Care Quality Commission

The state of health care and adult social care in England

An overview of key themes in care in 2011/12

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The state of health care and adult social care in England in 2011/12

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About the Care Quality Commission

The Care Quality Commission is the independent regulator of health care and adult social care services in England. We also protect the interests of people whose rights are restricted under the Mental Health Act. Whether services are provided by the NHS, local authorities or by private or voluntary organisations, we focus on:

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


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Introduction

This report to Parliament describes the state of health care and adult social care services in England in 2011/12. The report has two main sections, dealing with the shape of care provision and the quality and safety of services. Each section looks at the different care sectors in turn: NHS healthcare, independent healthcare, dental care and adult social care.

In 2010, a new system for registering and regulating health care and adult social care in England came into effect, as a result of the Health and Social Care Act 2008. For the first time there is one set of national standards of quality and safety that all registered health care and adult social care providers must meet.

The new system has been phased in over several years, and 2011/12 was the first year in which CQC inspected NHS, independent healthcare and adult social care services for a complete year under the new system.

This development of this new system comes at a time of change both in the wider health and social care system and for CQC.

Having set out in 2010 its plans for the NHS, the Government introduced legislation in 2011/12 which was enacted as the Health and Social Care Act 2012 in March 2012. This abolishes strategic health authorities and primary care trusts in 2013 and puts clinicians and GPs in charge of shaping NHS services through the new Clinical Commissioning Groups supported by the new NHS Commissioning Board. New Health and Wellbeing Boards will bring together local commissioners of health and social care, elected representatives and new local Healthwatch representatives to agree an integrated way to improving local health and wellbeing.

At the same time, the draft Care and Support Bill proposes a single set of legislation for adult care and support and sets out a number of changes to make the current system fairer and more equitable.

An ageing population is placing higher demands on our care system and reduced economic growth provides further challenge for care providers. Both have significant implications for the way care services are delivered in future.

There are five influences on the quality of care: commissioners, providers, professionals and care staff, regulators and the voice of people who use services.

This report comments on the quality of care in 2011/12 but CQC has set out its plans for the future in the consultation on its new strategy *The next phase*, published in September 2012. The consultation is ongoing and early indications have been very supportive. CQC proposes six strategic priorities to drive improvement in the quality of care:

1. Making greater use of information and evidence to achieve the greatest impact.
2. Strengthening how it works with strategic partners.
3. Continuing to build better relationships with the public.
4. Building its relationships with organisations providing care.
5. Strengthening the delivery of its unique responsibilities on mental health and mental capacity.
6. Continuing its drive to become a high-performing organisation.

One of CQC's key proposals is to improve the way it uses evidence and intelligence, working with partners to ensure our combined resources have the greatest impact. It provides CQC with the opportunity to think differently about its relationship with partners and to build a better understanding of changes to the quality of services that its inspectors see. In this way, CQC can build a better picture of what underpins good care and what all parts of the health and social care system must do to drive improvement.

CQC's State of Care and Market Reports will be an important part of this picture in the future. It intends to develop the content of these reports to reflect the developing nature of CQC's activity.

In particular CQC will work with others to improve understanding in two areas.

- The shape of the market, including:
  - Trends in who is delivering care.
  - Where organisations provide services to the private and public sectors.
  - How demand varies with supply by sector.
  - The consolidation and fragmentation occurring in sectors.
- The quality of provision, including:
  - The quality of care for private buyers and the public.
  - The link between commissioning of services and quality.
  - Trends in quality in each sector over time.

These developments will support CQC in its purpose of driving improvement in the quality of services.

Summary

This report to Parliament describes the state of health care and adult social care services in England in 2011/12. CQC has drawn on evidence from its register of care providers, its inspections, the experiences of people who use services, and national statistics. It also includes findings from CQC's themed inspection programmes, which examine concerns that CQC has about the way certain sectors or types of service operate. In 2011/12, CQC looked at dignity and nutrition for older people in NHS acute hospitals, and services for people with learning disabilities.

The report has two main sections dealing with the shape of care provision and the quality and safety of services. Each section looks at the different care sectors in turn: NHS healthcare, independent healthcare, dental care and adult social care.

Overall CQC is finding that the increasing complexity of conditions and greater co-morbidities experienced by people are impacting on the ability of care providers to deliver person-centred care that meets individuals' needs. It is also seeing increasing pressures on staff, both in terms of the skills required to care for people with more complex conditions and in terms of staff numbers.

> The increasing complexity of conditions and greater co-morbidities experienced by people are affecting the ability of providers to deliver person-centred care.

These are challenging times for providers. CQC continues to see many examples of organisations that meet these challenges and deliver an excellent quality of care. But it also sees others, across both health and social care, that are failing to manage the impact of these pressures effectively.

Shape of the health and social care sector

England's population is both growing and ageing, as people live longer. Latest figures show that by mid-2011 England's population was at its highest ever level, at an estimated 53.1 million. Within this, 8.7 million people were aged 65 or over, and 1.2 million were 85 or over.

As the population ages, we are seeing a rise in health conditions for which age is a major risk factor, such as dementia. There are now 800,000 people living with dementia across the UK. It is forecast that one in three people over 65 will develop dementia, which means providers will have to develop increasingly specialised skills to care for people.

More and more people are living with long-term conditions such as diabetes, coronary heart disease and respiratory diseases. The success story that is cancer treatment means that more people are living with cancer for longer. And older people are increasingly living with co-morbidities such as heart disease, hypertension, arthritis and diabetes.

In addition, one in four people will experience mental health problems at some point in their lifetime.

All of these factors are increasing the pressures on both healthcare and social care services, and require increasingly specialised care and treatment.

Changes in health care

Within the healthcare landscape, there have been a number of changes in recent years.

There has been a progressive increase in NHS day treatment and a corresponding decrease in the total number of overnight beds in the NHS, with people spending less time in hospital for their treatment and being able to recuperate in their own homes or community services. However, as people live longer they have greater co-morbidity and more complex care conditions and CQC's inspectors are seeing a growing number of people with complex needs being cared for in social care environments.

NHS services are increasingly being delivered by independent sector providers, with 4.3% of elective procedures being carried out by private providers in 2011/12, up from 4.0% in 2010/11.

Furthermore, under the policy of Any Qualified Provider (AQP), all healthcare providers (including NHS, independent providers, charities and social enterprises) that meet qualifying requirements will be allowed to bid to deliver some NHS services. This is being phased in over time and it is probable that more non-NHS organisations will enter or expand in the market to deliver health care services to NHS-funded patients.

Also, the consolidation in recent years among NHS trusts has continued. There were 291 NHS provider trusts registered with CQC on 31 March 2012, compared with 378 NHS trusts at the start of 2010/11.

As with other public services, the NHS is facing a significant financial challenge with efficiency savings of £20 billion to be found between 2010 and 2015.

Finally, older people are accounting for a bigger proportion of NHS hospital activity every year. This is particularly the case with inpatient care, with the number treated growing at a much faster rate compared to any other age group. Older people also tend to stay in hospital much longer. And any problems with discharge arrangements, such as poor communication with social care services, can increase the risk of emergency readmission back to hospital.

Changes in adult social care

In recent years the adult social care sector has been changing, with a decline in residential care services, and new types of support and provision being developed that enable more people to live at home for longer. There has been an increase in models of care such as Extra Care housing, and short-term nursing care in homes replacing extended stays in hospital. Reablement services have been extended, and are now a mainstream part of the support offered by many local authorities.

The provision of home care rose significantly in the year: there were 6,830 domiciliary care agencies

registered with CQC, an increase of 16% on 2010/11. At the same time, the number of residential care homes registered with CQC decreased by 2.5%.

However, with the increase in the number of people with complex co-morbidities and the rising numbers of people with dementia, there is a need for more nursing care within social care settings. This demand is reflected in an increase in the number of nursing homes registered with CQC in 2011/12 – the total rose by 1.4% and accounted for a 3.3% increase in the number of registered nursing home beds.

These demographic pressures are increasing at a time when local authorities are tightening their criteria for paying for people's care needs. In 2012, 83% of councils set their threshold for eligibility for state-funded care at 'substantial', compared with 78% in 2011.

A significant number of people now fund their own care. Forty-five per cent of care home places in England are occupied by people who fund their own care, and a fifth of people who receive care in their own homes are self-funding. Some people also pay top-up fees to bridge the gap between what their council will pay and what care providers charge.

In addition, the number of people exercising more choice over their social care through direct payments and personal budgets has risen sharply. In 2011/12 the number of people receiving self directed support was 527,000, a rise of 40% on the previous year, leading to a growth in more personalised care services.

Impact on the quality of care

There are therefore significant challenges throughout the healthcare and adult social care systems in maintaining and improving quality in the face of growing demand and complexity.

As CQC builds towards a comprehensive picture of each sector through its unannounced inspections, it can start to answer two questions: What changes is it seeing in the overall quality of care? And what are its biggest concerns for people who may be less able to speak up for themselves – people with dementia, people with a learning disability and people with mental health problems?

CQC's inspectors have seen and continue to see many examples of organisations that are able to balance resources against need and deliver an excellent quality of care, and we feature examples of good practice in this report. But CQC's inspectors also see examples of providers who struggle to cope and fail to deliver the quality of care that people have a right to expect.

We will not leave this poor care unchallenged. We will follow it through with further inspection and enforcement activity and we call on others in each sector to play their part in helping to drive this improvement.

Health care

In the NHS, CQC carried out a themed inspection programme looking at dignity and nutrition for older people in hospitals. Some hospitals struggled to make the respect and dignity of their patients their number one priority. Overall in 2011/12, nine out of 10 NHS hospitals that CQC inspected (350 inspections) met the standard on treating people with respect and dignity, and involving them in their care. Many of these showed a genuine commitment to delivering person-centred care, with registered nurses, doctors, other care professionals and healthcare staff pulling together to treat the people they cared for with compassion and respect.

But for the other 10%, (which equates to 35 hospitals) there were common themes in the experiences of patients and a lack of dignity and respect – including an obvious lack of privacy, call bells being out of reach, and staff speaking to patients in a condescending way. And only 85% of NHS hospitals (258 inspections) met the standard on making sure patients had the right food and drink and the help they needed.

Three things in particular underpinned this poor care:

- Cultures in which unacceptable care becomes the norm.
- An attitude to care that is 'task-based', not person-centred.
- Managing with high vacancy rates or poorly deployed staff.

Following the themed inspection programme, three-quarters of all the trusts inspected told CQC they had taken action to improve the way they approach dignity and nutrition as a result of the programme, and we continue to take action for this poor care when we find it.

In terms of staffing, CQC found that NHS staff were recruited effectively and checks were carried out to make sure they had the right skills and experience to do their jobs. But NHS services have to cope with fluctuating demand for treatment (compared with the independent sector where demand is more predictable and supply more controlled) and some have clearly struggled to make sure they had enough qualified and experienced staff on duty at all times, and then to make sure staff were properly trained and supervised – making it more difficult for staff to understand and focus on the needs of each and every patient. CQC's inspectors found wards running with high vacancy rates. They also found staff being asked to do too many different roles at once.

In contrast, independent sector hospitals performed well in treating people with dignity and respect: 98% met the standard in 2011/12 (365 inspections). Independent hospitals and community services had good staffing levels and support and training for staff in these settings was also good, with 91% meeting the standard (340 and 334 inspections respectively).

However, independent services play a particularly prominent role in providing longer-term care for people with mental health problems and people with a learning disability, and here CQC found significant problems.

For example, in CQC's themed inspection review of services for people with a learning disability, independent services were much poorer than those in the NHS: 49% of the 45 independent services inspected were meeting the general standard on ensuring people's care and welfare, compared with 71% of NHS providers. Many people had been in assessment and treatment services for disproportionate periods of time, with no clear plans for discharge arrangements in place and too many people had been in services away from their families and homes. In too many cases care was not person-centred.

Independent mental health, learning disability and substance misuse services were also poorer in relation to safeguarding people from abuse: 73% met the standard in 2011/12 (193 inspections), compared with 86% of NHS services (224 inspections).

And it was a similar picture in relation to the staffing standards: independent mental health, learning disability and substance misuse services performed less well than the NHS on all three standards in 2011/12.

However, treating patients with dignity and respect was challenging for NHS and independent mental health, learning disability and substance misuse services alike: 86% and 85% respectively met the standard (160 and 148 inspections).

This is a serious concern. A recurring issue was a lack of patients' involvement in their care plans, and not always having the opportunity to express their views about how they would like their care delivered.

With the increase in NHS on-day treatment, discharge arrangements for patients need to be robust and well-supported. CQC took a particular look at this issue and found that patients discharged over the weekend are at significantly higher risk of being readmitted as an emergency. This illustrates the different levels of service provision over the weekend, either in the hospital setting or the available social care services. Where these are poor, it has a knock-on effect on the ability of social care services to provide a good all-round quality of care.

Adult social care

The increased complexity of people's social care needs seems to be having a direct impact on the quality of care CQC is finding through its social care inspections. The poor performance in respect of medicines management continued across all types of social care setting, but was most evident in nursing homes, which proportionately have to deal with the more complex health needs.

Worryingly, the same picture emerges when looking at the respect and dignity of people in social care settings – while residential care homes and domiciliary care agencies performed relatively well on providing respectful and dignified care, with 93% and 95% of services meeting the standard in 2011/12 (5,984 and 1,680 inspections respectively), the performance of nursing homes was less positive at 85% (2,502 inspections). We will continue to take action against such poor care.

Information from CQC's inspections shows that those services that maintain people's dignity and treat them with respect all have a number of things in common: they recognise the individuality of each person in their care, and help them to retain their sense of identity and self-worth; take time to listen to what people say; are alert to people's emotional needs as much as their physical needs; and give them more control over their care and the environment around them.

However, across all social care settings, CQC still sees care that doesn't live up to this. This is often characterised by things such as: care staff talking over the person, as if they were not there; having things 'done' to them, rather than 'with' them; and getting people ready for bed at a time that suits the staff rather than the individual people being cared for.

This is of most serious concern when people may be less able to speak up for themselves. In CQC's themed review of learning disability services, only 63% of the 32 care homes inspected as part of the review met the general standard on care and welfare and only 59% met the standard on safeguarding.

In the review, CQC saw some very positive examples of people being involved in their care and being given control over their care plans. Where inspectors found problems, the most common issue was a lack of person-centred planning – with little information about people's individual preferences and likes and dislikes about how care is delivered.

In its report on the review, CQC stressed that further work is required by commissioners and providers to make sure that person-centred planning is embedded into all care for people using services. It will continue to assess this as part of the inspections it routinely carries out.

