental health needs or learning disabilities, many older people, and children and young people.

The need for good joined-up care

Society is experiencing significant demographic changes, largely because the population is living longer. This increased longevity also applies to many people with disabilities or long-term conditions.

The Government expects that, in 20 years' time, 1.7 million more adults will have a need for care and support.[40] There is, therefore, a rapidly growing need for more, and better, joined-up care. The challenge of achieving it is the subject of much debate.[41]

In one local study, 90% of people who received social care also received secondary health care over a three-year period (see figure 13).

- A few decades ago, children born with Down's syndrome would have been expected to live into their mid-20s, whereas now they often live much longer.[40,42]

- In the next 20 years, the number of people over 65 is projected to grow by almost half. The number of people aged over 85 in England will double, and the number over 100 will quadruple.[43]

- The number of people with mental health needs is set to grow substantially.[44] For example, 570,000 people live with dementia in England and this figure is expected to double over the next 30 years.[13]

Marc's story

Marc has mental health needs, problems with substance misuse and is living with HIV. He has to collect different medications from a number of different services, which is time-consuming and expensive. Marc has found it particularly difficult getting an appointment with his GP. He ends up seeing a number of different GPs and often has to repeat his story. He has not seen the same mental health professional twice and each new person knows little about his case.

Marc talks about too much "red tape" between his GP and his hospital consultant, which has resulted in considerable delays to his treatment. His consultant decided on a four-week course of antidepressants and asked him to go to his GP for the prescription. When Marc went to the GP, he was told they had not received confirmation from the consultant and that they could not prescribe the medication. Marc went backwards and forwards between consultant and GP for a number of weeks. When the situation was finally resolved, his new treatment had been put back by three months.

Figure 13: Overlap of people using health care and social care services in a typical locality

Number of people aged over 55 registered continuously with local GPs, 2005-2008: 77,000

90% overlap

People receiving secondary care: 53,000 (69% of registered population)

People receiving social care: 13,000 (17% of registered population)
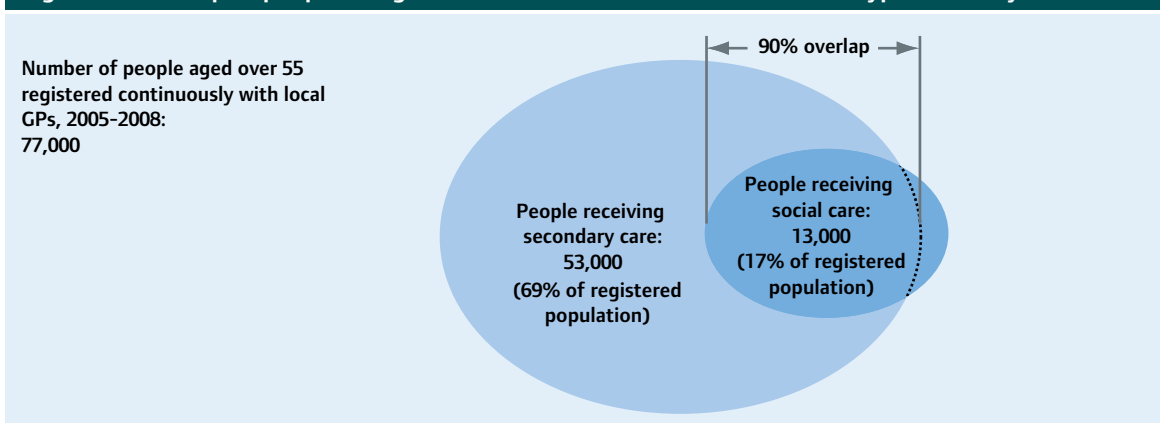
Source: Nuffield Trust.

The Government expects that, in 20 years' time, 1.7 million more adults will have a need for care and support. There is therefore a rapidly growing need for more, and better, joined-up care.

Around 90% of people who received social care in one local study also received secondary health care.

To meet the future needs of the population, with constrained resources, will require a fundamental shift in the way care is delivered, with a greater emphasis on preventive care, early intervention and helping to change unhealthy lifestyles.

There is an ever-increasing focus on the use of resources in health and social care.[45,46] Preventive, joined-up approaches to care should help improve efficiency, which in turn will achieve cost savings. Services that work together well have shown that they can provide greater value for money and cost effectiveness. For example:

- A systematic review and critical appraisal of studies that evaluated health care and social care from an economic perspective found that integrated early intervention programmes can generate savings of between £1.20 and £2.65 for every £1 spent.[47]

- The Kaiser NHS Beacon sites have improved services as a result of working closer together. For example, one area has reduced its use of acute clinical beds for emergency admissions of older people, virtually eliminated delayed transfers of care, and improved access to intermediate care.[48]

- The Partnerships for Older People Projects (POPP) aimed to create a shift in resources and culture away from institutional and hospital-based 'crisis' care towards earlier, targeted interventions for older people in their homes and communities. An evaluation found that POPP services were helping to reduce emergency bed days, and that every additional investment of £1 in them produced £1.20 additional benefit in savings on emergency bed days. These financial benefits were seen throughout the local system along with improvements in older people's quality of life. [49]

- The comprehensive area assessment of the performance of local public services describes an innovative project that set up 94 'Active Living Centres' for people over the age of 50: "Older people are staying independent for longer and feel less isolated. This is also saving money, as preventing health care and social care problems costs less than treating them in hospital… They are run by local residents for local residents and have already catered for around 17,000 people in two years. Since they opened, the centres have made a real difference to people's lives. Fewer older people have suffered falls, and the number of older people starting new health care or social care packages has dropped. Estimated savings on local health care and social services are around £600,000 so far, with more expected. The organisations involved have worked hard to build and support this vibrant network of centres that is serving so many people's needs."

Relatively little research has been carried out in the area of joined-up care, especially looking at the outcomes for people who use services.[50] The Government is using Integrated Care Pilots to explore different ways that health care and social care services can help improve local health and wellbeing. Using their in-depth knowledge of the local population, the pilots are designing services to be flexible, personalised and seamless. One of the main aims of the pilots is to build a robust understanding of the impact of integration, including the potential for cost-saving.[51]

A truly joined-up approach, moving away from a territorial approach to budgets, is essential in making the most of any financial savings. For example, where savings are realised from reducing emergency hospital bed days, money could be redirected to

further fund community intervention and prevention services. Councils, hospitals and PCTs will need to take a long-term view of this in order to avoid, as far as practicable, the defensive reaction that is inevitable in the current economic downturn and additional pressures being placed on budgets. In the light of the financial downturn, the Audit Commission reported that joint financing should focus on outcomes for people using services rather than processes or the specific method by which the service is paid for.[52]

Where money may be shifted from one part of the system to another, the transformation of services may sometimes be cost neutral, rather than reducing costs. However, if such service transformation results in improved outcomes for those using the services and a greater sense of empowerment and quality of life, then this certainly represents far greater value for money for all involved.

Policy context

Joined-up care has been part of government policies and strategies for a number of years. The Health and Social Care Act 2001 opened the way for the creation of care trusts, which combine NHS and council responsibilities across a number of areas, including mental health and care for older people. To date, 10 care trusts have been established.[53]

The need for improvements across both health care and social care was set out in 2006 in *Our health, our care, our say*.[4] *Putting People First* then sought to embed a shared vision for a single system of support for health care and social care as well as wider issues of housing, employment and education.[6] In 2008, the Next Stage Review of the NHS, *High Quality Care For All* emphasised the need to join up care around the needs of individuals.[1] Pilot sites have developed an integrated model of care for different groups: people with dementia, people with drug and alcohol problems, people who need end-of-life care, older people and people with chronic obstructive pulmonary disease.[51]

The NHS operating framework continues to encourage a whole-system approach and creative thinking about joined-up care.[54] The Government presented a fundamental rethink about the social care and support system in its green paper, *Shaping the Future of Care Together*.[40] Throughout, the document reiterates the need for better coordinated care.

Joining up care also means looking beyond the short term – for example, planning for the time when young people make the transition from children's services to adult services, which can be very different in nature. In this context, children's trusts have a key role to play in coordinating the commissioning and delivery of social health, social care and education services.

What we know about joined-up care

In this part of the report, we draw on a range of evidence on joined-up care to look at:

- The extent to which outcomes for people are improving as a result of joined-up care.

- Whether health care and social care services are sharing information effectively.

- Strategic approaches to joining up care.

"My consultant acts as my care coordinator, and it works for me. He contacts my GP and carer as needed."

Person who is detained under a section of the Mental Health Act

Achieving good outcomes through joined-up care

We have looked at how effectively health care and social care are working together, focusing on three outcomes:

- Are people staying healthier for longer?
- Are they being supported to live independently at home?
- Is their stay in hospital or residential care kept as short as possible, and are they discharged on time?

There has been good progress. For example, more people are being supported to live independently at home and the amount of intermediate care is growing. And there are signs that, across the country, there is better joint planning when people are discharged from services. However, this national picture masks considerable local variation. We discovered a number of areas where services need to work together better.

Are people staying healthier for longer?

Life expectancy continues to rise: men and women aged 65 today are expected to live to 83 and 85 respectively.[55] However, the healthy life expectancy of older people – that is, the age to which they can expect to live free of long-term illness or disability – continues to lag behind longevity. If this trend persists, people will have longer periods of ill health, more frequent and more severe long-term conditions, and a greater need for care in later life.[56]

Nationally, in recent years there has been good progress in managing long-term conditions, although a considerable minority of general practices have not achieved the relevant indicators (see table 2).

Table 2: National averages for practice-level achievement of selected quality and outcomes framework indicators, 2006/07 – 2008/09

Indicator	2006/07	2007/08	2008/09
Proportion of people with coronary heart disease whose last blood pressure reading was 150/90 or less	88.9%	89.4%	89.7%
Proportion of people with coronary heart disease whose last measured total cholesterol was 5 mmol/1 or less	81.9%	82.5%	82.1%
Treatment for people with heart failure	89.6%	89.9%	90.1%
Proportion of people with a history of stroke or transient ischaemic attack whose last blood pressure was 150/90 or less	86.9%	87.5%	87.9%
Proportion of people with hypertension whose last blood pressure was 150/90 or less	77.6%	78.3%	78.6%
Proportion of people with asthma who received an asthma review	78.9%	79.3%	78.5%
Proportion of people with dementia who have had their care reviewed	81.5%	80.5%	78.9%

Source: Information Centre for Health and Social Care.[57]

Are people being supported to live independently at home?

If people are supported to live as independently as possible, it not only improves the quality of their daily lives but also minimises permanent admissions to care homes and the need for emergency hospital care.

Intermediate care services are designed to encourage independence. They provide enhanced services from the NHS and councils, including rehabilitation services. This intermediate care prevents people being admitted to hospital unnecessarily, enables them to leave hospital earlier than might otherwise be possible, and prevents them being admitted to long-term residential care prematurely or unnecessarily.

The amount of intermediate care available in England has risen significantly. The number of people receiving council funded non-residential intermediate care to prevent hospital admissions has nearly doubled in the last five years, from around 65,000 to 128,000, while the corresponding residential care has increased by more than 25% from around 16,000 to 20,000.[58]

At the same time, nationally, the rate of council-funded permanent admissions to residential and nursing care has fallen by 16% – from 2.5% of people aged 65 and over in 2005/06 to 2.1% in 2008/09. This reduction may reflect, in part, the rise in intermediate care, respite care and Extra Care housing. Another factor may be the increase in the number of people funding their own residential and nursing care.