Ensuring that the people in their care are helped with the food and drink they need is central to respectful and dignified care. There were some concerns in

nursing homes and residential care homes. Our inspections found that 80% of nursing homes (1,362 inspections) and 89% of residential care homes (2,114 inspections) met this standard in 2011/12.

Given that this is so vital to good care – particularly for older people – this is a real concern. This issue is a focus of CQC's targeted inspection programme of 500 care homes in 2012/13, and it will report its findings in early 2013.

The increased co-morbidity and complex care needs of people requiring social care – for example managing people with dementia and cancer in the same setting – also has a direct impact on staffing levels and in particular the increasingly specialist skills, training and support that care staff need. A number of services across the social care sector were not able to support staff with proper training, supervision, appraisals and development opportunities in line with the national standards. Of those CQC inspected in 2011/12, 76% of nursing homes, 84% of residential care homes and 85% of domiciliary care agencies did not meet the relevant standard (2,283, 4,944 and 1,721 inspections respectively).

Leadership also becomes even more important. In a number of social care settings, CQC's inspectors have found poor managers in place, or even the absence of a manager altogether. Very often, a change of registered manager following action by CQC was the impetus for dramatic changes in the quality of care provided.

Given the increasing integration of health and social care services, CQC is pleased to see that cooperation with other providers was good across all types of adult social care: 96% of nursing homes, 95% of residential care homes and 96% of domiciliary care agencies met the relevant standard in 2011/12 (640, 1,299 and 376 inspections respectively).

Next steps

In line with its proposed strategic direction over the next three years, set out in its consultation document *The next phase* published in September 2012, CQC's intention is to make more use of its unique sources of information, and the information held by others, to drive improvement in how services are provided and promote best practice. Its discussions with the public and stakeholders have strongly indicated that they would welcome CQC using its voice in this way.

CQC will do this by:

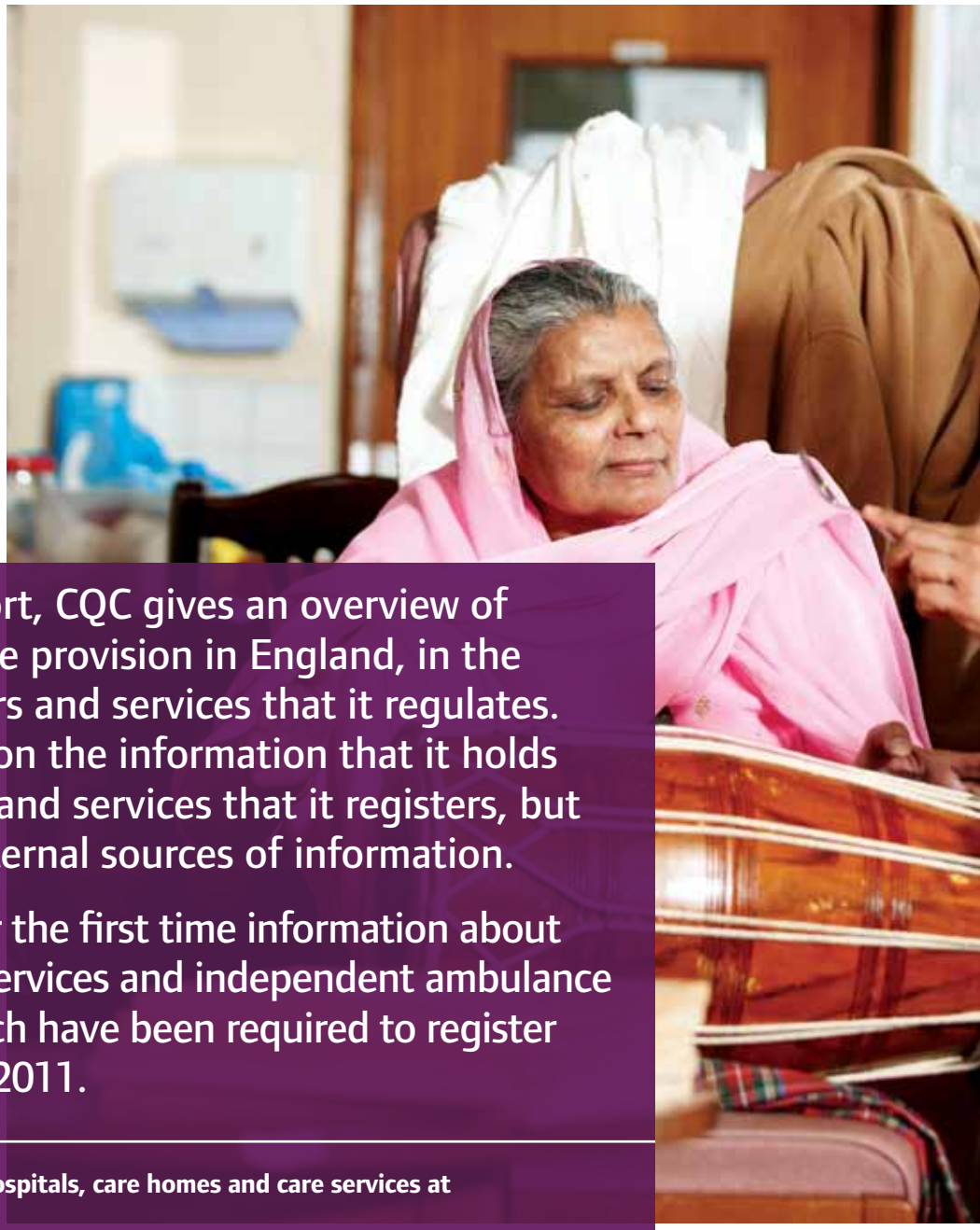
- Being clear about good care (what works well) and poor care.
- Reporting on the state of the different sectors, identifying problems and challenges in how services are provided and commissioned and recommending action.

The State of Care report for 2012/13 and future Market Reports will incorporate and synthesise CQC's findings from the following pieces of work that it will be publishing in the coming months:

- The themed inspection programme examining the care given to people in their own homes by 250 domiciliary care providers.
- The themed inspections of dignity and nutrition in 500 care homes and nursing homes.
- The follow-up inspection programme looking at issues of dignity and nutrition in 50 NHS hospitals.
- Reviews of information and data on three topic areas:
  - Dementia care during admissions to hospital
  - The experiences of people waiting for NHS treatment
  - The physical health needs of people with a learning disability.

In addition, CQC will be able to include the findings of some of the first inspections it carries out in GP surgeries and practices.

01 Shape of the health and social care sector in England



In part 1 of this report, CQC gives an overview of health and social care provision in England, in the context of the sectors and services that it regulates. It has mainly drawn on the information that it holds about the providers and services that it registers, but also includes key external sources of information.

CQC also presents for the first time information about primary dental care services and independent ambulance services, both of which have been required to register with CQC since April 2011.

Search for registered hospitals, care homes and care services at www.cqc.org.uk

Health care provision

NHS health care

The NHS is broadly divided into primary care and secondary care. Primary care is the first point of contact with the health service for most people, and is delivered by GPs, dentists, community pharmacists, opticians and district nurses. Some primary care providers are independent contractors, working to agreed contracts with the NHS.

Secondary care is provided by specialists who are not generally the first point of contact with patients. People are usually referred to secondary care by their GPs. Secondary care can be provided in hospitals and clinics, and can be either elective (planned), or urgent and emergency (unplanned) care. Secondary care services are provided by NHS trusts, which between them cover the whole of England. There are various kinds of NHS trust. Acute trusts run general and specialist hospitals and specialist care centres. Foundation trusts also run hospitals, but have more financial and operational freedoms than other NHS trusts. Secondary mental health services are provided by NHS mental health trusts, and emergency ambulance vehicles are provided by ambulance trusts.

In addition, a small number of care trusts have been created by the NHS and local authorities working together, mainly with the aim of better integrating health and social services. Often these bring together various primary care, mental health and social care services.

The NHS is by far the most sizeable and significant employer within the overall health sector. In September 2011, there were more than 1.35 million people in the NHS workforce in England.[1] Many staff work part-time. The number of full-time equivalent staff was 1.15 million.

Since 2010, there has been a decrease of more than 28,000 (headcount) in the total NHS workforce, and just over 20,000 in full-time equivalent posts (July 2012 figures). These decreases are 2.3% and less than 2%. The greatest percentage decrease has been in managers and senior managers, and there have been increases in some areas; one of the largest percentage increase was in consultants, including directors of public health.

The 2010 White Paper *Liberating the NHS* and subsequently the Health and Social Care Act 2012 set out a profoundly new vision for the way the NHS will work in the future. Following the passage of the Health and Social Care Act, strategic health authorities and PCTs will cease to exist in April 2013. Responsibility for commissioning approximately £65 billion of health care services across England will transfer to new Clinical Commissioning Groups (CCGs).

CCGs will be responsible for commissioning:

- Hospital services (planned, routine care, and urgent and emergency care)
- Community and primary care services (e.g. community matrons, district nurses)
- Continuing health care
- Mental health services
- Learning disability services
- Rehabilitation services
- Prescribing
- Management support for GPs.

33.9%

Day cases as a proportion of all NHS hospital activity in 2011/12, compared with 33.0% in 2010/11

Another key initiative that will impact on the way services are delivered is the Government policy of Any Qualified Provider (AQP). All healthcare providers (including NHS, independent providers, charities and social enterprises) that meet qualifying requirements will be allowed to bid to deliver some NHS services. Providers will have to deliver treatment and care in line with agreed clinical pathways and quality standards, and will be paid NHS prices. Individual patients will be able to choose any provider that is qualified to provide the treatment and care they need. This policy is being introduced in a phased way, starting with some community and mental health services in 2012. Choice of provider has already been available to patients needing routine elective (planned) hospital care for some years.

Although it is too early to know the effects of these changes in both health care commissioning and provision, it is likely that over time we will see greater diversity within the provider market for health care in England. It is probable that more non-NHS organisations will enter or expand in the market to deliver health care services to NHS-funded patients. Providers will need to be registered with CQC to meet the AQP qualifying requirements. CQC will monitor changes in registered providers, and report on any trends it identifies.

CQC registered services

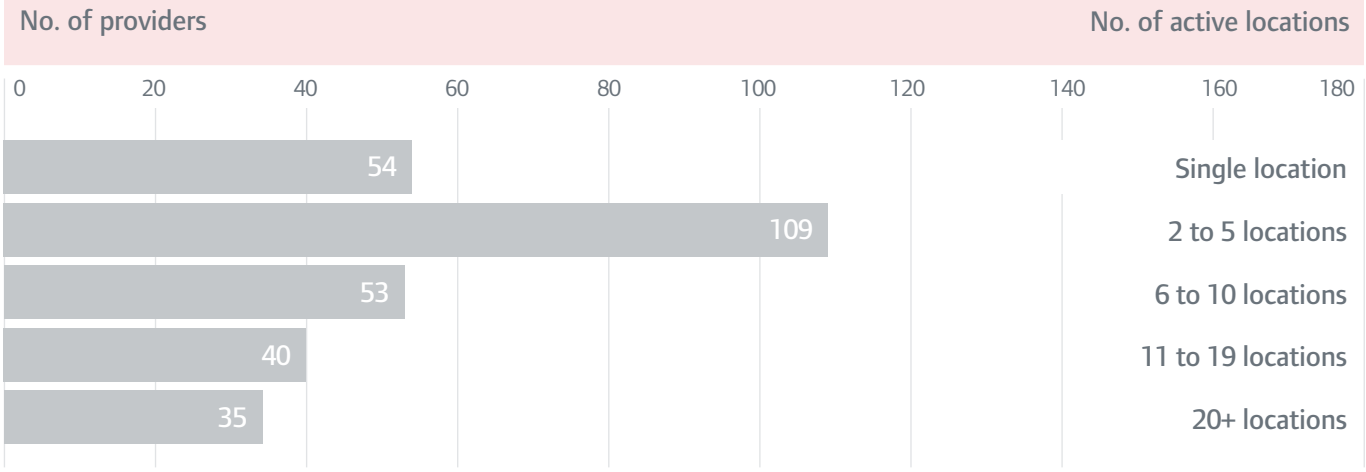
All NHS trusts have been required to be registered with CQC since April 2010.

Registration data shows that there were 291 NHS provider trusts registered with CQC on 31 March 2012. This compares with 378 NHS trusts at the start of 2010/11, and reflects the continuing consolidation among NHS trusts through mergers and the Transforming Community Services programme in 2010 and 2011, in which primary care trusts had to separate out their provider and commissioning activities.

Between them, the trusts delivered health care in 2,396 service locations across England, as at 31 March 2012. Each location represents a hospital, clinic or other healthcare service that is registered with CQC by the provider trust.

The size of NHS trusts varies, not only in terms of income, staffing and numbers of patients they care for, but also in the number of locations from which they operate. Figure 1 gives an overview of the number of active locations from which current NHS provider trusts are operating.

Figure 1: Overview of the number of active locations from which different NHS provider trusts were operating, 31 March 2012



Source: CQC

NHS hospital activity

The total number of available beds in the NHS has continued to reduce in recent years.[2] However, a progressive increase in day cases has meant more people needing to spend less time in hospital for their treatment, and has increased overall treatment capacity. There were 17.5 million hospital episodes in 2011/12 in total, an increase of 1.1% on 2010/11.[3] Of these, 33.9% (5.9 million) were day cases, compared with 33.0% in the previous year.

In some cases, NHS functions have been transferred to other services, and this may be a factor in explaining the reduced number of beds.

NHS bed capacity for people with learning disabilities has been largely replaced over several decades by alternatives in private or voluntary sector care homes, in group homes or in individual accommodation supported by social carers.

Table 1 shows the number of available beds open overnight and under the care of consultants, and the number of day-only available beds under the care of consultants, for each quarter from April 2010 through to March 2012, in NHS hospitals in England. The figures are sub-divided into different sectors. The figures do not include beds closed temporarily for refurbishment or cleaning, or cots on maternity wards for babies that are well.

Table 1: NHS bed numbers in England by quarter, 2010/11-2011/12

Period	Total (Overnight)	General & acute (overnight)	Learning disabilities (overnight)	Maternity (overnight)	Mental Illness (overnight)	Day only
Apr – Jun 10	144,455	110,568	2,465	7,906	23,515	11,783
Jul – Sept 10	141,477	108,349	2,237	7,962	22,929	10,990
Oct – Dec 10	141,630	108,023	2,088	7,778	23,740	10,916
Jan – Mar 11	142,319	108,890	1,974	7,848	23,607	11,328
Apr – Jun 11	137,347	104,550	1,721	7,823	23,253	10,703
Jul – Sept 11	138,646	105,623	1,784	8,031	23,208	11,468
Oct – Dec 11	138,080	105, 318	1,756	7,990	23,016	11,324
Jan – Mar 12	140,449	107,444	1,937	7,948	23,121	11,715

Source: Department of Health, *Average daily Available Beds Time Series, England 2010 - 2012,* May 2012

A small increase in bed numbers can be seen from July 2011 onwards. However, this can be explained by the fact that from this quarter (Q2, 2011/12) onwards the figures include bed numbers from six NHS foundation trusts that had not been previously included.

NHS hospital-based services

CQC's registration figures show that there were 1,003 NHS locations in England registered with CQC to provide 'hospital-based services' on 31 March 2012. Providers register for specific 'service types', and they can register for more than one service type. For the purposes of this report, 'hospital-based services' cover a number of different service types: acute services with overnight beds; acute services without overnight beds; long-term conditions services; and diagnostic and/or screening services. Therefore this category is larger than just 'acute' hospitals.

Providers are registered with CQC to carry on 'regulated activities', which they must specify on registration. The most commonly registered activities among NHS hospital-based services were:

- Treatment of disease, disorder, or injury (for which 932 NHS locations are registered, or 93% of the total),
- Diagnostic and screening procedures (848 NHS locations, or 85%)
- Surgical procedures (473, 47%)
- Assess or treat people detained under the Mental Health Act 1983 (300, 30%)
- Maternity and midwifery services (265, 26%)
- Family planning (237, 24 %)
- Termination of pregnancies (212, 21%)
- Manage the supply of blood and blood-derived products (84, 8%).

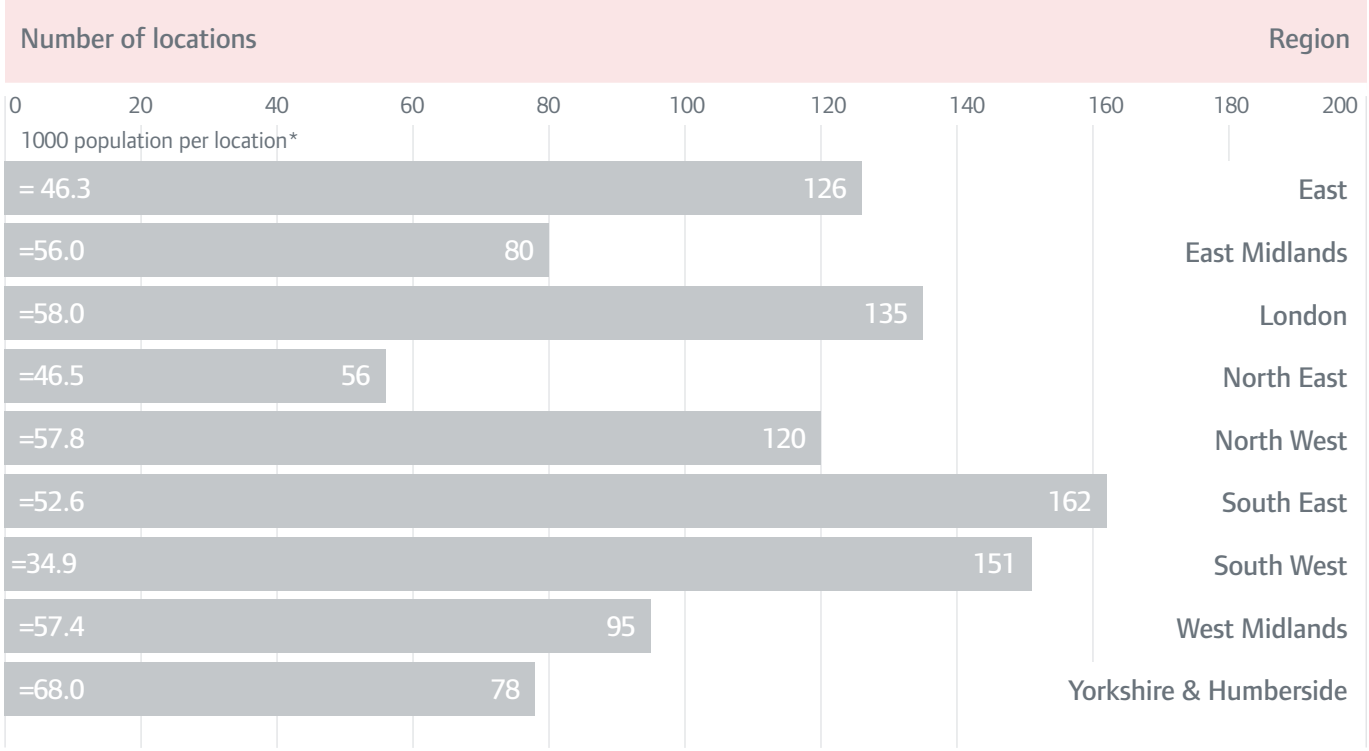
Figure 2 provides a breakdown of the distribution of NHS hospital-based locations by region.

NHS community health care

There were 1,079 NHS locations registered to provide 'community health care' services across England on 31 March 2012.

For the purposes of this report, community health care services cover the following service types: community nursing agencies; community midwifery and nursing teams such as district nurses, health visitors, and children's community nursing; school nursing; family planning and sexual health clinics; community physiotherapy teams; and hospice services. They also include doctors' consultation and treatment services, for example NHS GP practices provided directly by a primary care trust and polyclinics.

Figure 2: NHS hospital-based services registered with CQC by region, 31 March 2012



Source: CQC

*Average population per location is calculated by dividing number of locations into mid – 2010 ONS population estimate for each region.

In addition they include mobile doctor services such as community doctors and GP out-of-hours services; rehabilitation services; urgent care services such as walk-in centres and emergency/urgent triage centres; and remote clinical advice services.

Note that there is overlap with the number of 'hospital-based' locations referred to above, as one location can provide more than one type of service and will be registered with CQC on that basis. For example, the Royal Marsden in London is registered both as a hospital and as a rehabilitation service.

Figure 3 provides a breakdown of the distribution of NHS community health care services by region. The highest concentration can be found in the North West (18% of the total, 189 locations) and South East (16%, 169 locations).

NHS mental health, learning disability and substance misuse services

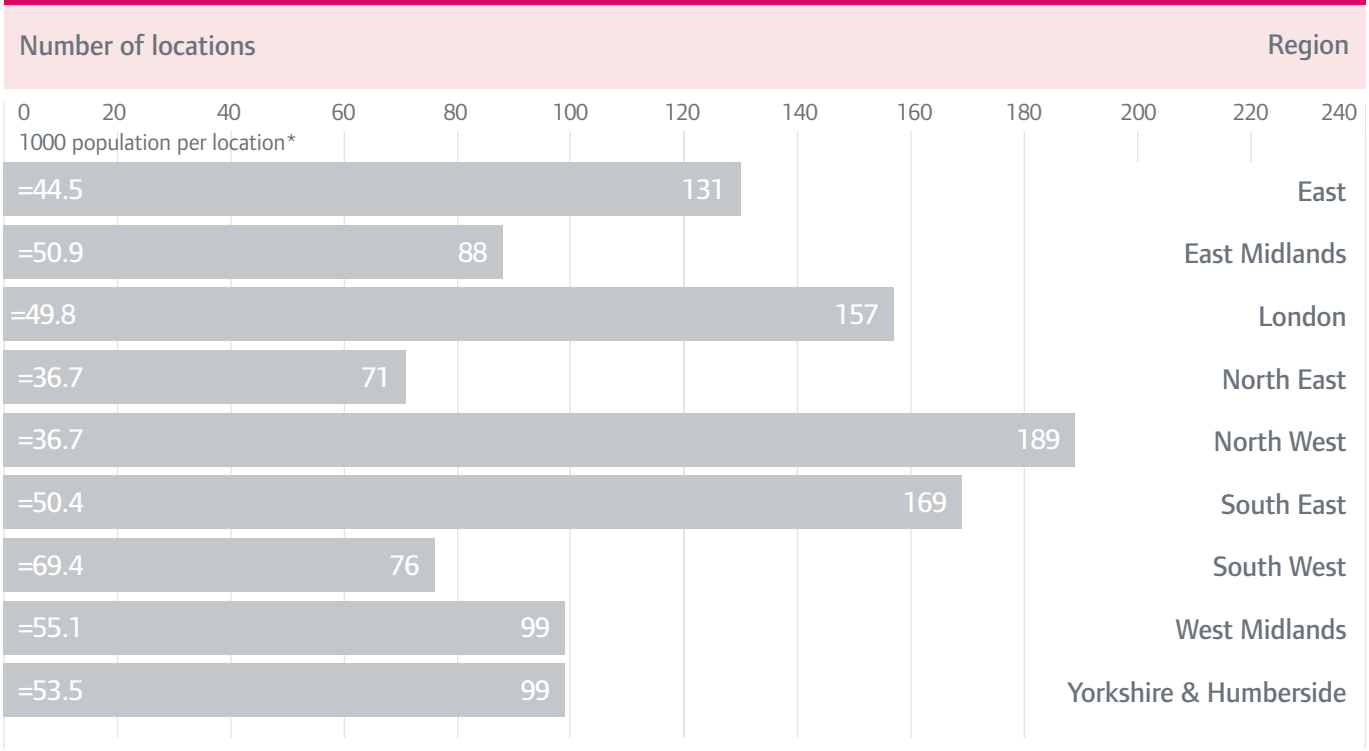
On 31 March 2012, there were 746 NHS locations registered with CQC to provide mental health, learning disability and substance misuse services in England. This includes both hospital-based services and community-based services for people with mental health needs, learning disabilities, and people receiving care and treatment in relation to substance misuse (including residential treatment and/or rehabilitation services). These locations include 602 (81%) that are registered to assess or treat people detained under the Mental Health Act 1983. Again, note that there can be overlap with the 'hospital-based' and 'community health care' locations set out above.

Figure 4 provides a regional breakdown of the distribution of NHS mental health, learning disability and substance misuse services. The South East and the North West have the highest numbers of NHS mental health, learning disability and substance misuse services with the South East having 17% of the total (125 locations) and the North West 14% (103 locations).

746

NHS locations registered to provide mental health, learning disability and substance misuse services

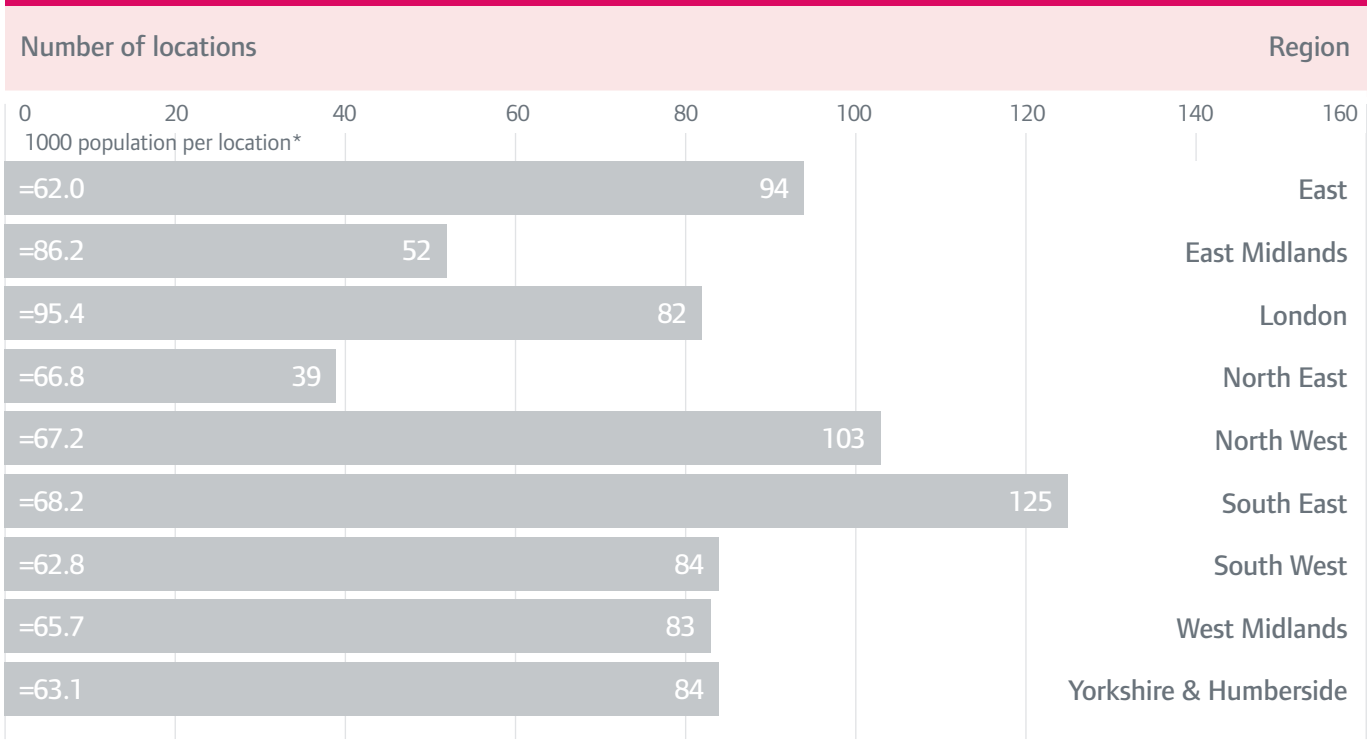
Figure 3: NHS community health care services in England by region, 31 March 2012



Source: CQC

*Average population per location is calculated by dividing number of locations into mid – 2010 ONS population estimate for each region.