The progress in reducing emergency admissions has not been as clear. It had appeared that the rise in repeated admissions had begun to level off (only a 1% rise for both 2006/07 and 2007/08). However, in 2008/09, the rate for people aged 75 and over rose again, by 9% – from 63.5 people per 1,000 to 69.2. This may have been partly due to more severe weather and flu epidemics, but may also reflect the quality of data in some cases.
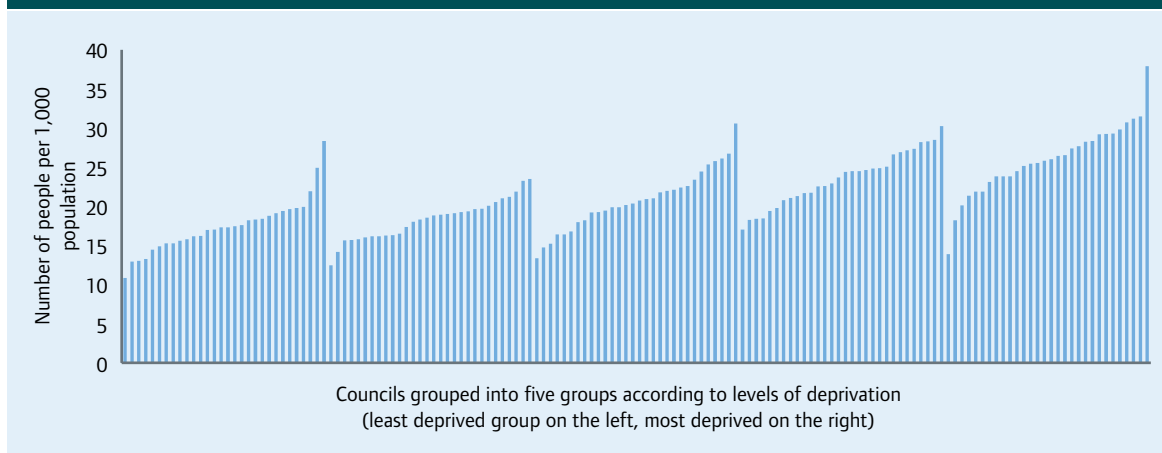
These overall signs that people are being supported better to live independently at home again mask considerable differences at a local level. In 2008/09, there was a three-fold variation in the use of council-funded residential and nursing care. Some, but not all, of this can be explained by the proportion of people eligible for council funding. However, figure 14 shows councils grouped according to measures of deprivation and illustrates that variations persist across all levels.

Similarly, while 8% of areas have reduced repeated emergency admissions for people aged 75 and over in the last five years, and there are examples of excellent progress being made[48], 15% of areas have seen a rise of a third or more. In 2008/09, there was a four-fold variation in the rate of occupied bed days associated with repeated emergency admissions for people aged 75 and over (see figure 15). Those areas that are struggling to improve need to better understand the pattern of repeated emergency admissions and occupation of beds. And services need to work together to give effective support to those people whose circumstances put them at the greatest risk.

More people are being supported to live independently at home and the amount of intermediate care is growing.

Figure 14: Number of people aged 65 and over in council-funded residential and nursing care, grouped by deprivation, 2008/09

Number of people per 1,000 population

Councils grouped into five groups according to levels of deprivation
(least deprived group on the left, most deprived on the right)

Source: Information Centre for Health and Social Care and the Office for National Statistics.

Figure 15: Change in the rate of repeated emergency admissions for people aged 75 and over, five years to 2008/09

% chagne in rate
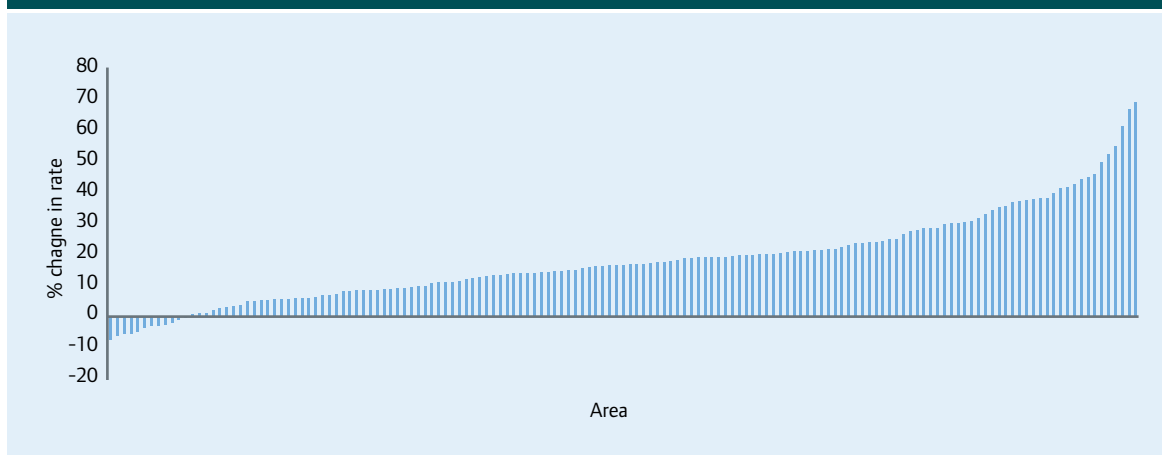
Area

Source: Hospital Episode Statistics.

If local areas reduced their rates of emergency admissions and the associated occupied bed days, this could have a significant impact overall. Our analysis suggests that, if every local area could reduce emergency stays in hospital for people over the age of 75 years to the levels seen in the best performing parts of the country, this would result in eight million fewer days in hospital for people, and a saving of about £2 billion a year for NHS hospitals.

We derived this estimate by looking at emergency occupied bed days for people aged 75 and over who had experienced two or more emergency admissions in the financial year. We applied occupied bed-day rates per 1,000 people to the national population, to estimate how many bed days would be saved if all areas performed at a level equal to five areas with the highest levels of performance in England. We also assumed that each day in hospital costs £300. Clearly, making savings on this scale would be extremely challenging and require a considerable redesign of services in the areas concerned.

Figure 16: Delayed discharges from acute hospital beds for people aged 65 and over, 2008/09
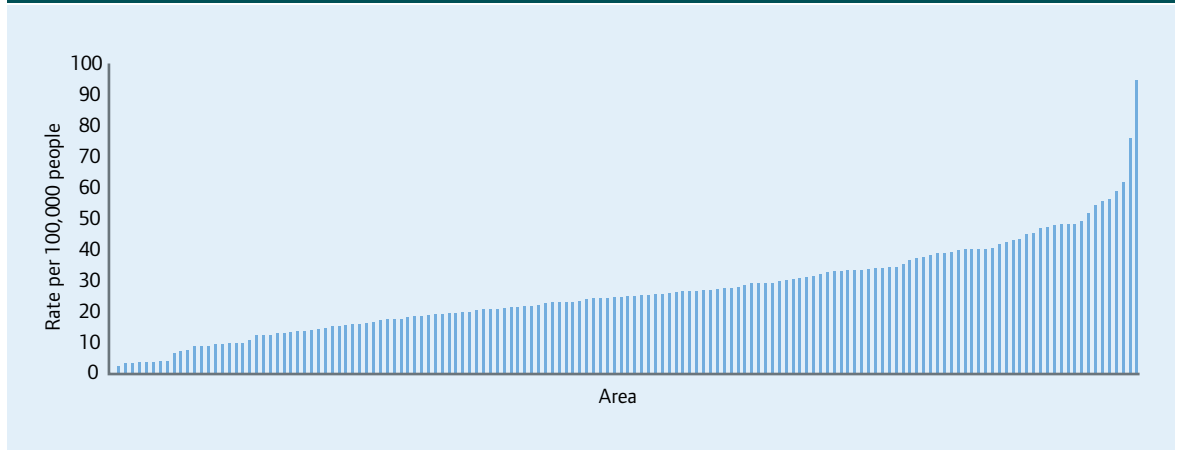
Source: Information from NHS organisations through Unify2.

The number of people receiving council-funded non-residential intermediate care to facilitate discharge has risen by more than 40% in the last four years. The number of people receiving the corresponding residential care has increased by more than 20%.

Are people's stays in hospital or residential care being kept as short as possible, and is the support in place to help them recover?

Leaving hospital is a key point of transition for people that involves a number of organisations. Many intermediate care services provide rehabilitation services so that people can go back to their own homes rather than being prematurely or unnecessarily admitted to long-term residential care.

The use of council-funded intermediate care to enable people to go home after discharge has increased considerably in the last five years. The number of people receiving non-residential care has risen by more than 40% from around 85,000 to 122,000 people. The number of people receiving the corresponding residential care has increased by more than 20% from around 27,000 to 34,000.[58] Nationally, 78% of people who use rehabilitation and reablement services achieve independence when they leave hospital.

At the same time, the number of delayed discharges from hospital has fallen considerably. Nationally, the number of people kept in hospital unnecessarily because of delays over their intermediate care fell from an average of 3,600 a week in 2003/04 to 2,200 in 2008/09. But the rate of progress has now slowed down to the point where it is no longer discernible.

In some parts of the country, the level of delayed discharges remained high and there was considerable national variation (see figure 16). Similarly, the proportion of people who achieved independence through intermediate care after discharge varied from 53% to 100%.[59]

The importance of communication and sharing good quality information

Good quality information and communication are vital when people move within a service, or between health care and social care. While organisations often have policies in place to guide effective communication, we often see examples of poor practice. This can seriously affect their ability to meet people's needs, and to provide safe care.

Communication between professionals

Over the last year, we have looked in depth at three areas of communication between professionals: safeguarding arrangements; communication about medicines between hospitals and GPs; and information exchanged between hospitals and care homes on people's healthcare-associated infections.

A failure to communicate information can have stark consequences. In our review of the actions taken by health bodies in relation to Peter Connelly (Baby P), we found that a number of professionals had contact with Peter.[60] But it was clear that communication was very poor, both between the health professionals and between the NHS, social services and the police. This badly affected the assessment of Peter's needs and the professionals' ability to protect him.

Since Peter's death, the NHS trusts involved have taken action to address the serious shortcomings. For example, the introduction of on-site social workers in one trust has significantly improved communication between health care and social care staff, allowing frequent discussions of cases. A new process whereby a doctor and a social worker conduct joint reviews and make joint decisions was commended. And improved electronic systems provide a more robust referral and management system.

…we found that a number of professionals had contact with Peter Connelly (Baby P). But it was clear that communication was very poor, both between the health professionals and between the NHS, social services and the police.

Only
53%
of GPs said that they received discharge summaries from acute trusts in time for them to be useful.

"I have on several occasions been sent illegible pink discharge sheets for people, which apparently informed me that an MRSA infection was present. I think it important to advise more clearly."

Manager of a care home

We conducted a national review of arrangements in the NHS for safeguarding children.[61] We found that most trusts have the right arrangements in place. Ninety-five per cent of trusts said that they had protocols for sharing information on children and their families, both within their own organisation and with other key organisations. However, there are still some concerns:

- 36% of acute trusts did not have a policy for joint working between maternity services and social services.

- 81% of mental health trusts had joint protocols in place between their services and children's services.

When people are transferred from one care setting to another, managing their medicines is central to safe, high-quality care. In one study, we found that GPs and hospitals need to do more to ensure they are sending the right information to each other, on time. For example, only 53% of GPs said that they received discharge summaries from acute trusts in time for them to be useful, and 81% said that the details that they contained about people's prescribed medicines were incomplete or inaccurate "all" or "most" of the time.

While most GPs said that they provide information on patients with multiple conditions, known allergies and previous drug reactions, there was a considerable minority (14%, 11% and 24% respectively) who did not systematically do so. Also, 11 out of the 12 primary care trusts, with varying characteristics, that we visited had little or no reliable information on whether GPs were sending hospitals the correct information at the right time.

Ally's story

Ally has been using mental health services in Doncaster for six years and has seen some really positive progress locally in joined-up care. "My experiences this summer were a wonderful example of how far services have come. I had become very ill, but had a detailed crisis plan in place. As soon as I visited my GP she contacted the crisis team, who came to see me at home two hours later. Within 24 hours their psychiatrist was in my kitchen talking to me. He knew I objected to some types of medication, so gave me time to do my own research about a new type of mood stabilizer before I decided whether or not I wanted to try it." Two hours after Ally told the team she wanted to try the medication, there was a nurse at her door with enough for seven days. "And, in accordance with my wishes, I didn't have to go into hospital to be started on it, which may not have been the case six years ago. I could stay in my own home with all my things close to me, knowing that my daughter was safe. The crisis team visited every day and my psychiatrist phoned me as I wasn't well enough to go to see him. It all worked beautifully. I was able to have my daughter home within a couple of weeks and to pick up my life almost where I left off."

Healthcare-associated infection can be a major problem for people living in care homes. Because they tend to have regular contact with health care services, it can lead to a 'revolving door': people bring infections they have picked up in hospital into the care home, and are then readmitted to hospital because the care home feels unable to manage the infection. We found that, although some care settings communicated well, others were not routinely providing high-quality information on infections to each other in a coordinated way.[62] In a survey of care homes, 17% had received no information about people's infections from the hospitals that had discharged them. The information that standard NHS contracts require in a discharge summary, including information on infections, was often incomplete or missing.