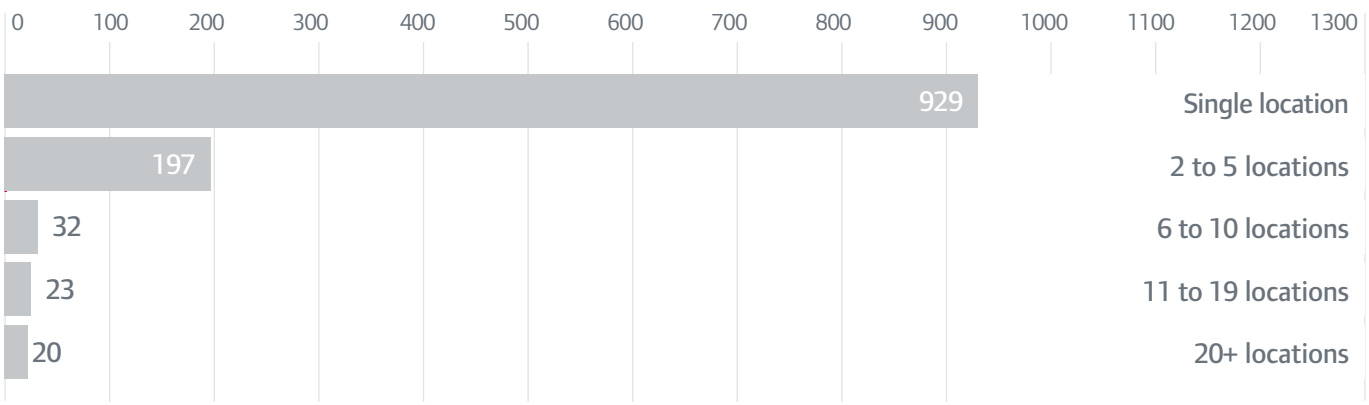
Figure 4: NHS mental health, learning disability and substance misuse services in England by region, 31 March 2012



Source: CQC

*Average population per location is calculated by dividing number of locations into mid – 2010 ONS population estimate for each region.

Figure 5: Overview of the number of active locations from which independent healthcare providers were operating, 31 March 2012



Source: CQC

Note: This chart takes account of corporate 'brands' which own a number of providers but are not themselves registerable entities.

Independent health care

The independent healthcare sector encompasses a wide range of health care services and treatments that are provided by consultants, medical and clinical professionals in private hospitals, clinics and units. These are funded largely by private insurance schemes but are used only by one in 10 of the population.

The sector includes for-profit and not-for-profit (for example, charity) providers – in mid-2011, three-quarters of independent capacity (measured by numbers of beds) was provided by for-profit organisations.[4]

NHS services are increasingly being delivered by independent sector providers, with 4.3% of NHS elective procedures (345,200) being carried out by private providers in 2011/12, up from 4.0% (312,300) in 2010/11.[5]

In March 2012, CQC's registration data shows that there were 1,227 independent healthcare providers, who between them delivered care in 2,764 locations across England. As illustrated in figure 5, the vast majority (76%) of independent healthcare providers operate from a single location – often a single hospital or clinic.

Independent hospital-based services

On 31 March 2012, there were 1,542 locations across England registered with CQC to provide independent 'hospital-based' services. As for NHS services above, for the purpose of this report, 'hospital-based' services cover the following service types: acute services with overnight beds; acute services without overnight beds; long term conditions services; and diagnostic and/or screening services.

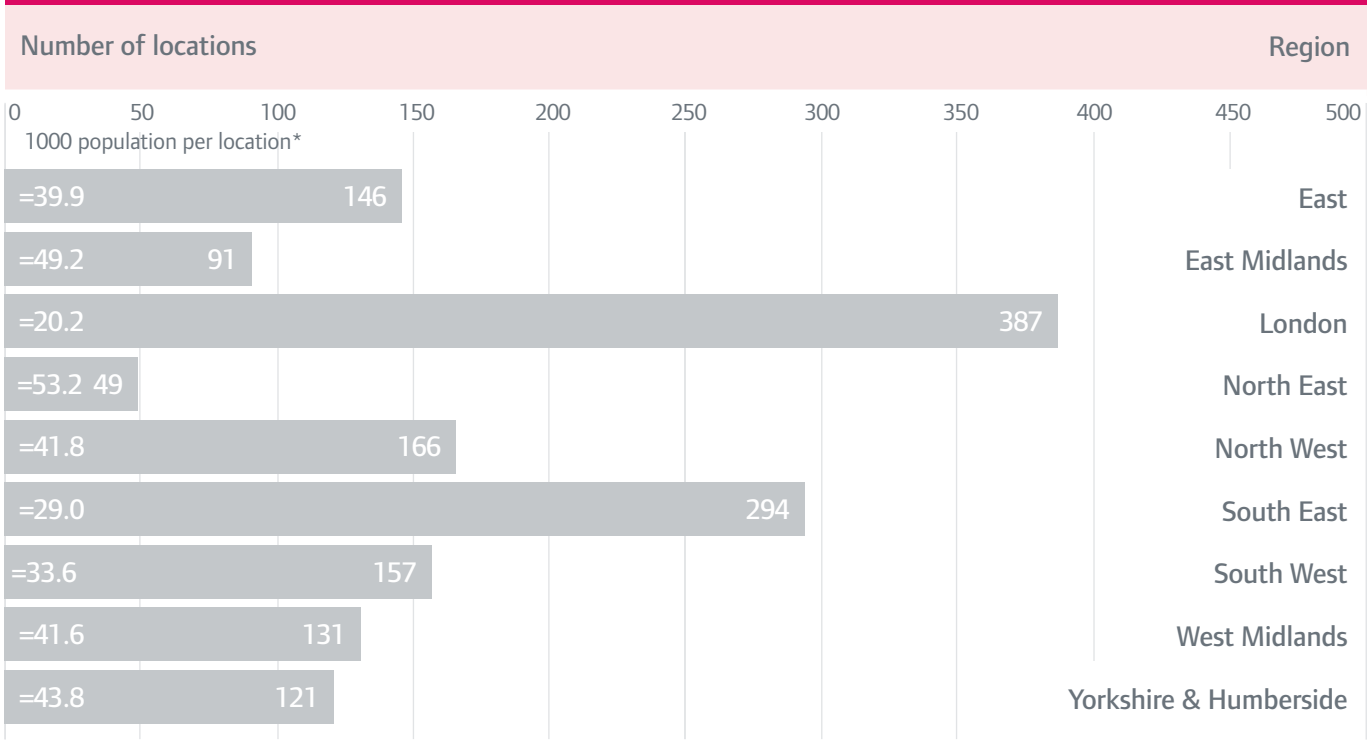
The most common registered activities among independent hospitals were:

- Diagnostic and screening procedures (1,349 registered to provide, or 87% of independent hospital-based services)
- Treatment of disease, disorder or injury (1,220, or 79%)
- Surgical procedures (750, 49%)
- Family planning (186, 12%)
- Termination of pregnancies (100, 6%)

There were 208 locations providing independent hospice services, including adults' and children's hospices, day hospices, end-of-life care teams and those providing hospice-at-home services.

> 4.3% of NHS elective procedures were carried out by private providers in 2011/12, up from 4.0% in 2010/11

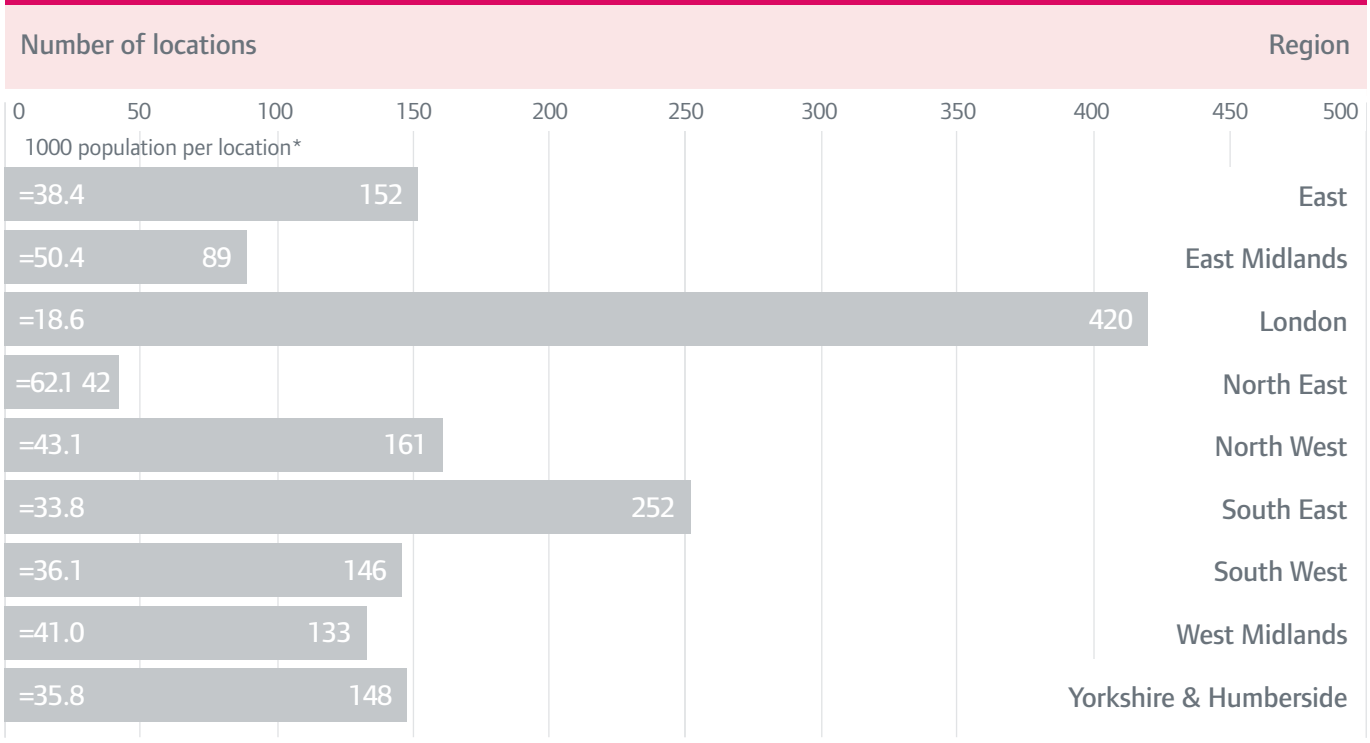
Figure 6: Independent hospital-based services in England by region, 31 March 2012



Source: CQC

*Average population per location is calculated by dividing number of locations into mid – 2010 ONS population estimate for each region.

Figure 7: Independent community healthcare services in England by region, 31 March 2012



Source: CQC

*Average population per location is calculated by dividing number of locations into mid – 2010 ONS population estimate for each region.

Figure 6 provides a breakdown of the distribution of independent hospitals by region. London and the South East have the highest numbers of independent hospitals, with London having 25% of the total (387 locations) and the South East 19% (294 locations).

Independent community health care

There were 1,543 independent locations registered with CQC to provide 'community healthcare' services on 31 March 2012. These include the following service types: nursing agencies; doctors' consultation and treatment services, such as independent doctors' consulting rooms; mobile doctor services; rehabilitation services; hospice services; urgent care services and remote clinical advice services.

Again, note that there is overlap with the number of 'hospital-based' locations referred to above, as one location can provide more than one type of service and will be registered with CQC on that basis.

Some community health care providers are registered as 'independent' with CQC, although most or all of their patients may be funded by the NHS.

The most commonly registered activities among independent community healthcare services were:

- Treatment of disease, disorder or injury (for which 1,387 are registered, 90% of all independent community healthcare services)
- Diagnostic and screening procedures (1,160 or 75%)
- Surgical procedures (517, or 34%)
- Slimming clinics (69, 4%).

Figure 7 provides a regional breakdown of independent community healthcare services. By far the largest number are in London (27%, 420 locations).

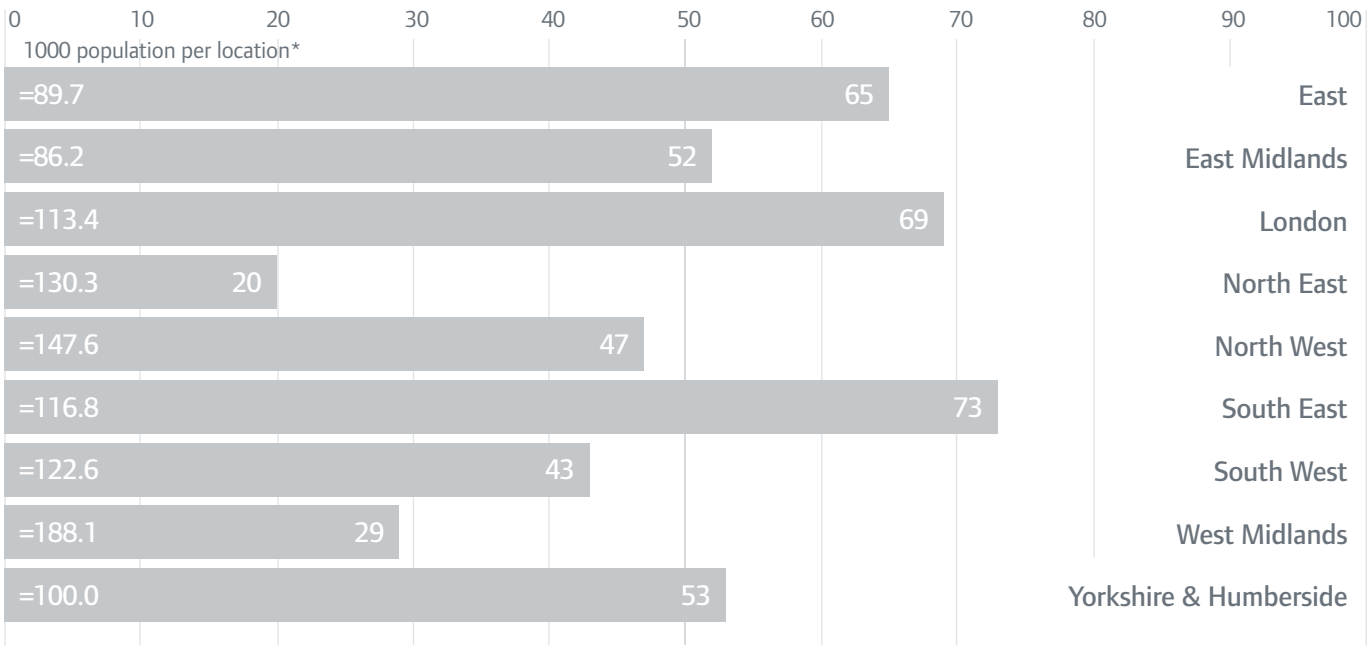
Independent mental health, learning disability and substance misuse services

There were 451 locations registered with CQC to provide independent mental health, learning disability and substance misuse services in England on 31 March 2012. The figure includes both hospital services and community-based services. Two hundred and twenty five (50%) of these were registered to provide services for assessing or treating people detained under the Mental Health Act 1983.