Good information systems

A number of studies have identified incompatible electronic systems as a barrier to joined-up care.[32] We looked at the extent to which health care organisations meet information governance standards and found that performance was patchy.[22] Our findings show that some trusts have inadequate systems for collecting and analysing data across services and rely on information that is of poor quality and is not well timed. This can lead to delays when people move between services. During our visits to providers, we found that staff supported the principle of sharing information between health care and social care, but that there are technical and cultural barriers to this. For example, some health care staff think that social care staff are working to different protocols, which makes sharing information difficult.
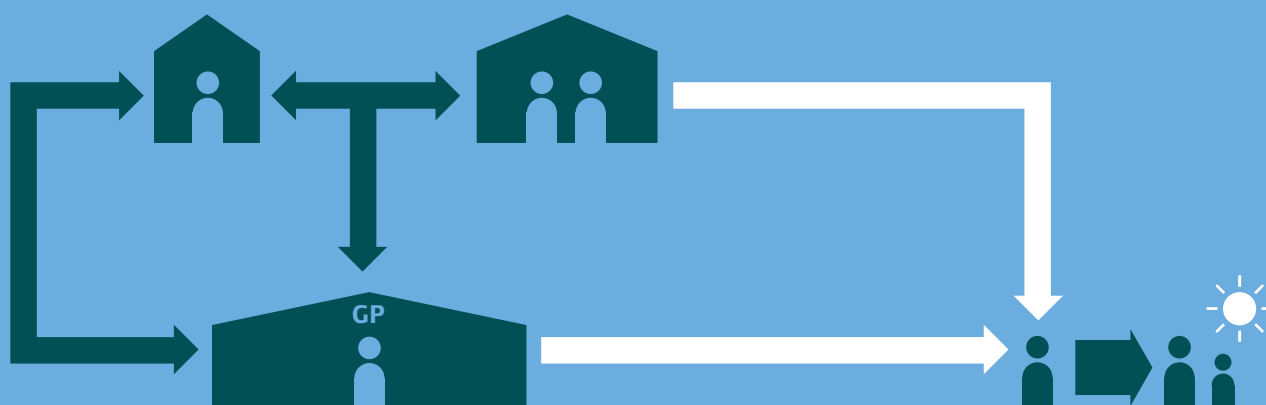
Ally had a detailed crisis plan, so she was able to have treatment and support in her own home when she became unwell.

Everything was managed according to her wishes, and she was soon able to pick up her life again almost where she left off.
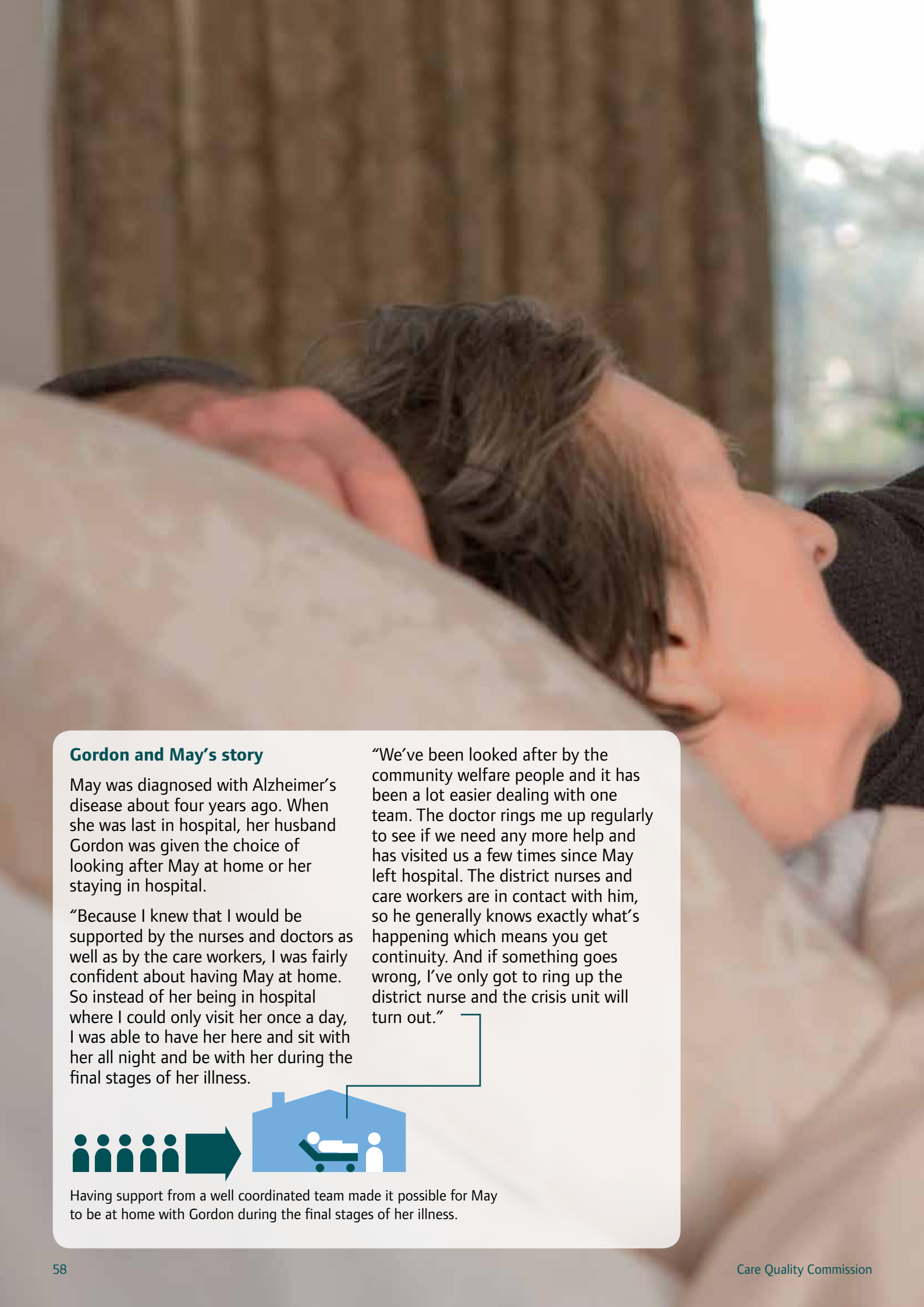
Gordon and May's story

May was diagnosed with Alzheimer's disease about four years ago. When she was last in hospital, her husband Gordon was given the choice of looking after May at home or her staying in hospital.

"Because I knew that I would be supported by the nurses and doctors as well as by the care workers, I was fairly confident about having May at home. So instead of her being in hospital where I could only visit her once a day, I was able to have her here and sit with her all night and be with her during the final stages of her illness.

"We've been looked after by the community welfare people and it has been a lot easier dealing with one team. The doctor rings me up regularly to see if we need any more help and has visited us a few times since May left hospital. The district nurses and care workers are in contact with him, so he generally knows exactly what's happening which means you get continuity. And if something goes wrong, I've only got to ring up the district nurse and the crisis unit will turn out."

Having support from a well coordinated team made it possible for May to be at home with Gordon during the final stages of her illness.

Strategic approaches to joining up care

"Sometimes we're set targets that ask us to do things that contradict what the council is asked to do – for example, with regard to direct payments. It's the little things like that that can make joined-up care more difficult."

Primary care trust

Health care and social care services can do a number of things at a strategic level to improve joined-up care and outcomes for people. When we looked at how strategically councils and primary care trust were working together, the picture was mixed. Although many are working together more effectively to help people live independently, we would like to see more councils and trusts developing joint policies that approach people's needs from a holistic perspective.

Shared agreements and working in partnership

The wide range of mechanisms that councils and primary care trusts can use to join up care include:

- Local area agreements, through which councils, trusts and other agencies agree their joint commissioning plans for the next three years.[63]

- Local strategic partnerships, which encourage organisations to work together and coordinate plans to improve the social, economic and environmental wellbeing of an area.

- Joint strategic needs assessments, through which councils and trusts are required to identify the current and future health and wellbeing needs of their local people. They draw together and analyse data about local needs and health inequalities, to build a picture of where services should be developed.

In 2008/09, almost all health care services met the standard on cooperating with each other and with social care services to ensure people's needs are met addressed (99.6% of trusts met the standard, up from 97.2% in 2005/06). For nearly two-thirds of councils with adequate to excellent performance, working in partnership was a positive factor in achieving better outcomes for people. And we identified innovative practice between councils and health partners in a small number of areas.

On the other hand, joined-up strategies are being developed at different rates for different groups of people. For example, progress on joint planning for adults on the autistic spectrum and for older people may be more advanced than that for disabled parents, children about to transition to adult services, and those with learning disabilities (see boxes 1 to 3).

Where the management of health care and social care was aligned, we saw improvement in the coordination of planning and the subsequent quality of care. For example, our study of mental health services for older people found that trusts used a variety of approaches to integrate the care programme approach used in mental health care with the single assessment process used in social care.[32]

Where health care and social care services were integrated at both team and management levels, and where staff worked in integrated community teams, their services were more likely to offer a high standard of care and a greater range of services.

Box 1: Meeting the needs of adults on the autistic spectrum

As part of the annual performance assessment, we asked councils for details of their analysis of the needs of adults on the autistic spectrum.[*] Their performance was positive overall:

- 83% of councils considered the needs of adults on the autistic spectrum using local joint strategic needs assessments, commissioning strategies and plans, and through partnership boards and local service strategies.

- Councils worked with trusts in a number of ways, including needs assessments led by public health, developing pathways and protocols for people with Asperger's syndrome, and jointly planning three years ahead to identify future demands on services.

- 78% of councils are developing specialist services that offer health and mental health care (such as psychiatry, psychology, speech and language therapy) and social care (such as advocacy services, behavioural support and home care). One small group of councils is working with the third sector to develop a multi-agency strategy for people on the autistic spectrum.

Box 2: Supporting disabled parents and their families

We took an in-depth look at how far council policies, services and practice were providing appropriate support to disabled parents and their families and children. We found that parents and their families were not being served well enough as a consequence of weak inter-agency working.[64] For example:

- Disabled parents and their families continue to face difficulties in accessing services that support family life. This included education services and health care, as well as social care services.

- 66% of councils said that their policies focused separately on adults and children. Councils that focused on the whole family were largely family pathfinder sites (a government project to explore the best ways to promote partnership working).

- Only 34% of councils systematically collected data on, for example, how many disabled parents lived in their area, the services they used and their needs, which means that most were not planning and commissioning services on the basis of sound knowledge of the needs of the area.

- Only 30% had joint working protocols for supporting disabled parents, so different agencies' roles and responsibilities were often not clearly set out.

Box 3: Moving from children's to adult services

In our annual performance assessments of councils, we asked them to identify the risks they encountered in supporting young people as they moved to adult services:

- 38% said that they did not have early links between children's and adult services and a resulting lack of planning, making it more likely that they would not be able to meet people's needs.

- 40% said that they did not have a clear process for children transferring into adult services, and a risk that there was insufficient information about children's needs.

- 48% said that planning was not timely enough to enable information to feed into commissioning and service planning.

We also looked at councils' person-centred transition planning for young people with learning disabilities.[*] While councils had made some progress, the range and scale of initiatives to make transition better for these people is still seriously underdeveloped. For example:

- Only 40% of councils said that they were developing transition-specific training for their own staff or with other professionals.

- Only 68% reported having joint arrangements and multi-agency protocols in place for transition.

- Councils continued to report problems in working across services during transition.

---

* We analysed responses from a representative sample of 40 councils.

78% of councils are developing specialist services which offer health care such as psychiatry, psychology, and speech and language therapy, and social care such as advocacy services, behavioural support, and home care.

Strategic flexibility

The Health Act 1999 and subsequent legislation introduced a number of 'Health Act flexibilities' that allow different organisations to integrate their managerial and strategic activities:

- **Lead commissioning:** where one authority transfers resources to the other, which then takes the lead in commissioning both health care and social care.

- **Integrated provision:** where one authority takes responsibility for providing both health care and social care.

- **Pooled budgets:** where both authorities transfer resources into a single budget that is managed by one of the authorities on behalf of both.

The Audit Commission has found that not all NHS bodies and councils understand what options are available and how to make them work.[65]

Health Act flexibilities tend to be used most frequently for community equipment, services for people with learning disabilities and services for people with mental health needs. Given the pressures on the system as a whole, it is surprising that there is relatively low use of them for services for older people and for delayed transfers of care (see table 3). Also, the number of areas using Health Act flexibilities has not changed a great deal over the last three years (table 4). Changes in leadership in the local health care and social care economy tend to be the catalyst for adopting such approaches to formal partnership arrangements.