1,543

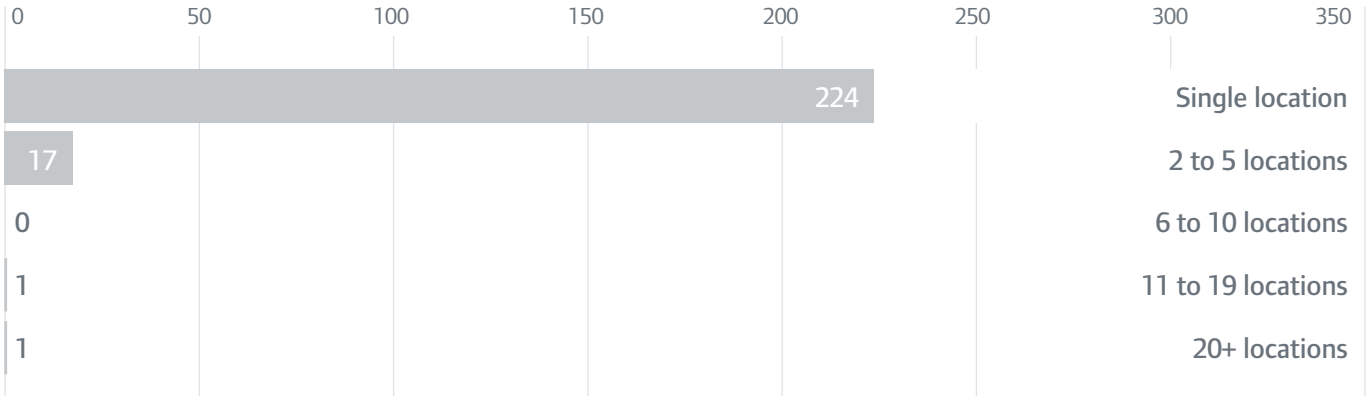
Independent services registered with CQC to provide community healthcare servicess

Figure 8: Independent mental health, learning disability and substance misuse services in England by region, 31 March 2012



Source: CQC
*Average population per location is calculated by dividing number of locations into mid – 2010 ONS population estimate for each region.

Figure 9: Overview of number of active locations from which different independent ambulance service providers were operating, 31 March 2012



Source: CQC

Figure 8 provides a regional breakdown of the distribution of independent mental health, learning disability and substance misuse services. Compared to other kinds of independent healthcare provision, the regional differences in numbers of independent mental health, learning disability and substance misuse services are less pronounced.

Independent ambulance provision

Since April 2011, providers of independent ambulance services have been required to register with CQC. Independent ambulances include those providing patient transport services privately or under contract to NHS trusts; those providing clinically staffed ambulances privately or under contract to the NHS; and the charitable air ambulance services and the British Red Cross and St. John.

At 31 March 2012, there were 243 independent ambulance providers registered with CQC, providing services from 323 registered locations across England. This is the first time anyone has put together a national register of independent ambulance provision.

For ambulances, each registered location represents a management centre from which a service is operated; a large service may be run from only a few management centres. As illustrated in figure 9, the vast majority (92%, 224 locations) of independent ambulance providers operate from a single location.

Figure 10 provides a regional breakdown of independent ambulance services. The highest concentration can be found in South East (23%, 77 locations).

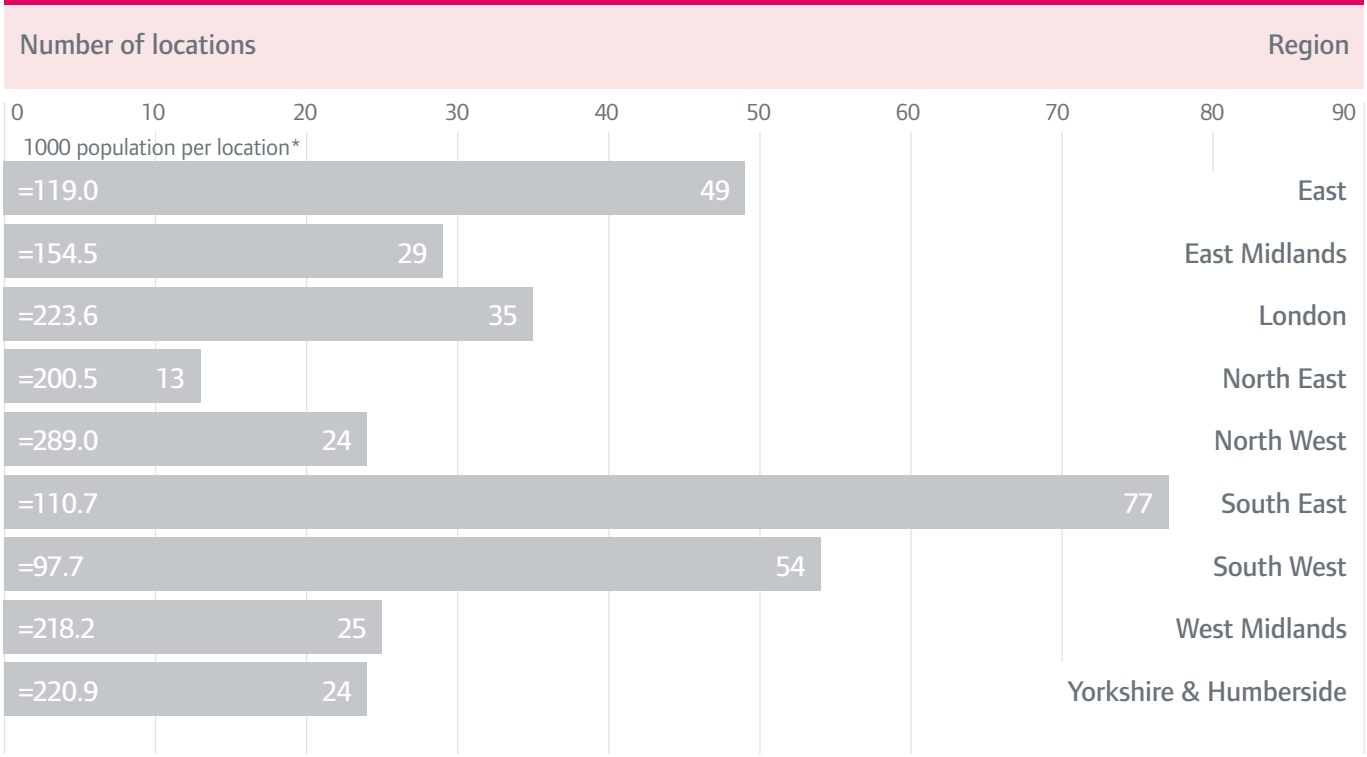
Primary dental care

It became mandatory from April 2011 for all NHS and private dental practices to be registered with CQC. This is the first time a register of dental provision has been held in this way.

On 31 March 2012, there were 8,112 primary dental care providers registered with CQC, providing services in 10,130 locations. As shown in figure 11, the vast majority (90%) of primary dental care providers operate from a single location.

Figure 12 provides a breakdown of primary dental care providers by region. London and the South East have the highest numbers, with each having 19% of the total (1,930 and 1,900 locations respectively).

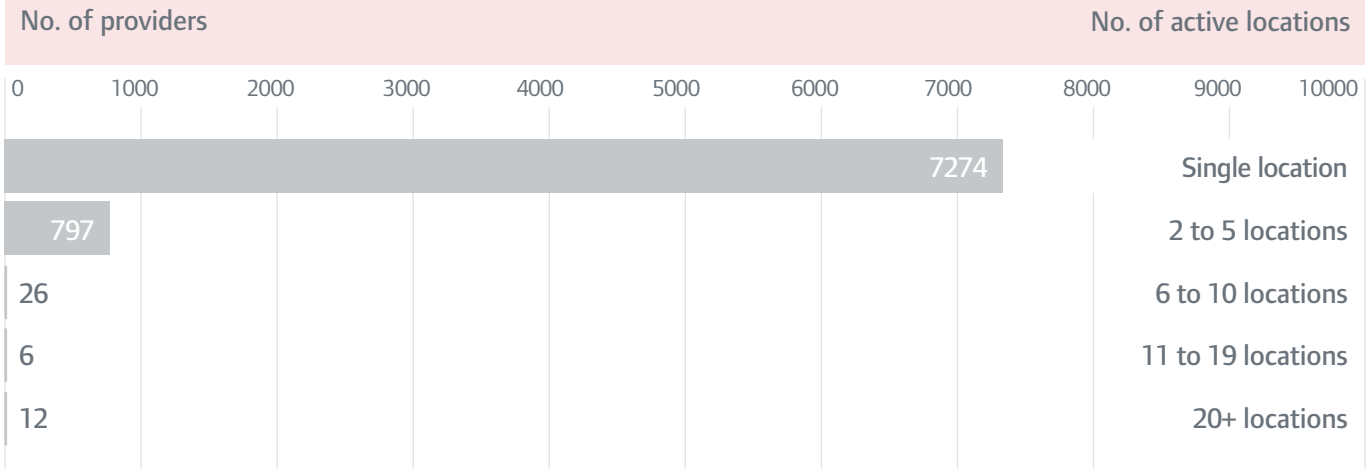
Figure 10: Independent ambulance services in England by region, as at 31 March 2012



Source: CQC

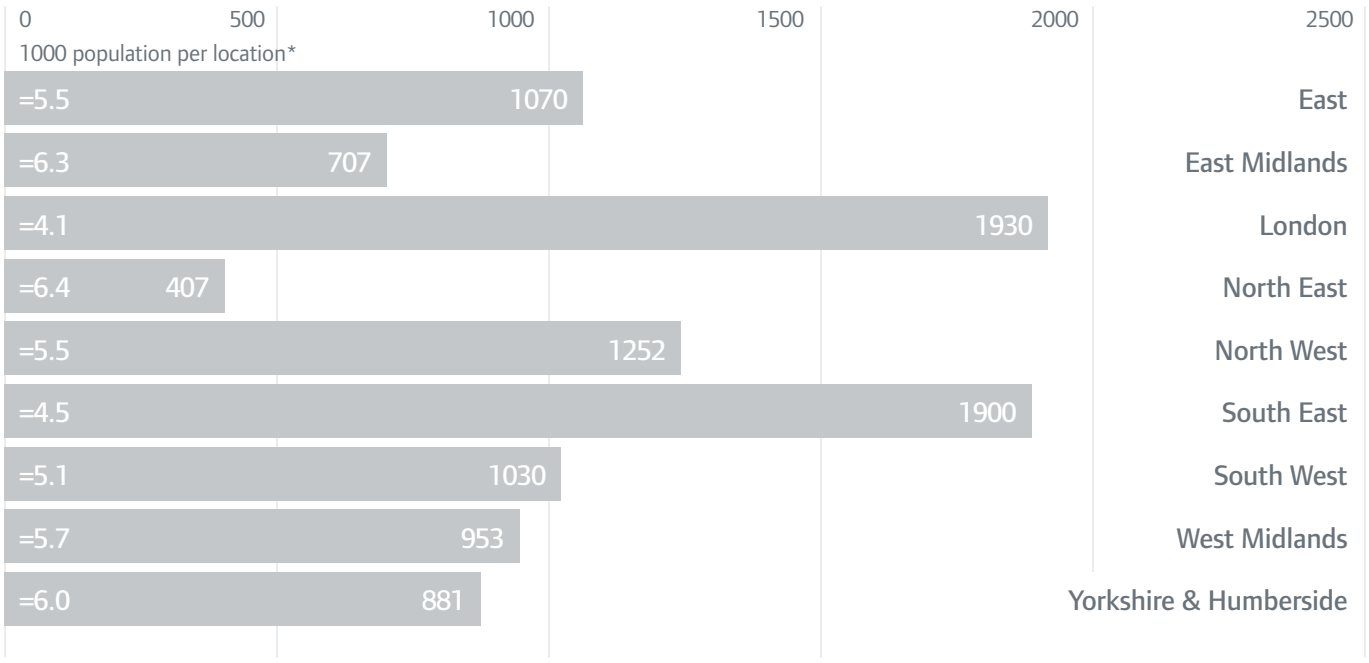
Note: Includes seven locations from the independent health care and adult social care sectors.
*Average population per location is calculated by dividing number of locations into mid – 2010 ONS population estimate for each region.

Figure 11: Overview of the number of active locations from which primary dental care providers were operating, 31 March 2012



Source: CQC
Note: This chart takes account of corporate 'brands' which own a number of providers but are not themselves registerable entities.

Figure 12: Primary dental care services in England by region, 31 March 2012



Source: CQC
*Average population per location is calculated by dividing number of locations into mid – 2010 ONS population estimate for each region.

Primary medical services

Since April 2012, out-of-hours primary care services have been required to register with CQC. This is the first time these services have been regulated as a single entity. At 31 March 2012, there were 49 such providers, operating services from 126 locations.

From April 2013, other primary medical services, including GP practices and NHS walk-in centres, will have to be registered with CQC, and the registration process began in the summer of 2012.

Most people in England are registered with a general practice providing NHS services. Latest figures show that in September 2011 there were 8,316 GP practices in England; these range from single-handed practices run by a sole GP to large, multi-partner and multi-site practices.[6] Many GP practices employ practice nurses, other clinical staff (such as physiotherapists and chiropodists), practice managers, receptionists and administrative staff. In September 2011, there were 35,319 full time equivalent (fte) GPs in England, 13,573 (fte) practice nurses and 63,995 (fte) other practice staff.

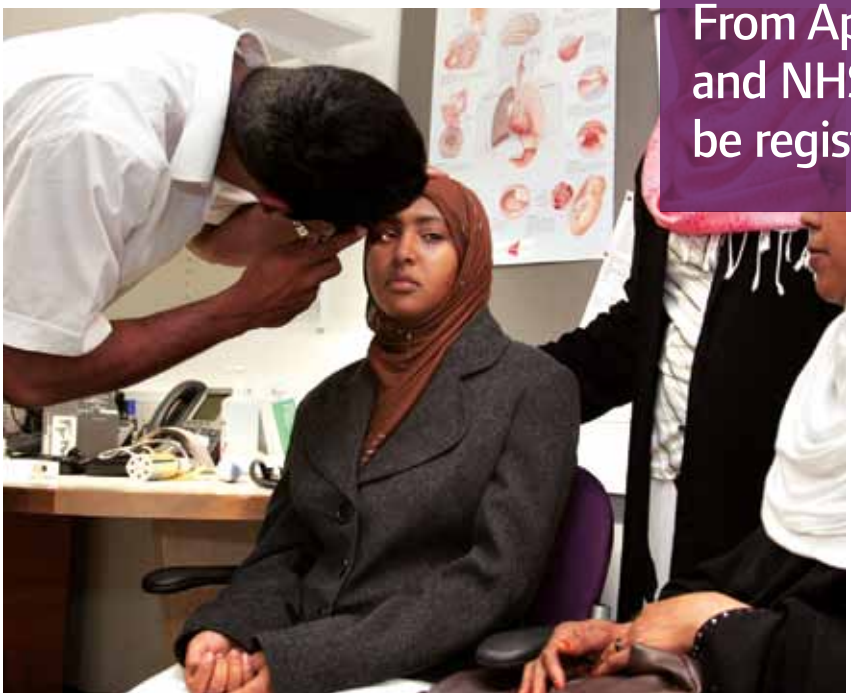
The average number of patients per practice has grown during the past decade, and now stands at 6,651 - reflecting the trend towards larger practices employing more GPs and registering a larger number of patients. There is some regional variation, with average number of patients per practice ranging from 5,754 in the North West to 8,609 in the South Central region. At 5,789, the figure for London is lower than the national average.