Table 3: Use of Health Act flexibilities through the use of pooled budgets, 2008/09				
	Proportion of areas reporting a formal partnership arrangement	Of those with a formal partnership arrangement		
		% NHS led	% social service led	% led by others
Community equipment*	94%	22%	72%	6%
Learning disabilities	85%	4%	95%	1%
Mental health	82%	87%	5%	8%
Intermediate care*	60%	61%	29%	10%
Older people with mental health needs	57%	63%	23%	14%
Delayed transfers of care*	52%	32%	48%	19%
Older people	47%	16%	68%	16%

* 2007/08 data.

Table 4: Uptake of Health Act flexibilities, 2006/07 – 2008/09			
	Proportion of areas reporting any formal agreement		
	2006/07	2007/08	2008/09
Community equipment	93%	94%	N/A
Learning disabilities	83%	85%	85%
Mental health	76%	82%	82%
Intermediate care	53%	60%	N/A
Older people with mental health needs	N/A	51%	57%
Delayed transfers of care	43%	52%	N/A
Older people	49%	44%	47%

N/A = information not available.

The level of integration between organisations had a significant impact on whether people using the services, and their carers, could get the right help at the right time.

3 Patterns in quality and trends in performance

Great improvements have been made over recent years as more health care and social care services, councils and primary care trusts have been assessed as "good" or "excellent". However, a small proportion of services are falling below minimum standards of quality and safety. Five per cent of NHS trusts are rated "weak" and 2% of adult social care services are "poor". In independent health care, there are major shortfalls from the standards in 10% of cases. In particular, good practice relating to safety, safeguarding arrangements and workforce training needs to be implemented more widely.
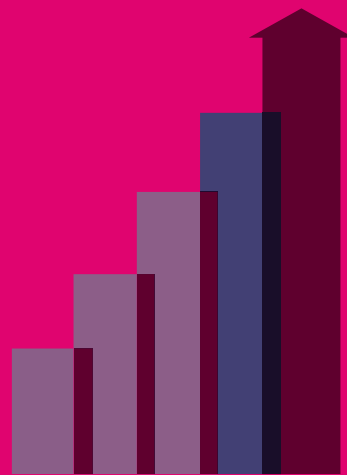
Here are some of our findings for 2009:

- There has been a steady increase in the number of councils performing "well" or "excellently".

- The proportion of social care services (such as care homes) rated as "good" or "excellent" rose from 69% to 77% between 2008 and 2009.

- The proportion of trusts scoring "excellent" or "good" for overall quality has risen from 41% in 2005 to 63% in 2009.

- Providers of independent health care, such as hospitals, hospices and private doctors, on average met 64% of minimum standards and almost met a further 26% of them.

- One in six care homes and home care agencies was "adequate" or "poor"; 426 social care services (2%) were rated "poor" overall.

- 20 (5%) of the 392 NHS trusts assessed were rated "weak", and 32 (8%) have never been rated higher than "fair" over the last four years.

- The number of safety incidents reported by health care organisations has improved greatly, but the reporting rate can vary widely across different types of organisation.

- 9% of NHS organisations did not comply with the minimum standard on child safeguarding, compared to 4% in 2008.

- Improvements in safeguarding procedures were needed in 10% of councils, and over a third had to make further improvements in their safeguarding training.

- All types of services, as well as primary care trusts and councils that purchase care for people, find the standards on staff training the hardest to meet.

Introduction

In this section, we focus first on overall trends in the performance and quality of services, and then look at three crucial areas of care in which we saw significant variation throughout the country.

Our role as England's regulator of health care and adult social care is to make sure that all registered services meet essential standards of quality and safety. We also use a range of assessment methods to encourage services to improve beyond these essential standards.

We assess and report on the performance of providers of health care and social care, and that of the primary care trusts (PCTs) and councils that buy (commission) services for local people. When doing so, we bring together a range of evidence and, most importantly, the views and experiences of people who use the services and their families and carers.[66] Where we find poor quality care we act quickly, using our increased powers to ensure improvement.

In this section, we focus first on overall trends in the performance and quality of services, and then look at three crucial areas of care in which we saw significant variation in quality and performance throughout the country.

The overall picture of quality

Our analysis of overall trends in performance and quality is based on the following reports, in which we looked at the different sectors in detail (available at www.cqc.org.uk):

- Performance assessments for 148 adult social services in England, including the quality of care services purchased by councils and those councils that were classed as a priority for improvement (covering the assessment year April 2008 to March 2009).

- An overview of the quality and performance of more than 24,000 regulated adult social care services (as at 31 March 2009).*

- Assessment of the performance of 392 NHS trusts (for April 2008 to March 2009).**

- Our detailed report on the operation of the Mental Health Act, published in July 2009.

- The performance of 3,650 registered independent health care services, provided by 2,326 establishments (as at 31 March 2009).

---

* These consist of 18,378 residential homes, 5,134 home care agencies, 731 nursing agencies and 131 Shared Lives schemes.

** These consist of 169 acute and specialist trusts, 152 PCTs, 57 mental health trusts, 11 ambulance trusts, two learning disability trusts and one community trust.

We have seen great improvements across health care and social care over recent years.* In general, fewer services were being rated "poor" and more were achieving "excellent" and "good" scores:

- More than three-quarters of adult social care providers were providing an excellent or good service.

- 95% of councils were judged good or excellent in providing better outcomes for people.

- Three in four places purchased by councils were in good or excellent care homes.

- In the NHS, the national rate of compliance with minimum standards is the highest it has ever been this year, at 96%.

- 63% of NHS trusts were assessed as excellent or good for overall performance.

- Our Mental Health Act Commissioners reported on a number of examples of people who have been detained receiving effective treatment in appropriate and safe environments.

However, the national picture masks unacceptable variations in quality. A small proportion of services were falling below essential standards of quality and safety, and some were persistently failing to improve. For example:

- One in six social care services were rated either "adequate" or "poor" (17% services were adequate and a further 2% were poor).

- In both 2008/09 and 2007/08, only a third of councils performed adequately in maintaining people's dignity.

- Some NHS services have never reached a good standard over the last four years: 32 of the 392 trusts assessed this year have not scored higher than fair for either overall quality or financial management.

- In independent health care, performance in 10% of all the core and service-specific standards inspected fell far short.

---

* We assess independent health care providers against national minimum standards, but do not make a judgement about their overall quality.

Patterns in quality and trends in performance

Quality of commissioning

Primary care trusts and councils both performed less well in areas relating to human rights, including promoting dignity and respect, and tackling discrimination.

Trends in performance

In 2008/09, for the first time, we assessed PCTs for the quality of their commissioning of services. The assessment looked at their performance against core standards, existing commitments and national priorities. The great majority of PCTs either "fully" or "almost" met the standards overall (see figure 17).

The core standards were set by the Department of Health in 2004 and all NHS organisations should have been meeting them since then. So, while it is encouraging that 100% of PCTs as commissioners were complying with 14 of the core standards, it is worrying that fewer than 90% of them met the standards for records management, staff training and human rights (see box 4).

There has been a steady rise in the number of councils performing "well" or "excellently" (see figure 18) and, for the sixth year running, no councils were assessed as "poor". Since 2008, the assessment has changed for 38 councils (26% of all councils). Of these, 27 have improved and 11 have deteriorated. The greatest improvement was in the shire (non-metropolitan) counties and outer London boroughs. In 2008, there were 19 councils designated as a priority for improvement. By 2009, 16 of these had moved out of the category. It is positive that there were, in 2009, only eight councils (all assessed as adequate) classified as a priority for improvement. Box 5 shows the areas of good and weaker performance.

Figure 17: Performance of PCTs as commissioners in complying with core standards, 2008/09

2 (1%)

43 (28%)

107 (70%)

- Fully met
- Almost met
- Partly met
- Not met = 0
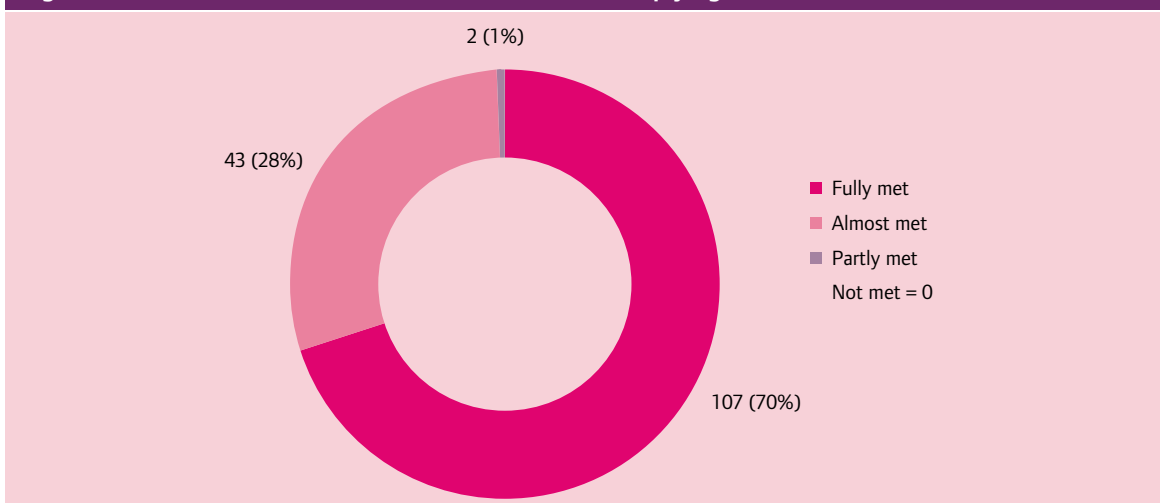
Source: Care Quality Commission.

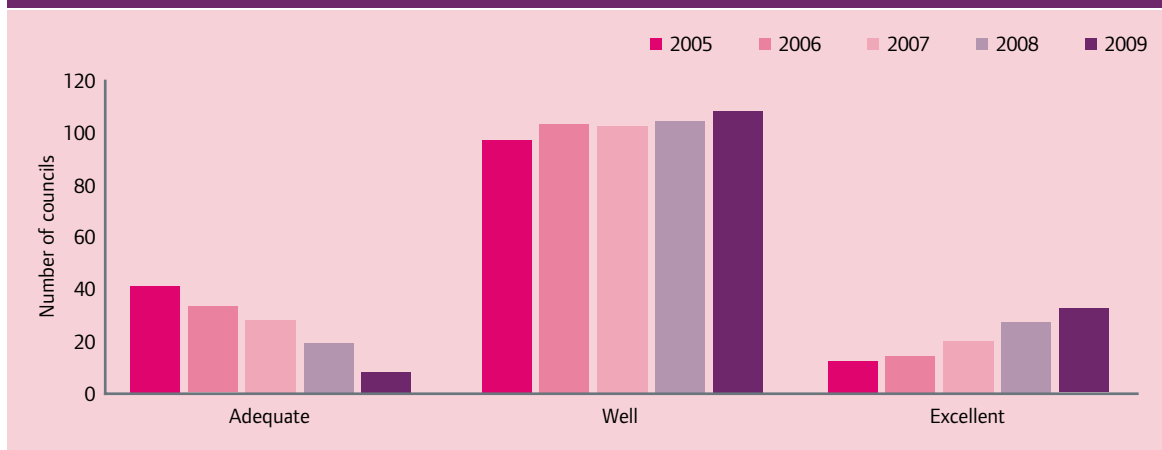**Box 4: Areas of stronger and weaker performance by PCTs as commissioners**

Standards for which all PCTs were compliant

- Clinicians regularly update and review their key skills (C5c).
- Clinical and corporate governance (C7a/c).
- Supporting staff through promoting openness, honesty, probity and accountability (C7b).
- Supporting staff to raise/report issues of concern (C8a).
- Staff abide by their relevant professional code of conduct (C10b).
- Systems in place for obtaining patient consent (C13b).
- Access to information about the process for making a complaint (C14a).
- Patients are assured that the organisation will act appropriately on any concerns raised (C14c).
- Patients are provided with a choice of meal (nutrition) (C15a).
- Individual dietary needs are taken into account and met (C15b).
- Patient and public views are sought and taken into account in planning and delivering health care processes (C17).
- Health care services are provided in environments which promote effective care (C20b).
- Ensuring that the local director of public health's annual report informs the local polices and practices of health care organisations (C22b).
- Systematic and managed disease prevention and health promotion programmes (taking into account best practice guidelines) (C23).

Standards with the lowest compliance rates

- Having a systematic and planned approach to records management (C9) (87% of PCTs are compliant).
- Ensuring that all health care staff participate in mandatory training programmes (C11b) (87%).
- Challenging discrimination, promoting equality and respect for human rights (C7e) (88%).

Figure 18: Performance of councils in delivering outcomes for people who use social care, 2005 - 2009

Source: Care Quality Commission.

Note: There were no "poor" councils in these years.

Box 5: Areas of stronger and weaker performance by councils as commissioners

Stronger areas

- The performance of councils delivering improved health and emotional wellbeing was high: 92% were assessed as performing well or excellently. Forty-three councils (29%) provided excellent outcomes.

- 37 councils (25%) were judged excellent for improving quality of life for people who use services.

- Councils have continued to perform strongly in making a positive contribution, with 49% of councils performing well and 51% achieving excellent outcomes.

- 134 councils (91%) performed excellently or well in meeting the outcome on freedom from discrimination and harassment.

- Overall, councils continued to perform relatively well in achieving economic wellbeing. Sixty-six per cent of councils performed well, and 30% achieved excellent outcomes.

Weaker areas

- Only 26 councils performed excellently at increasing choice and control. Fifty-nine per cent performed well and 23% performed adequately.

- Only 12 councils performed excellently in maintaining dignity and respect. The number of councils performing well was 60%. Two councils performed poorly.

There has been a steady rise in the number of councils performing "well" or "excellently" and, for the sixth year running, no councils were assessed as "poor".

PCTs and councils both performed less well in areas relating to human rights, including promoting dignity and respect, and tackling discrimination. But in general they seemed to be weaker in different aspects of their work.

There are 106 local areas where the PCT and the council have matching geographical boundaries, and so serve the same population. Yet when we looked at councils' and PCTs' performance as commissioners from a geographical perspective, and using overall ratings as a measure, we found no statistically significant relationship between their performances. This suggests that the performance of commissioners was not affected by the needs of the local population. Instead, the characteristics of the organisations and the fact that they work under different constraints seem to be what made the difference.

Variations in the quality of care purchased by councils

Overall, three out of four places in care homes purchased by councils were in good or excellent homes. More detailed analysis, however, showed that the quality of adult social care purchased by councils varied considerably at a local level.* For example, 58 councils (39%) had 80% or more supported people in homes that were rated good or excellent, but 22 councils (14%) had less than two-thirds of people in such homes.

The quality of the care home places purchased by councils in September 2008 was lower than what was available in the overall marketplace. This particularly applied to nursing care: 71% of nursing care places purchased by councils were in homes rated good or excellent, whereas 75% of nursing care places available in the overall marketplace were in homes rated good or excellent.

Furthermore, the quality of new permanent places purchased by councils was only marginally better than the quality of what they were already buying. For example, 23% of new personal care home places for older people were poor or adequate, compared with 24% of all the places already in use.

Councils were improving the quality of what they bought overall, but the rate of improvement was no faster than what was happening in the market generally. Between 2007 and 2008, there was a rise in the proportion of council-supported people in homes rated good or excellent. This was most marked for those in homes providing personal care for older people (8 percentage points improvement), with other categories improving by 5 or 6 percentage points. Given that all sectors experienced a rise of between 6 and 8 percentage points over a similar period, council purchasing is not getting ahead of the market.

There were also differences between councils in the quality of the home care they funded. Eighty-one per cent of councils had more than three-quarters of the people they supported using services rated as good or excellent. However, in 17 councils (11%), more than a third of people were using home care services rated as poor or adequate.

25% of councils were assessed "excellent" on improving quality of life for people using social care.

* We are in the second year of undertaking these assessments in social care. We are piloting how we can give PCTs feedback on the quality of care they are purchasing from social care providers and we will explore how the concept might apply to their purchasing from NHS providers in due course.

Quality and performance of providers

During the last four years, there has been a steady increase in the proportion of trusts scoring either excellent or good for their quality of services, and/or for their financial management.

Table 5: Quality ratings across different types of adult social care, 2008 - 2009								
	3 Stars – Excellent		2 Stars – Good		1 Star – Adequate		0 Stars – Poor	
	May 2008	April 2009	May 2008	April 2009	May 2008	April 2009	May 2008	April 2009
Shared Lives	27 20%	42 32%	89 66%	81 62%	12 9%	5 4%	2 1%	0 0%
Non-medical care home	1 4%	3 14%	12 52%	10 45%	8 35%	7 32%	0 0%	0 0%
Nursing home	557 13%	698 16%	2,160 52%	2,413 57%	1,137 27%	871 21%	181 4%	113 3%
Home care agency	719 15%	963 19%	2,844 58%	2,956 58%	988 20%	694 14%	85 2%	64 1%
Nursing agency	114 16%	141 19%	409 57%	410 56%	136 19%	114 16%	4 1%	2 0%
Residential home	1,824 13%	2,321 16%	8,134 57%	8,664 61%	3,456 24%	2,382 17%	401 3%	247 2%

Note: These figures do not include new services that received a rating from their first inspection at either point in time (1,009 in May 2008 and 1,153 in April 2009). Also, they do not include services undergoing enforcement proceedings (34 in May 2008 and 20 in April 2009).

The national picture

The quality and performance of health care and social care providers improved overall between 2008 and 2009. More than three-quarters of regulated adult social care providers were providing an "excellent" or "good" service for people using their services. Ninety-five per cent of councils were performing "well" or "excellently". The national rate of compliance with minimum standards, 96%, was the highest it has ever been for the NHS, and 63% of NHS trusts were assessed "excellent" or "good" for overall performance.

However, across both health care and social care there were a significant minority of adequate or poor services:

- 4,073 regulated social care services were judged to be "adequate" and 426 were "poor".

- Eight councils were classified as a priority for improvement (that is, the poorest performing).

- 127 trusts (32%) were rated "fair" and 20 (5%) were rated "weak".

- In independent health care, there were minor shortfalls in the performance of 26% of the standards that apply. Performance in a further 10% of standards fell far short.

Adult social care

In adult social care, the proportion of services rated good or excellent rose from 69% to 77% between 2008 and 2009, with those rated excellent increasing by 4% to 17%. There was also a small reduction in the number of poor services (down from 3% to 2%). Table 5 shows the pattern of quality ratings across adult social care services.

NHS trusts

During the four years that the NHS performance ratings have been in place, there has been a steady increase in the proportion of trusts scoring either excellent or good for their quality of services. This levelled off in 2008/09, when 63% of trusts were assessed as excellent or good for overall performance. There has also been a steady rise in the proportion of trusts being scored excellent or good for financial management (see table 6). A breakdown of performance by type of trust for quality of services in 2008/09 is shown in table 7.

Although the weaker organisations do appear to be improving after four years of the assessment, about 8% of trusts (32 of the 392 assessed in 2009) have never scored higher than fair for either their overall quality of services or their financial management. (A score of fair means that a trust performed adequately in terms of the overall score.) So while there have been considerable improvements in the overall level of performance, we still have concerns about trusts at the lower end of the scale.

Independent health care providers

Independent health care providers are assessed against both core and service-specific national minimum standards.* They met, on average, 65% of core standards and 63% of service-specific standards. These minimum standards were first set out in 2000 and came into force from 2002 onwards. Given the time that has elapsed since then, there is room for considerable improvement in the sector. Table 8 shows the proportion of standards met by each type of provider.

The proportion of social care services rated good or excellent rose from 69% to 77% between 2008 and 2009.

---

* Note, national minimum standards are different to the core standards that are used to assess NHS trusts.

Table 6: Performance of NHS trusts for overall quality of services and for financial management, 2005/06 – 2008/09				
Overall quality scores	**Excellent**	**Good**	**Fair**	**Weak**
2008/09: number of trusts assessed = 392	59	186	127	20
	15%	47%	32%	5%
2007/08: number of trusts assessed = 391	100	138	131	22
	26%	35%	34%	6%
2006/07: number of trusts assessed = 394	65	121	175	33
	16%	31%	44%	8%
2005/06: number of trusts assessed = 570	25	207	286	52
	4%	36%	50%	9%
Overall financial management scores	**Excellent**	**Good**	**Fair**	**Weak**
2008/09: number of trusts assessed = 392	103	176	102	11
	26%	45%	26%	3%
2007/08: number of trusts assessed = 391	94	145	132	20
	24%	37%	34%	5%
2006/07: number of trusts assessed = 394	57	91	142	104
	14%	23%	36%	26%
2005/06: number of trusts assessed = 570	19	71	270	210
	3%	12%	47%	37%

Table 7: Performance of NHS trusts for overall quality of services, by type of trust, 2008/09				
Organisation type	**Excellent**	**Good**	**Fair**	**Weak**
Acute and specialist trusts	37	81	43	8
	22% ↓	48% ↑	25% ↑	5% ↔
Ambulance trusts	0	2	6	3
	0% ↓	18% ↓	55% ↑	27% ↑
Learning disability and community trusts	1	0	2	0
	33% ↔	0% ↔	67% ↑	0% ↓
Mental health trusts	18	26	8	5
	32% ↓	46% ↑	14% ↑	9% ↑

Table 8: Proportion of independent health care providers meeting core and service-specific standards, 2008/09		
Provider type	**Average percentage of core standards met**	**Average percentage of service-specific standards met**
Hospices	73%	77%
Termination of pregnancy clinics	69%	80%
Acute hospitals	67%	64%
Private doctors	67%	85%
Prescribed techniques and technologies	66%	66%
Mental health establishments	57%	58%

Note: We have not shown scores for independent maternity hospitals as the numbers of services are too small to give a fair comparison.

Key areas of concern

Not only were some individual organisations failing to meet minimum standards in these important areas, but also the national level of performance was lagging behind what is needed for really good quality care.

Our performance assessments not only revealed marked differences in the quality of individual services, but also highlighted three areas of care in which performance showed unacceptable variation. We found that performance on safety, safeguarding and training of the workforce varied widely within both health care and social care, despite overall improvement in recent years. Not only were some individual organisations failing to meet minimum standards in these important areas, but also the national level of performance was lagging behind what is needed for really good quality care.

Safety, safeguarding and staff training are fundamental to achieving good outcomes for people. They have repeatedly been shown to be major contributing factors when we have carried out major investigations into serious failings in care.[67,68,69] The good practice that we found was lacking, when assessing services in 2009, should be in place as a matter of course.

Safe care

Safe and effective care was one of the six dimensions of quality highlighted in the *NHS Next Stage Review*[1], and the House of Commons Health Committee gave renewed impetus to the topic when it published its report *Patient Safety*.[70] The report identified a number of current failings and made recommendations for change, including the prioritisation of safe care across organisations. This called for safe care to be the top priority of NHS managers and boards, and for a greater culture of openness – so that when people are harmed they receive an explanation, an apology and a firm undertaking that the same mistakes will not happen again.[71]

Reporting and learning from incidents in the NHS

Things sometimes go wrong when people receive care. It is crucial that organisations report their mistakes and near misses (called 'incidents'). This is so that they can learn and put things right, which creates a culture of improvement in safety, rather than one of blame. Reporting rates vary from organisation to organisation, but places with few (or no) reported incidents are not necessarily safer. A higher level of reporting can reflect a stronger culture of safety, with a greater potential to learn from incidents and prevent the same things happening again.

Figure 19: Number of incidents reported in the NHS in England, 2003 – 2009
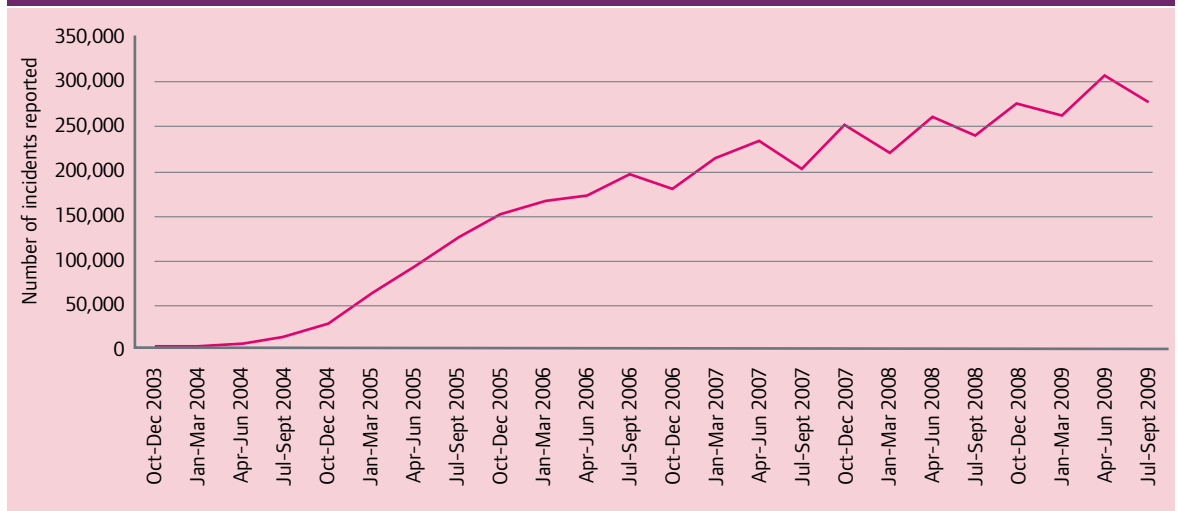
Source: **National Patient Safety Agency.**

96%
of NHS staff responding to a 2008 survey said they had reported the most recent error, near miss or incident they had witnessed – a 2% increase since 2007.