There are an average 67.8 GPs per 100,000 population, with regional variation ranging from 62.8 in East of England to 77.2 in the South West.[7]

Adult social care provision

In recent years the adult social care sector has been changing, with a decrease in the number of residential care services, and new types of support and provision being developed that enable more people to live at home for longer. There has been an increase in models of care such as Extra Care housing, and short-term nursing care in homes and reablement services replacing extended stays in hospital.

There has also been an increase in people moving from hospital services into social care more quickly, to help with their recuperation and rehabilitation. These people generally have greater co-morbidity and require more complex care, putting more pressure on social care provision.



> From April 2013, GP practices and NHS walk-in centres will be registered with CQC.

In 2010/11 councils with adult social care responsibilities received 2.2 million new contacts from potential users of services. This represents a 2% increase from 2009/10 and a 6% increase from 2005/06. Of these, 1 million (45%) resulted in a further assessment or commissioning of ongoing service in 2010/11 (down 4% from 2009/10).

A quarter (547,000; 25%) were self-referrals, 477,000 (22%) were referred from secondary health sources, such as hospital wards or hospices, 306,000 (14%) were referred from primary or community health services, and 301,000 (14%) were referred by family, friends or neighbours. First assessments were completed for 661,000 (30%) new people, which is a decrease of 6% from 2009/10 but an increase of 2% from 2005/06.[8]

Changes to the future provision of adult social care have been set out in the Government's response to the Dilnot Commission, outlining its proposal in relation to funding reform of care and support, and subsequently (in 2012/13) in the 2012 Social Care White Paper *Caring for our Future* and the Care and Support Bill.

Caring for our Future sets out a number of changes to the current system intended to make it fairer and more equitable. It includes provisions for national eligibility criteria and portability of care assessments, sets out how the Government will work to establish a new national information website that provides a clear and reliable source of information on care and support, and says the Government will work with a range of organisations to develop websites that make it easy for people to give feedback and compare the quality of care on offer.

The Care and Support Bill seeks to address the fact that systems to improve quality in adult social care are currently less developed than in acute health care, by including an overarching duty of responsibility to promote quality in the provision of social care services.

Eligibility criteria

Local authorities' adult social care support is controlled by the application of eligibility rules that are determined by central government but applied locally. Local authorities must use a national framework to determine whether a person's needs are 'critical', 'substantial', 'moderate' or 'low'. Each authority sets its own eligibility threshold, deciding which categories of need will enable people to receive state-funded community care within their local authority area.

> The number of people able to exercise more choice over their social care has risen sharply over the past year

Over the last couple of years there is evidence that local authorities have been tightening their eligibility criteria, in the face of social care budget reductions and demographic pressures. For 2012/13, 83% of councils have set their threshold for eligibility for state-funded care at 'substantial' (see figure 13). This compares with 78% in 2011/12 and 70% in 2008/09. The proportion of councils setting their threshold at 'critical' reduced from 4% to 2%.

In June 2012 the Association of Directors of Adult Social Services published a survey completed by 145 (95%) local authorities with social service responsibilities in England.[9] However the survey suggested that councils have this year limited the rises in the threshold for eligibility. Only six councils changed their threshold from where it was in 2011/12 (from 'moderate' to 'substantial' needs).

A report published by the Local Government Association, using data from the Information Centre, shows that the number of people receiving council-supported services reduced by 4% since 2010/11: this splits into 4.3% fewer people aged 18 to 64 and 3.9% of those aged 65 and over.[10]

Direct payments and personal budgets

Over the past decade, there has been a policy drive encouraging the take-up of self-directed support by people receiving adult social care – mostly in the form of personal budgets and direct payments.

A personal budget is a sum of council money that people can use to pay for their care and support; it gives people flexibility in how their care needs are met and puts the person more in control of their own care. With direct payments, people eligible for support can receive an agreed amount of money from the council to spend directly on meeting their social care needs, rather than having this arranged and paid for them by the council.

The number of people able to exercise more choice over their social care in this way has risen sharply over the past year. In 2011/12, the number of people receiving self-directed support was 527,000 (a rise of 40% on the 2010/11 figure).[11] Of these 139,000 received a direct payment (up 11% from the previous year). Local authorities' expenditure on direct payments for adults had risen by 15% in real terms to £960 million in 2010/11.[12]

A survey completed by 131 councils for the Association of Directors of Adult Social Services in March 2012 reported that the increase in personal budgets has continued further, with an estimated 432,349 people using personal budgets in 2011/12.[13]

However, this survey found that nearly all of the increase has been in 'managed' personal budgets, with the number of direct payments remaining fairly stable overall since 2011 (with a slight reduction (1%) in those aged 18 to 64 and slight increase (2%) in those aged 65 and over with a direct payment).

Although progress remains variable, this survey suggests that more councils are delivering larger numbers of personal budgets, with 59% of responding councils delivering personal budgets to more than half of all people in receipt of community-based services and nine councils providing to a quarter (25%) or less of people in receipt of community-based services.

Self-funding of adult social care

An estimated 45% of care home places in England are occupied by people who are self-funding, meaning their costs are met privately rather than by the state. In addition, some people funded by local authorities have their care home fees 'topped up' by relatives or other third parties, to bridge the gap between what their council will pay and what the care home charges. Across England, around a quarter of local authority care home placements may be co-funded in this way.[14]

Figure 13: Local authority eligibility thresholds, 2011/12 and 2012/13

	Low	Moderate	Substantial	Critical
2012/13	1%	13%	83%	2%
2011/12	3%	15%	78%	4%

Source: ADASS

Figures in the social care White Paper *Caring for our Future* show that around 220,000 of the 1.1 million people in England who receive care in their own homes are self-funding.[15]

Reablement

Reablement has been defined as "services for people with poor physical or mental health to help them accommodate their illness by learning or relearning the skills necessary for daily living". Reablement focuses on supporting people in developing confidence and relearning self-care skills, and helping people to "do things for themselves" rather than "having things done for them". Reablement support is time-limited (usually for up to six weeks), outcome-focused, and aims to reduce or minimise people's need for ongoing support after reablement.

Reablement services are usually led by local authorities, although they are often developed in partnership with the NHS, and sometimes with other organisations such as charities or independent sector providers. The number of councils offering reablement services has grown and they are now a mainstream part of the social care support offered by many local authorities across England.[16]

Adult social care workforce

The number of jobs in adult social care in England was estimated by Skills for Care at 1.85 million in 2011, an increase of 4.5% on the previous year. The actual number of people doing these jobs was estimated at 1.63 million.[17]

Around two-thirds (65%) of all jobs in adult social care were in the private and voluntary sectors, and around a quarter (23%) where the employers were recipients of direct payments. The public sector (local authorities and NHS) accounted for just 13% of adult social care jobs.

The majority of the increase in the total number of jobs came from jobs for direct payment recipients. Skills for Care noted that the increasing numbers of direct payment recipients and the number of personal assistants they employ reflect the continued shift towards the personalisation of adult social care.

CQC registered services

As mentioned above, the adult social care sector has been changing in recent years, with an overall declining trend in traditional residential care services and new types of support and provision being developed that enable more people to live in their homes and communities for longer.

Data at 31 March 2012 shows that there were nearly 12,500 social care providers registered with CQC to provide regulated services, operating services in just over 25,000 locations in England. Just over half of these locations were residential care homes (with a CQC service type of 'care home without nursing') and around a fifth were nursing homes ('care home with nursing'). More than a quarter were domiciliary care agencies. A small number provided other community-based social care, including supported living services (1,555 locations), extra care housing (569 locations) and Shared Lives schemes (160 locations).†

Figure 14 provides an overview of the number of active locations from which current providers of adult social care services are operating. The vast majority of providers in this sector are operating from a single location. Larger providers are more likely to be providing 'mixed provision' – a combination of residential and nursing homes and/or domiciliary care.

Residential and nursing homes

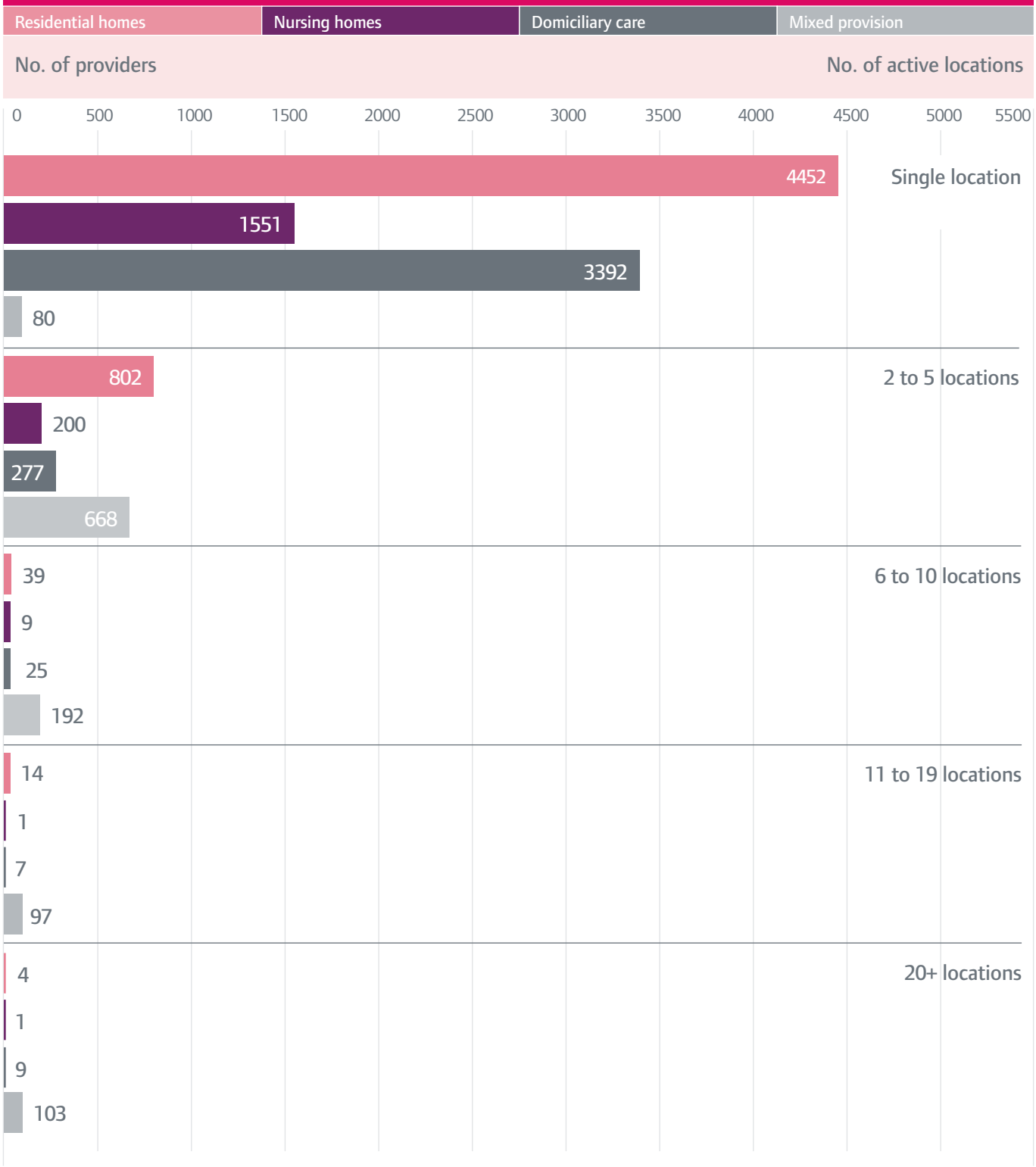
CQC data shows that at 31 March 2012 there were 13,134 residential care homes with 247,824 beds registered in England, and 4,672 nursing homes with 215,463 beds.

Compared with the July 2011 figures reported in last year's State of Care, this is an overall decrease – consisting of a decrease in the number of residential care homes (down 2.5%) and beds (down 5.1%) offset by a smaller increase in the number of nursing homes (up 1.4%) and beds (up 3.3%).

However, the percentage of all people supported by councils who are in residential and nursing care increased from 4.2% to 4.6% during 2011/12; this contrasts with the trend of support in previous years. Further decline in local authorities' directly provided care home places means that the independent sector now accounts for around 96% of council-supported placements.[18]

† These figures are not mutually exclusive, as one location can provide more than one type of service.