The National Reporting and Learning System (NRLS), managed by the National Patient Safety Agency (NPSA), collects patient safety incident reports from all NHS organisations. Between July 2008 and June 2009, 1.06 million incidents were reported to the NPSA, compared to 920,000 incidents in the previous year. This is further evidence of a continual increase in incident reporting since the system began in October 2003 (see figure 19) and is positive, because it shows a greater awareness of safety and more openness about mistakes. It is crucial that organisations report their mistakes and near misses, so that they can learn and put things right.

It is encouraging that 96% of staff responding to a 2008 survey said they had reported the most recent error, near miss or incident they had witnessed, up from 94% in 2007. This is despite a small but significant proportion (11%) who felt that reporting of errors would lead those involved being blamed or punished (a finding in line with the 2007 results). Eighty per cent of staff felt encouraged to report errors, near misses and incidents, a rise from 75% in the previous year.

As well as a rise in the overall reporting rate, there has also been an increase in the number of organisations reporting. For example, of the 389 NHS organisations reporting to the NRLS, 95% reported at least one incident every month between 1 July 2009 and 30 September 2009. This was a significant improvement on the corresponding period in the previous year, when only 48% of organisations reported every month.

However, when comparing organisations that have the same sort of function (for example, PCTs that have inpatient beds), the reporting rate varies considerably (see figure 20), as does the timeliness and consistency of reporting.

We are currently working with the NPSA to identify organisations where there are concerns about their reporting rates. We will be taking this information into consideration in our registration and monitoring activities.

The lack of reporting by primary care services is another concern. Despite 90% of people's contacts with the NHS occurring within this setting – GPs, dentists, health visitors and so on – very few incidents were reported to the NRLS from the sector. Between July 2008 and June 2009, 693,700 incidents came from a hospital setting, but only 3,417 incidents were reported from general practice. It is encouraging, though, that the numbers increased sharply (there were only 1,962 reports from general practice from July 2007 to June 2008).

Figure 20: Incident reporting rates for PCTs with inpatient beds (October 2008 – March 2009)

Reported incidents per 1,000 bed days

200
150
100
50
0

PCTs
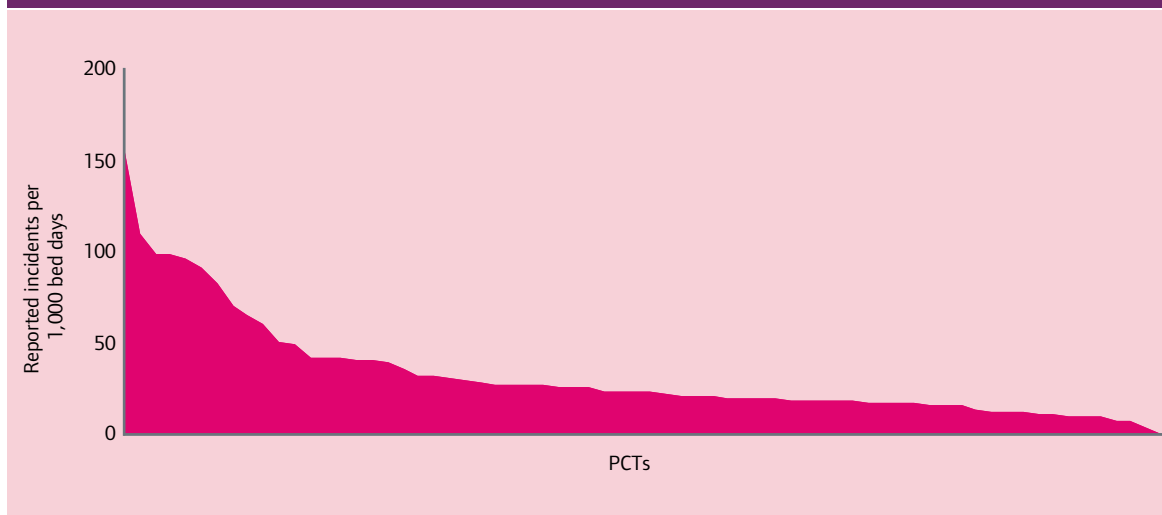
Source: National Patient Safety Agency.

The NPSA routinely analyses the information it receives to identify areas of urgent risk and then sends safety alerts to NHS trusts and independent providers. These alerts are a critical tool for ensuring safer care and implementing them will help to prevent potential adverse outcomes for people in the future.

It is essential, therefore, that alerts are responded to within the set timeframe. Based on a small sample of NHS trusts, our research showed that the rate of implementation was variable. Of the 11 trusts we asked, only two provided protected time for training on safety alerts. Furthermore, five of the 11 said they did not audit whether the actions required by safety alerts had been implemented.[72]

It will become mandatory to report serious patient safety incidents from April 2010, as this is included in the registration regulations. We are working with the NPSA to identify those organisations where there are unexplained concerns about reporting rates, and we will be taking this into consideration as part of registration and ongoing monitoring.

Analysing mortality rates

Standardised mortality can be an important, system-wide, indicator of safety and quality. Some variations in mortality rates are due to case mix and patient characteristics, and some variation may be due to other issues, for example the configuration of local services. Hospitals are complex organisations with patients moving through several different care pathways, and CQC primarily assesses mortality among groups of patients defined by the care they receive, for example, patients admitted with a stroke or hip fracture. CQC's approach to high mortality alerts is to first understand the underlying causes and, in particular, whether there is sufficient evidence that they are not a consequence of poor care quality – for example they could be because of how a trust reports data or because of the mix of patients it treats. If concerns remain then CQC works with the trust until the causes of the problem are explained. More in-depth work with the trust can be triggered.

"Staff have got these ideas and are keen to put them into practice to see whether they work."

David Dalton's story

David Dalton is Chief Executive at Salford Royal NHS Foundation Trust, where the patient safety and quality improvement plan is based on deep staff engagement. It has already delivered results and saved additional lives: "Some wards had the idea of going back to staff observation for taking measurements such as blood pressure. Instead of putting the patient's arm onto the machine, pressing a button, leaving the room, then coming back and recording the measurement, we are back to nurses taking measurements manually by the bedside.

"This change of approach was not because the equipment was at fault or that staff were doing things incorrectly, but because a nurse will engage more directly with the patient when manually testing and can spot signs of deterioration that otherwise could be missed. You may be thinking, so what? The number of cardiac arrest calls outside of the Intensive Care Unit at Salford Royal has fallen by 40%, with some wards reducing cardiac arrests by as much as 70%, and in part that is because staff have got these ideas and are keen to put them safely into practice."

New approaches to safety based on staff engagement with patients are already delivering results and saving lives at Salford Royal NHS Foundation Trust.
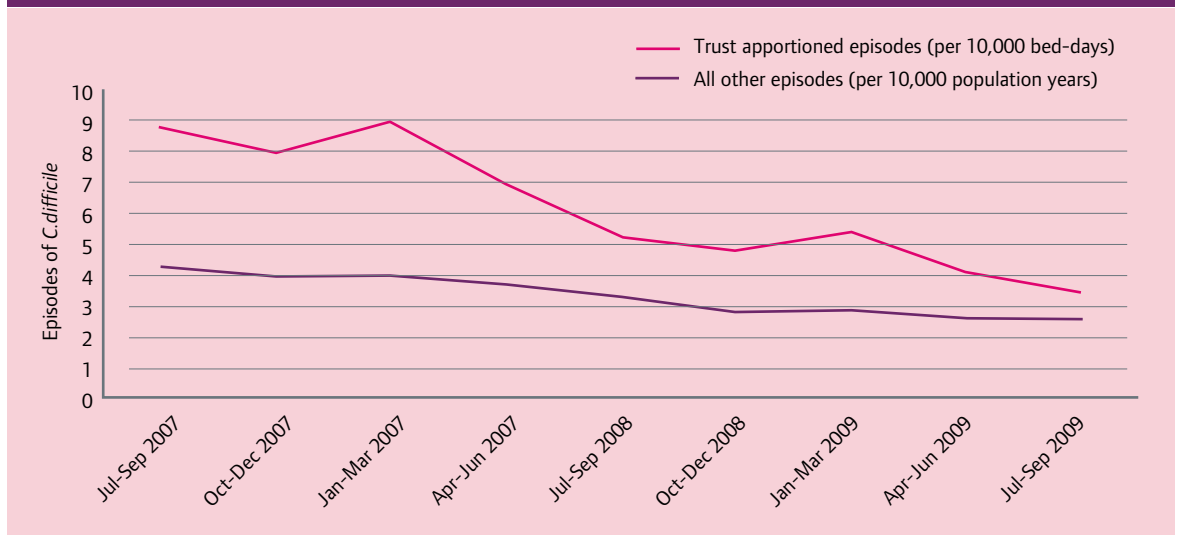
Figure 21: Episodes of MRSA in NHS acute services, 2007 - 2009

— Trust apportioned episodes (per 100,000 bed-days)
— All other episodes (per 100,000 population years)
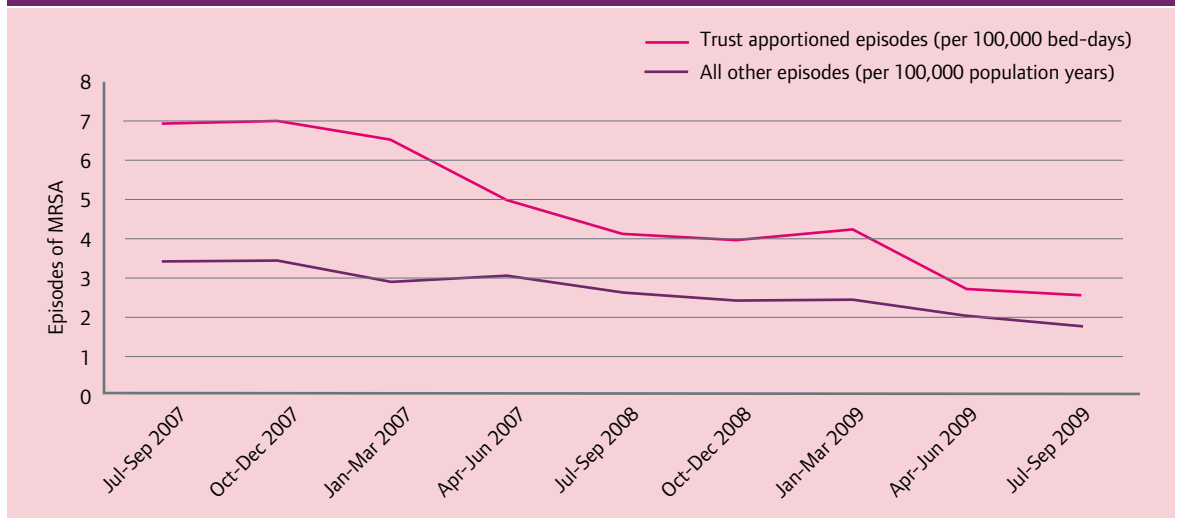
Source: Health Protection Agency.

There has been a 35% fall in cases of *C. difficile* cases and a 34% fall in cases of MRSA since 2007/08.

Figure 22: Episodes of *C. difficile* in NHS acute services, 2007 - 2009

— Trust apportioned episodes (per 10,000 bed-days)
— All other episodes (per 10,000 population years)

Source: Health Protection Agency.

Tackling healthcare-associated infections

Tackling healthcare-associated infections, such as MRSA and *Clostridium difficile* (*C. difficile*), continues to be a top safety issue. The considerable progress made at a national level shows that, where there is sustained national* and local focus on an issue, there can be real improvements in safety.

In 2008/09, there was a 35% fall in *C. difficile* cases and a 34% reduction in MRSA cases compared with the previous year. There was also a downward trend in the numbers of surgical site infections in most types of surgical procedure.

The latest data on MRSA cases associated with acute NHS care shows that rates have decreased from 6.9 cases per 100,000 bed days in 2007 to 2.5 per 100,000 bed days

---

* The 2009/10 *NHS Operating Framework* and the 2007 Public Service Agreement set targets to halve the number of MRSA in NHS acute and specialist trusts in England by March 2008 and cut the number of *C. difficile* infections by 30% by 2010/11, compared with 2007/08.

Figure 23: Proportion of NHS trusts meeting hygiene code standards, 2005/06 – 2008/09

Legend: 2005/06 2006/07 2007/08 2008/09

Y-axis: % of trusts (70, 75, 80, 85, 90, 95)

X-axis categories: C04a (infection control), C04c (decontamination), C21 (clean environments)
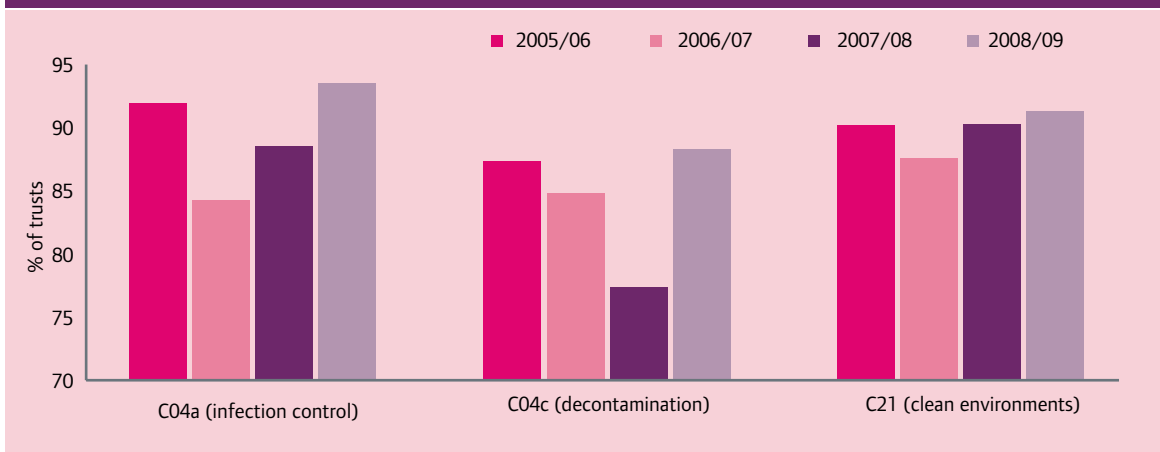
Source: Care Quality Commission.

in 2009 (see figure 21). This was a 63% decrease in the number of cases nationally. There have been fewer cases in all trust types in the past 12 months.

The latest data on *C. difficile* associated with acute NHS care shows that rates have decreased from 8.8 episodes per 10,000 bed days in 2007 to 3.4 per 10,000 bed days in 2009 (see figure 22). The majority of *C. difficile* infections have a very clear age distribution, with the largest rates occurring in older people.

These improvements mirror the findings from the 2008/09 NHS performance ratings. Three of the 44 standards relate to systems for infection prevention and control, decontamination and cleanliness. In both 2006/07 and 2007/08, all three were in the list of six standards with the lowest compliance rates. But, this year, only one of the three (decontamination) appears on this list. Furthermore, as can be seen from figure 23, the number of services meeting all three standards has increased compared with 2007/08.

Despite these improvements, some trusts still need to do more on infection control. This year, 48 acute trusts did not meet at least one of the three relevant standards, up from 44 the previous year.

Safeguarding children and adults

Protecting children and adults from abuse is everyone's responsibility.[73,74] The circumstances surrounding the death of Peter Connelly (Baby P) put a renewed focus on safeguarding across health care and social care. Earlier in this report (page 55) we discussed how poor communication between professionals was an important factor in the failure to protect Peter from harm.[60]

Safeguarding arrangements have improved across the two sectors, but more needs to be done to ensure a stronger, more constant focus on keeping people safe. We found that a small, but significant, number of services were particularly weak.

Overall trends
We carried out a follow-up review of the arrangements within NHS trusts for safeguarding children. Although this showed that most trusts had the right people and systems in place, it highlighted a need for them to urgently review their practices in some areas. In response, the NHS Chief Executive wrote to all chief executives and boards of NHS trusts, asking them to take urgent action to ensure that their trusts follow best practice and statutory requirements in relation to child safeguarding. He also asked trusts to make a public declaration when this work was completed.[75]

Compliance in the NHS with the children's safeguarding standard dropped from 96% to 91%.

Figure 24: Proportion of NHS trusts meeting the children's safeguarding standard, 2005/06 – 2008/09

Source: Care Quality Commission.

In addition, our 2008/09 performance assessment of the NHS showed that compliance with the children's safeguarding standard dropped to 91%, down from 96% in 2007/08. This was the lowest rate of compliance in four years, as shown in figure 24. While these lower scores were due in part to closer scrutiny about safeguarding, they nevertheless reflect an urgent need for improvement.

Similarly, Ofsted has found that a number of recommendations to improve safeguarding arrangements for children, following serious case reviews, have still to be implemented, and also that there is much more to do to ensure that services work together and to improve areas of poor performance.[76]

In adult social care in 2008/09, improvements in safeguarding procedures were needed in 10% of councils, and over a third had to make further improvements in their safeguarding training.

These concerns are not new and concerns have been raised by previous regulators about the responsiveness and effectiveness of multi-agency safeguarding arrangements. We carried out a study that indicated uneven progress between agencies, and the need for more to be done to safeguard people who direct their own care and support, such as those who buy it using personal payments from their council.[77]

We have since followed up this study by asking councils what they have done to address the key findings and how they are improving outcomes for people. Overall, around 45% of councils this year demonstrated a multi-agency commitment to developing adult safeguarding, an improvement of 30% since last year. Nevertheless, procedures for safeguarding adults were noted as a strength in only just over 10% of councils. Our analysis* of councils' actions showed some good positive performance overall, but no council could point to robust evidence of outcomes.

---

*   We analysed responses from a representative sample of 40 councils.

Figure 25: Proportion of adult social care services meeting protection standards, comparison of first year of inspection with 2008/09
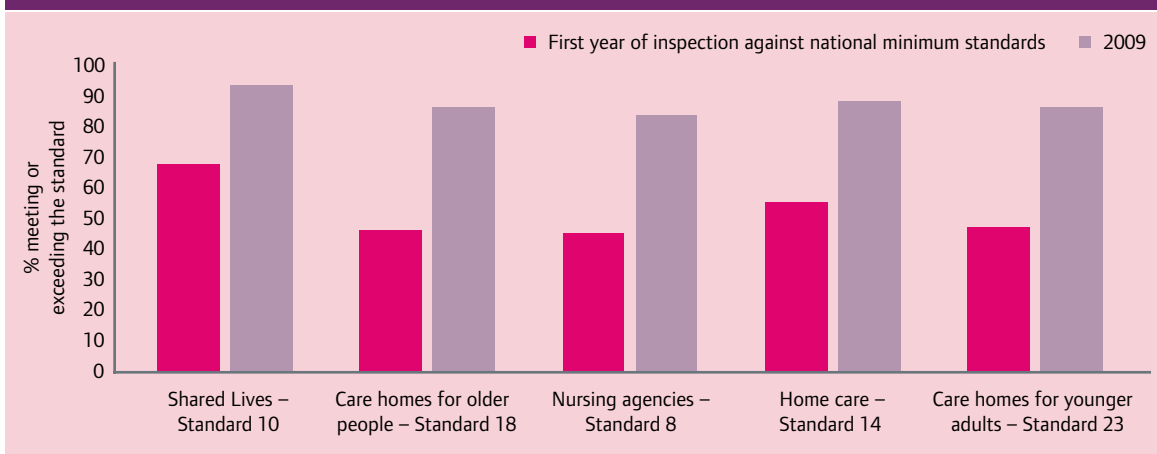
Source: Care Quality Commission.

Note: The first year of national minimum standards for care homes for younger adults and older people was 2002/03, for nursing agencies 2003/04, for home care 2004/05 and for Shared Lives schemes, 2005/06.

Examples of good practice included:

- 70% of councils had worked to improve monitoring systems, which included improved governance, better data collection, learning from events, and improved performance management systems (including moving to electronic records in some cases).

- 55% said that they had raised the profile of safeguarding through staff training and public awareness campaigns.

- 48% had undertaken, or planned to undertake, more work to provide better information, advice and support. This included providing advocacy, in particular the use of Independent Mental Capacity Advocates, and underlining the importance of a person-centred approach when dealing with safeguarding concerns.

- 28% had worked to include safeguarding within self-directed support.

Social care services perform well against their specific safeguarding standards. Figure 25 shows that between 85% and 93% of services met or exceeded the standards in 2009. However, this still means that, across the five service types shown, 3,268 services did not meet safeguarding standards.

In mental health services, crowded wards make it more likely that incidents will occur. In 64% of the acute wards visited by our Mental Health Act Commissioners between 2007 and 2009, bed occupancy rates were 100% or more.[78] Also, nearly three-quarters of admissions of people detained under the Mental Health Act were to mixed sex wards, which is a cause for concern as many of these wards are not providing single sex accommodation. Mixed sex wards are acceptable as long as they provide single sex sleeping areas, bathrooms and toilets together with access to a women-only lounge. Findings from the National Ethnicity Census 2009 showed that 24% of women and 19% of men did not have access to separate bathrooms and toilets and 51% of women did not have access to separate lounge space. This risks compromising the safety, privacy and dignity of women.

Nearly three in four admissions under a section of the Mental Health Act were to mixed sex wards.

Staffing is the one aspect of performance in which all types of provider and commissioner were least likely to meet minimum standards. Recruitment, overall staffing levels, training and workforce development are all issues that need attention.

Less than

50%

of NHS staff surveyed said that they had good development opportunities at work and strong support for training.

Staff training and qualifications were considered a strength in only 16% of councils.

Staffing and workforce development

Delivering a high-quality, integrated and personalised health care and social care system needs a skilled workforce. Staff need ongoing training and support and supervision if they are to be responsive and flexible, and fully understand the importance of maintaining people's dignity and respect at all times.

In 2009, the Government published *Working to put people first*, a strategy and framework to transform the adult social care workforce.[43] The new National Skills Academy for Social Care will develop the leadership, management and commissioning skills that are central to the reform of social care. Similarly, the Centre for Workforce Intelligence will take forward the planning that was set out in the *NHS Next Stage Review – A High Quality Workforce* in 2008.[79] The Centre will oversee the quality of workforce planning across health care, including aspects delivered by social care.

Overall trends

We are concerned about staffing because it is the one aspect of performance in which all types of provider and commissioner were least likely to meet minimum standards. Recruitment, overall staffing levels, training and workforce development were all issues that need attention (see box 6).

However, there were also considerable positive developments. For example, 57% of all NHS staff said that they were both supported to keep up to date with developments in their field and encouraged to develop their own expertise. This was backed up by the majority (95%) of NHS staff saying that they had had some type

of training in the previous 12 months – 80% of those felt that it had helped them to do their job better or to keep up to date with the demands of their job.

Where councils were performing well, they demonstrated:

- Effective workforce planning and recruitment, aimed at restructuring services to deliver personalisation.

- Liaison with local universities to recruit newly qualified social workers and to establish mentoring arrangements.

- Training and qualification routes to improve skills and develop careers, through regular supervision. Training and development was also extended to the independent and voluntary sector:

'Accredited training has been provided for care home cooks...'
Annual performance assessment report

There were areas where employers clearly need to learn from the best and do more to provide the right training and development opportunities. But staff have responsibilities too. A review of services for people with learning disabilities found that the take-up of training was disappointingly low from the very group of staff who had been identified as most needing it.

To deliver a personalised and integrated health care and social care system requires strong leadership and a skilled, stable and developing workforce that is supported by employers.

80% of NHS staff who had had training in the past year felt that it had helped them to do their job better.

Box 6: Concerns in performance relating to recruitment, staffing levels and training

Councils

- Staff training and qualifications were considered a strength in only 16% of councils.

- Only 13% of councils were performing well in workforce recruitment and retention.

- Only six councils in the annual performance assessment had identified improvements in the development of staff qualifications and training in line with the ambitions of *Putting People First*.[6]

Adult social care providers

- Compliance with standards on training and development ranged from 81% for care homes for older people to 86% for Shared Lives schemes.

- There was more variation in standards relating to supervision and support – care homes for older people again showed the lowest level of compliance (71%), and care homes for younger adults the highest (81%).

NHS trusts

- Only 40% of staff across the NHS said that they had good development opportunities at work, and only 45% agreed that there was strong support for training in their area.