Figure 14: Overview of the number of active locations from which different providers of adult social care services were operating, 31 March 2012



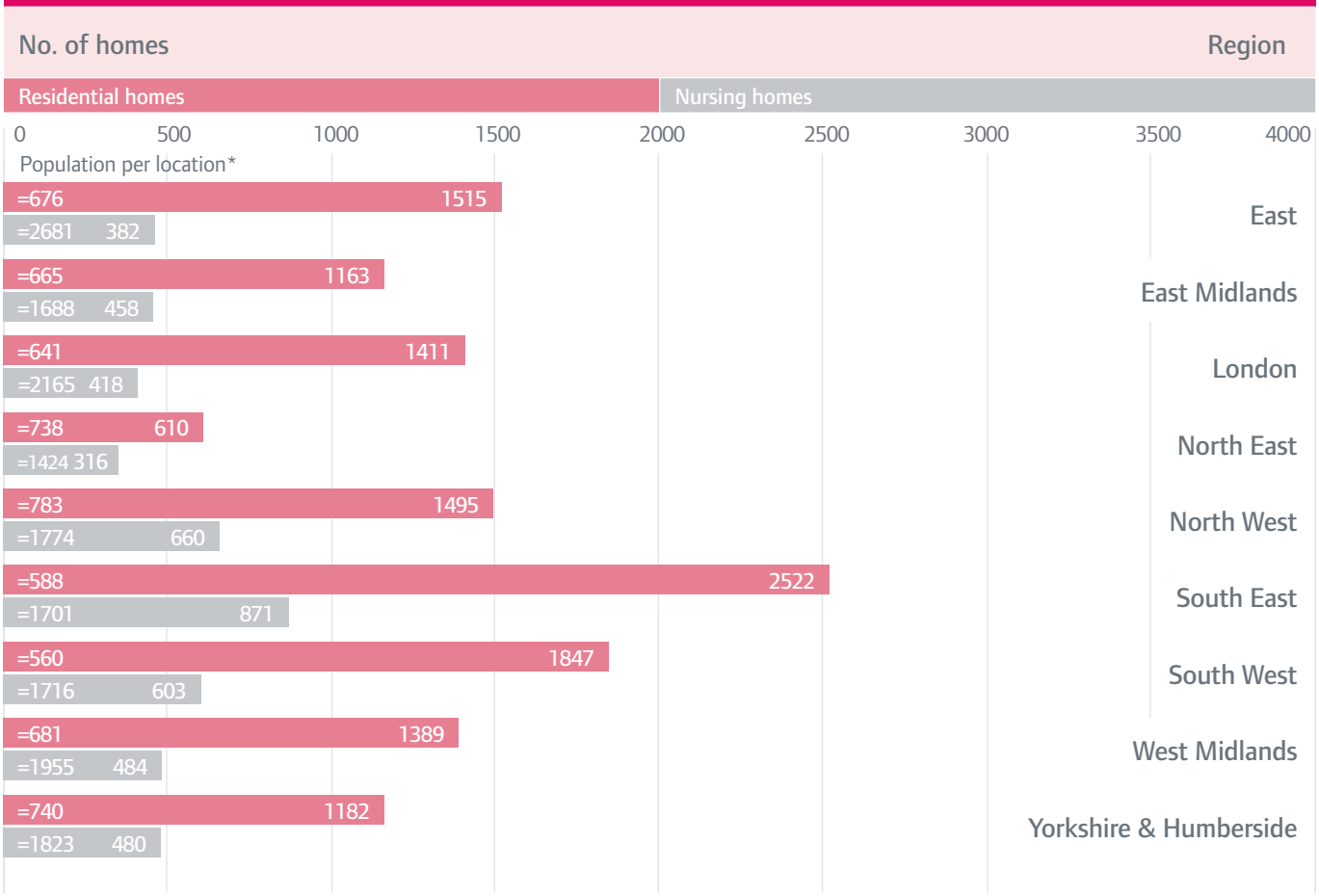
Source: CQC
Note: This chart takes account of corporate 'brands' which own a number of providers but are not themselves registerable entities.

Figure 15 shows the number of residential care homes and nursing homes by region. The highest proportion of residential care homes can be found in the South East (19%) and the South West (14%) and the highest proportion of nursing homes are in the South East (19%) and the North West (14%). The changes from last year have been spread fairly evenly across the country.

Figure 16 shows the proportion of residential care homes and nursing homes in England supporting different types of people who use services. It is common for a care home to be registered to care for more than one type of user.

Eighty-eight per cent of nursing homes are registered as providing care for older people, whereas the figure for residential care homes was 54%, and 55% of nursing homes are registered as providing care for people with dementia, compared with 33% of residential care homes.

Figure 15: Residential and nursing homes in England by region, 31 March 2012

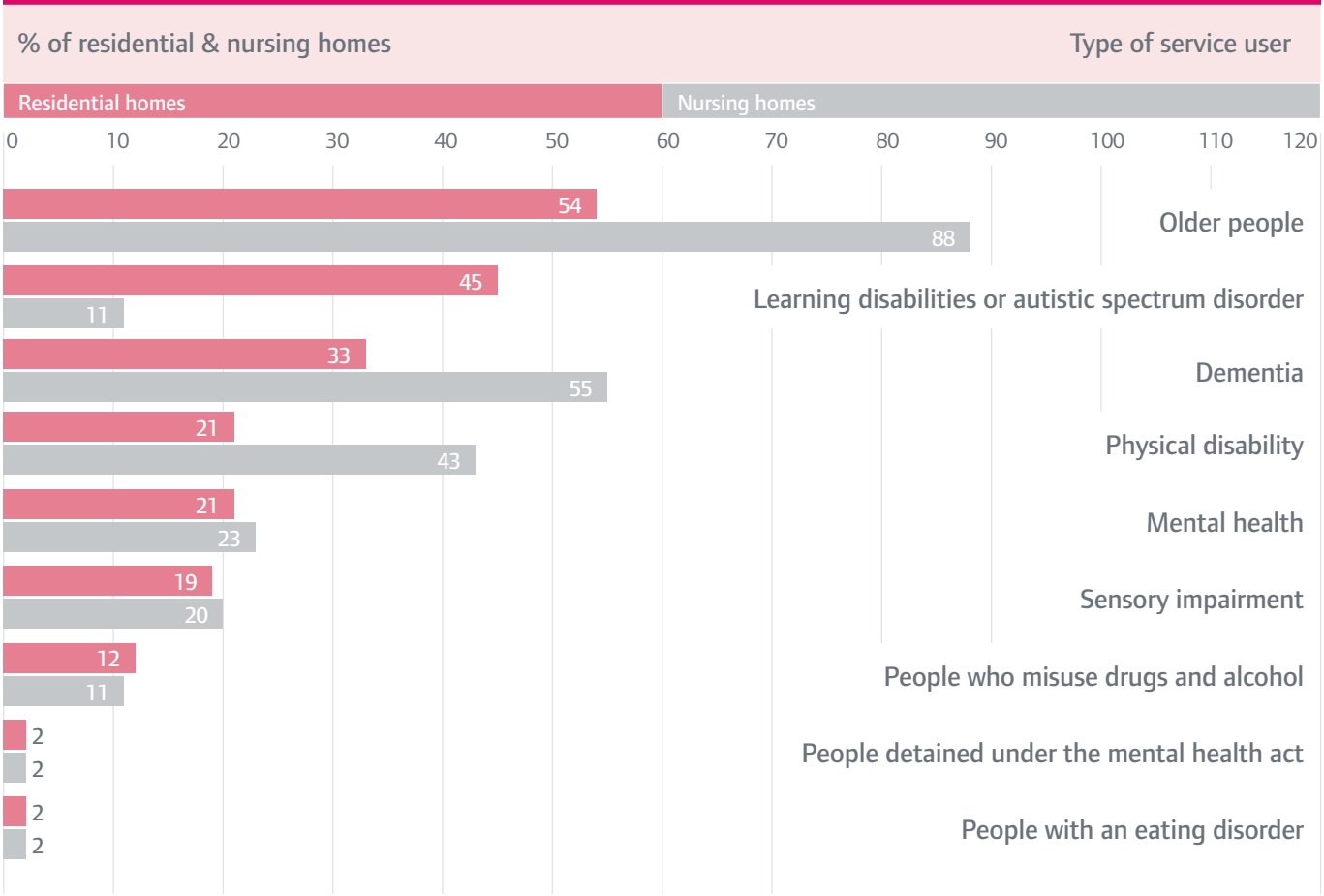


Source: CQC

*Average population per location is calculated by dividing number of locations into 2011 ONS population estimate of people aged 65+ for each region.

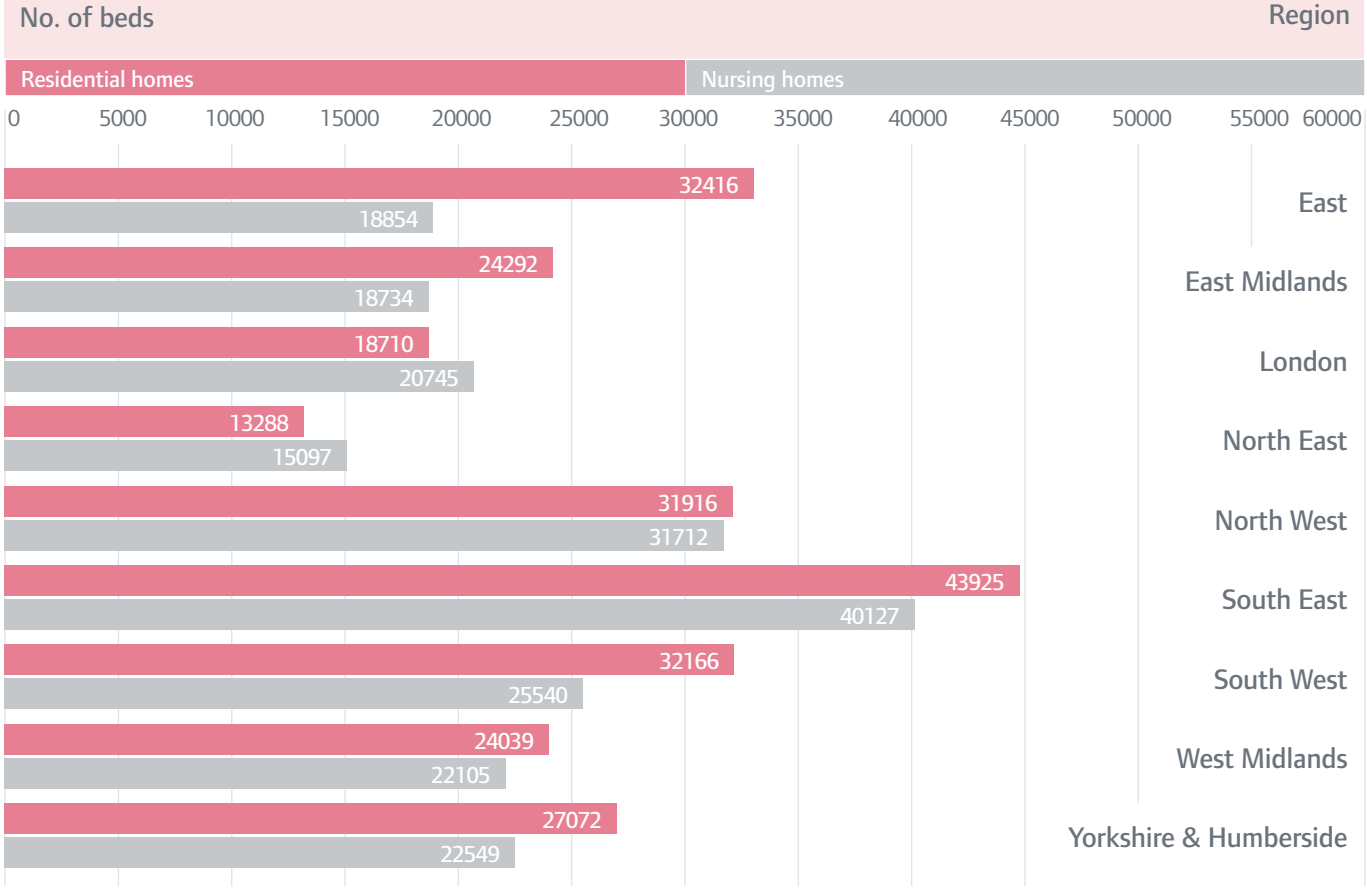
> Reablement services are now a mainstream part of the social care support offered by local authorities.

Figure 16: Proportion of residential homes and nursing homes in England registered to cater for specific types of people who use services, 31 March 2012



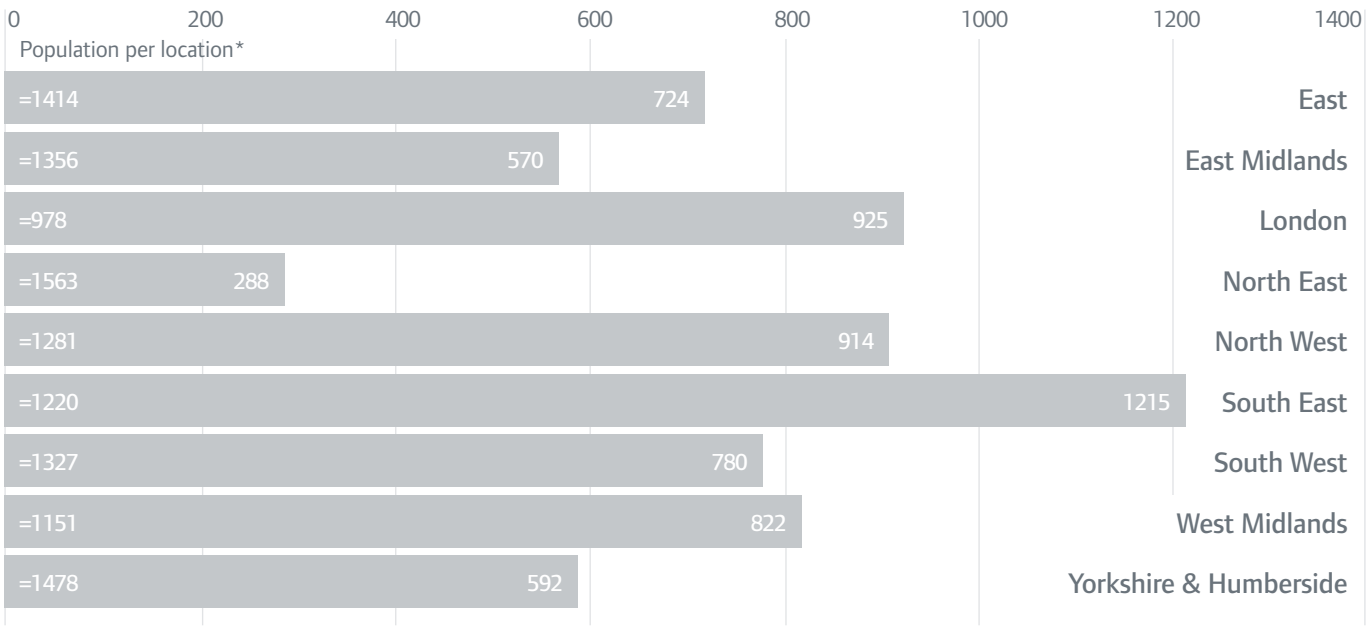
Source: CQC

Figure 17: Beds in residential homes and nursing homes in England by region, 31 March 2012



Source: CQC

Figure 18: Domiciliary care agencies in England by region, 31 March 2012



Source: CQC

*Average population per location is calculated by dividing number of locations into 2011 ONS population estimate of people aged 65+ for each region.

Figure 17 shows the regional distribution of residential care home and nursing home beds. The greatest number of both residential and nursing home beds can be found in the South East and the fewest in the North East.