- Only 75% of all NHS staff said that they had taken part in mandatory health and safety training in the previous 12 months. One of the minimum standards that had the lowest rate of compliance by all types of trust, including PCTs as commissioners, was that for staff participation in mandatory training programmes. The rate varied from 73% for ambulance trusts to 90% for mental health trusts.

- However, 95% of staff said that they had had some type of training in the previous 12 months.

Independent health care providers

- There was a mixed picture of performance. For example, only 54% of independent acute hospital services met the general standard on staff training, experience and qualifications. The corresponding figure for mental health services was 43%. However, 69% of mental health services met the standard for staffing levels and skills mix.

- Acute services and hospices achieved scores of 59% and 75% respectively for the standards that require staff to have specific qualifications and training in the care of children.

Moving forward

Those who provide services or purchase services for local people are responsible for improving their quality, by implementing essential improvements and learning from the very best in health care and social care. At CQC we will play our part in helping to improve the quality of people's care through our regulatory activities.

Major improvements have been made in health and social care services in the years leading up to, and during 2009. Yet there is variation in the quality of care, and we are concerned about a small number of organisations that do not meet current minimum standards or that persistently fail to improve.

Increased demand and tightened finances in the future mean that many organisations will need to fundamentally change the extent to which they join up services across traditional divides and give people more control and choice.

Those who provide services or purchase services for local people are responsible for improving their quality, by implementing essential improvements and learning from the very best in health care and social care. At CQC we will play our part in helping to improve the quality of people's care through our regulatory activities. At CQC we will play our part in helping to improve the quality of care through our regulatory activities. We are changing our approach to give more emphasis to people's experience of care and the outcomes for them.

We are committed to involving people who use health and adult social care services in everything we do and making sure that services involve people and respond to their views. We believe that this involvement is central to improving services for everyone.

These values are based on human rights, equality and diversity and we have set out how we will involve people in our first statement on user involvement, *Voices into Action*.[66] We will improve the information and intelligence that we hold on the views and experience of people using services, and give more weight to people's views in identifying risks that essential standards are not met and in assessing the quality and safety of care.

We are introducing a registration system across health and adult social care, with a common set of new essential standards of quality and safety that all services have a legal responsibility to meet. We will set clear expectations of services that focus on outcomes and are centred on people. We will look at whether people who use services receive safe and coordinated care, and in particular we will look at the quality of treatment and support where people receive more than one service or are moved between services, because these are key points where the quality of care can break down.

The new registration system will work in real time. We will identify serious issues by vigilant assessment of risks to the quality and safety of care, and by responding quickly to concerns as they arise. We will act swiftly to bring about change that improves people's care. We are working as part of the National Quality Board to ensure that early warning signs of concerns are tackled and that it is clear who is responsible for this.

Where we find shortfalls in performance against essential standards, we will impose conditions of registration, and we will refuse to register services that fall below the standards. We will use our enforcement powers where needed. We will also focus on driving improvements through performance assessment and our special reviews and studies.

References

1. Department of Health, *High Quality Care for All: NHS Next Stage Review final report,* June 2008

2. Department of Health, *NHS 2010–2015: from good to great. Preventative, people-centred, productive*, December 2009

3. Department of Health, *Independence, Well-being and Choice: Our Vision for the Future of Social Care for Adults in England*, March 2005

4. Department of Health, *Our health, our care, our say: a new direction for community services,* January 2006

5. Department of Health, *The NHS Constitution for England*, January 2009

6. HM Government, *Putting People First: a shared vision and commitment to the transformation of adult social care*, December 2007

7. Office for Public Management, University of York and GfK NOP for Department of Health, *Evaluation of Information Prescriptions: Final Report to the Department of Health*, August 2008

8. www.dhcarenetworks.org.uk/PHBLN/

9. Department of Health, *Direct Payments for Health Care: A consultation on proposals for regulations and guidance,* October 2009

10. Department of Health, *Valuing people now: from progress to transformation*: *A consultation on the next three years of learning disability policy*, January 2009

    Parliamentary and Health Service Ombudsman, *Six lives: the provision of public services to people with learning disabilities*, March 2009

    Michael J, *Healthcare for all: report of the independent enquiry into access to healthcare for people with learning disabilities*, Department of Health, July 2008

11. HM Government, Office for Disability Issues, *Independent Living: A cross-government strategy about independent living for disabled people,* February 2008

12. Department of Health, *Carers at the heart of 21st century families and communities*: *a caring system on your side, a life of your own,* June 2008

13. Department of Health, *Living well with dementia: a National Dementia Strategy implementation plan*, July 2008

14. Department of Health, *New Horizons: A shared vision for mental health,* December 2009

15. Care Quality Commission, *National NHS patient survey programme: Survey of adult inpatients 2008*, May 2009

16. Care Quality Commission, *Managing patients' medicines after discharge from hospital,* October 2009

17. Healthcare Commission, Her Majesty's Inspectorate of Probation, *Actions Speak Louder: A second review of healthcare in the community for young people who offend,* February 2009

18. Provisional data published by the Information Centre, 30 September 2009, www.ic.nhs.uk/statistics-and-data-collections/social-care/adult-social-care-information/personal-social-services:-care-users-aged-65-or-over-england--councils-with-adult-social-services-responsibilities-tables-provisional-2008-09.

19. Commission for Social Care Inspection, *Putting people first: Equality and Diversity Matters 1: Providing appropriate services for lesbian, gay and bisexual and transgender people,* March 2008

20. Commission for Social Care Inspection, *Putting people first: Equality and Diversity Matters 2: Providing appropriate services for black and minority ethnic people,* August 2008

21. Commission for Social Care Inspection, *Putting people first: Equality and Diversity Matters 3: Achieving disability equality in social care services,* February 2009

22. Care Quality Commission, *The right information, in the right place, at the right time: A study of how healthcare organisations manage personal data,* September 2009

23. Department of Health, *'Choose & Book' – Patient's Choice of Hospital and Booked Appointment,* August 2004

24. Department of Health, *Report on the national patient choice survey – March 2009.* Retrieved from www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_103681.pdf, last accessed 23/12/2009

25. Care Quality Commission, *National NHS patient survey programme. Mental health acute inpatient services users survey 2009,* September 2009

26. Ipsos MORI, *The GP Patient Survey results 2009/10,* www.gp-patient.co.uk/results/ last accessed 23/12/2009

27. Commission for Social Care Inspection, Mental Health Act Commission, Healthcare Commission, *Commissioning services and support for people with learning disabilities and complex needs: National report of joint review,* March 2009

28. Care Quality Commission, *Specialist inpatient learning disability services: Follow-up of audit services 2008/09,* September 2009

29. Department of Health, *Fair access to Care services – guidance on eligibility criteria for adult social care,* January 2003

30. Commission for Social Care Inspection, *Cutting the cake fairly: CSCI review of eligibility criteria for social care,* October 2008

31. Healthcare Commission, *Adult specialist community mental health services: Report of the follow-up to the 2005/06 review,* March 2009

32. Healthcare Commission, *Equality in later life: A national study of older people's mental health services,* March 2009

33. House of Commons Health Committee, *Health Inequalities: Third Report of Session 2008-09, Volume 1,* Stationery Office, March 2009

34. Communities and Local Government, *Place Survey 2008,* June 2009

35. Care Quality Commission, *Closing the gap: Tackling cardiovascular disease and health inequalities by prescribing statins and stop smoking services,* September 2009

36. Healthcare Commission, *Tackling the challenge: Promoting race equality in the NHS in England,* March 2009

37. Department of Health, *National Statistics, Report on the experience of patients in Black and Minority Ethnic groups, based on data up to and including 2008 patient surveys,* June 2009

38. Healthcare Commission, *Listening, learning and working together? A national study of how well healthcare organisations engage local people in planning and improving their services,* March 2009

39. Healthcare Commission, Her Majesty's Inspectorate of Prisons, *Commissioning healthcare in prisons,* February 2009

40. HM Government, *Shaping the Future of Care Together,* Stationery Office, July 2009

41. Nuffield Trust, *Only Connect: Policy options for integrating health and social care,* April 2009

42. Down's Syndrome Association, *Key Facts,* www.downs-syndrome.org.uk/news-and-media/key-facts.html

43. Department of Health, *Working to Put People First: The Strategy for the Adult Social Care Workforce in England,* April 2009

44. Government Office for Science, *Mental Capital and Wellbeing: Making the most of ourselves in the 21st century,* September 2008

45. Royal College of Psychiatrists, Mental Health Network, NHS Confederation and London School of Economics and Political Science, *Mental health and the economic downturn: National priorities and NHS solutions,* Royal College of Psychiatrists, November 2009

46. Department of Health, *Use of Resources in Adult Social Care: A guide for local authorities,* October 2009

47. Turning Point Centre of Excellence in Connected Care, *Benefits realization: assessing the evidence for the cost benefit and cost effectiveness of integrated health and social care,* February 2010

48. Ham C, *Working Together for Health: Achievements and Challenges in the Kaiser NHS Beacon Sites Programme,* University of Birmingham, February 2010

49. Personal Social Services Research Unit, *National Evaluation of Partnerships for Older People Projects. Final Report,* January 2010

50. Ramsay A, Fulop N and Edwards N, 'The evidence base for vertical integration in health care', *Journal of Integrated Care,* 17(2): 3-12, April 2009

51. Department of Health, *Integrated Care Pilots: an introductory guide,* September 2009

52. Audit Commission, *Means to an end: joint financing across health and social care,* October 2009

53. NHS Choices, www.nhs.uk/ServiceDirectories/Pages/CareTrustListing.aspx

54. Department of Health, *The NHS operating framework for England for 2010/11,* December 2009

55. Office for National Statistics, *Life expectancy at birth and at age 65 by local areas in the United Kingdom,* www.statistics.gov.uk

56. Office for National Statistics, *Health Expectancy - living longer, more years in poor health, 1981-2004,* www.statistics.gov.uk/cci/nugget.asp?id=934

57. Information Centre for Health and Social Care, www.ic.nhs.uk/statistics-and-data-collections/supporting-information/audits-and-performance/the-quality-and-outcomes-framework/qof-2008/09/data-tables/england-level-data-tables

58. Analysis of council self-assessments

59. Analysis of national indicator NI125, from the Information Centre website

60. Care Quality Commission, *Review of the involvement and action taken by health bodies in relation to the case of Baby P,* May 2009

61. Care Quality Commission, *Safeguarding children: A review of arrangements in the NHS for safeguarding children,* July 2009

62. Care Quality Commission, *Working together to prevent and control infection: A study of the arrangements for infection prevention and control between hospital and care homes*, September 2009

63. Department for Communities and Local Government, *Strong and Prosperous Communities – The Local Government White Paper*, October 2006

64. Commission for Social Care Inspection, *Supporting disabled parents: a family or a fragmented approach?*, February 2009

65. Audit Commission, *Means to an end: joint financing across health and social care*, October 2009

66. Care Quality Commission, *Voices into action: How the Care Quality Commission is going to involve people*, June 2009

67. Healthcare Commission, *Investigation into Mid Staffordshire NHS Foundation Trust*, March 2009

68. Care Quality Commission, *Investigation into West London Mental Health NHS Trust*, July 2009

69. Care Quality Commission, *Update on enquiry into Take Care Now and out-of-hours services*, June 2009

70. House of Commons Health Committee, *Patient Safety Sixth Report of Session 2008-09 Volume I, Report together with formal minutes*, Stationery Office, July 2009

71. National Patient Safety Agency, *Being Open. Communicating with patients, their families and carers following a patient safety incident*, November 2009

72. Healthcare Commission, *Safely does it: Implementing safer care for patients*, March 2009

73. HM Government, *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*, Stationery Office, September 2006

74. Department of Health and Home Office, *No secrets: guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse*, March 2000

75. Chief Executive of the NHS in England, *Safeguarding children and the Care Quality Commission Review*, Department of Health, July 2009

76. Ofsted, *Learning lessons from serious case reviews: year 2*, October 2009

77. Commission for Social Care Inspection, *Safeguarding adults: A study of the effectiveness of arrangement to safeguard adults from abuse,* November 2008

78. Mental Health Act Commission, *Coercion and Consent: Monitoring the Mental Health Act 2007-2009*, July 2009

79. Department of Health, *A High Quality Workforce: NHS Next Stage Review*, June 2008

References

Corporate member of
Plain English Campaign
459
Committed to clearer communication.

⊠ TSO
information & publishing solutions

ISBN 978-0-10-296430-1

9 780102 964301