Domiciliary care

CQC's registration figures show that as at 31 March 2012, there were 6,830 agencies providing domiciliary care (also known as home care) across England.

This is an increase of 16% since the July 2011 figure reported in last year's State of Care report, and continues the long-term trend towards people continuing to live in their own homes and communities, rather than going into a care home (see above for the overall reduction in care homes and beds). It also reflects the continuing growth in micro providers in the domiciliary care sector.

The number of adults aged 18-64 receiving a community-based service from councils fell during the year by 21,771 to a total of 432,331.[19] The use of direct payments increased by almost 11%, and this may partly explain a decline in the use of council-provided services. A total of 77,912 people were supported by direct payments in 2011/12, representing an increase of 7,505 new cases. There were decreases in day care services, meals at home and professional support. There was a 0.8% reduction in home care. Here again, reductions may be partly explained by the extended use of direct payments, where people who use services choose different kinds of support rather than council provided/arranged services.

Similar changes took place to the support used by people aged 65 and over. An estimated 43,558 fewer older people were supported in 2011/12 than in the previous year, a reduction of 5.2%. The highest reductions were in professional support, meals services and day care. There was a 2.0% reduction in home care.

Figure 18 provides a regional breakdown of home care agencies registered with CQC. The highest number of agencies can be found in the South East, London and the North West. It should be noted however that there is considerable variation in the size of agencies, the number of staff they employ and the numbers of people using their services.

“

6,830 agencies providing domiciliary care in England – an increase of 16% on the previous year.

Adjusting for population size, there is a notable variation in council-funded domiciliary services. People aged 65 and over living in the North East, North West or London are more likely to receive council-funded 'community-based services' (figure 19).[20] These services include home care, day care, meals at home and professional support. Regional variations can be partly explained by differences in the ability of people to pay for their own support. All regions except East Midlands showed a reduction in the number of people aged 65 and over receiving these services. However, it should be noted that data on the number of people who fund their own services is not available.

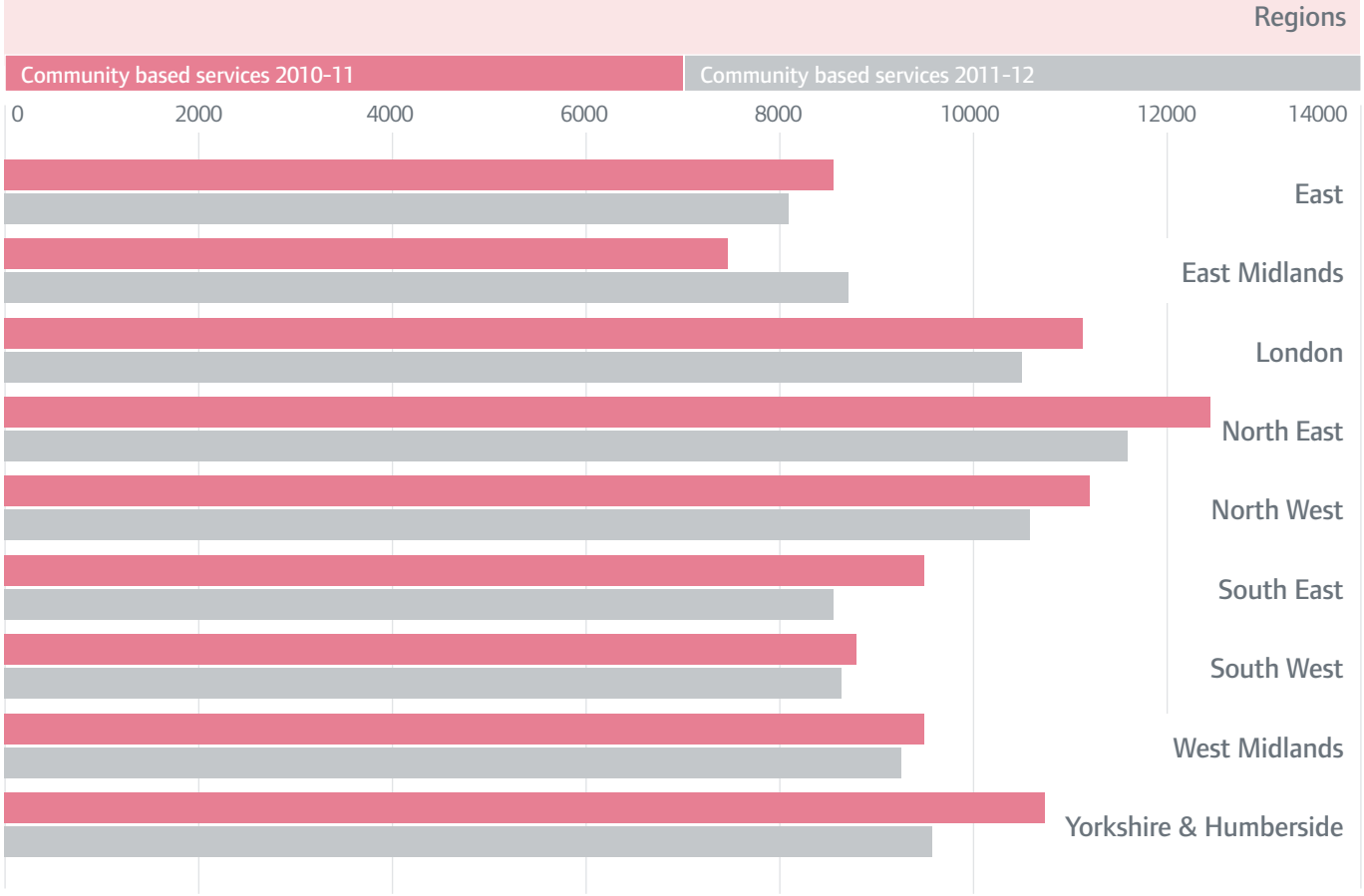
Figure 20 shows the proportion of home care agencies in England catering for the different needs of people who use services. The most common types of provision are for older people (up from 74% to 76%), followed by people with a physical disability, those with a learning disability or autistic spectrum disorder (up from 64% to 65%), and those with dementia (also up from 64% to 65%). These categories are not mutually exclusive: a single agency will usually be registered to provide care for more than one type of person.

Other community social care services

In March 2012, there were 2,034 other 'community' social care services registered with CQC across England. These include extra care housing, supported living services and Shared Lives schemes.

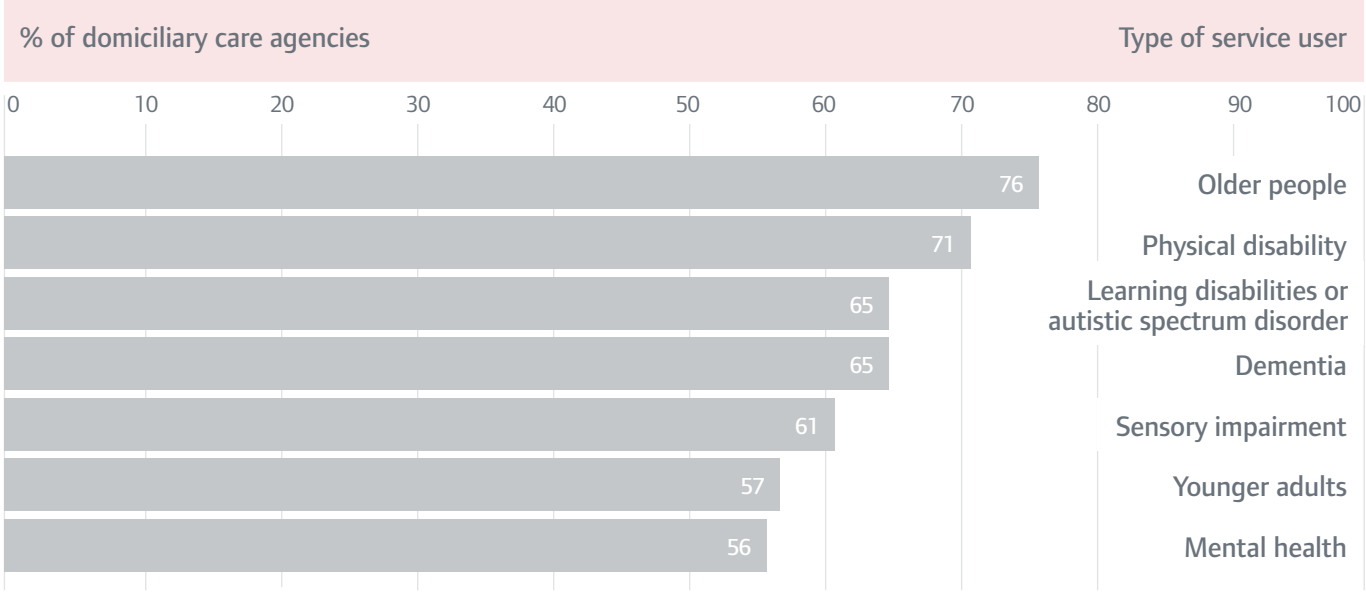
Extra care housing combines housing provision and care: the sector has evolved in recent years, and encompasses various service and business models, including very sheltered housing, retirement and care villages, and assisted living. Such services generally provide tailored care and support that can change as people's conditions deteriorate or fluctuate.

Figure 19: Total number of people aged 65 and over receiving council-funded community-based services during the year per 100,000 population



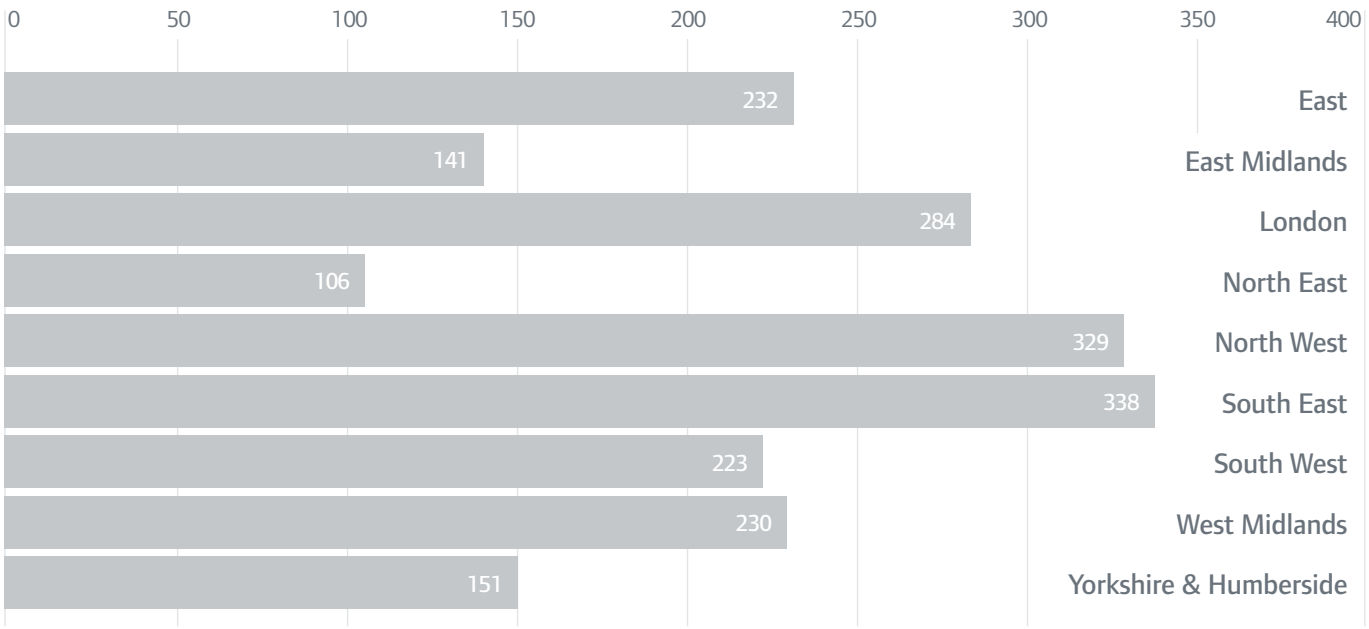
Source: Local Government Association

Figure 20: Proportion of domiciliary care agencies in England catering for the specific needs of people who use services, 31 March 2012



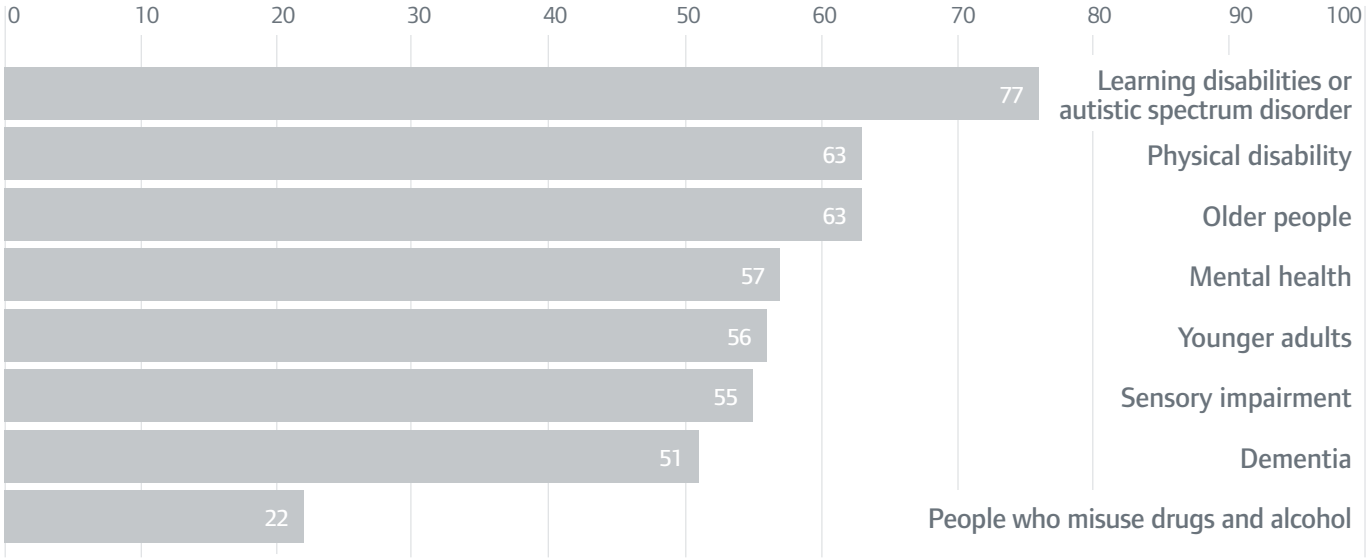
Source: CQC

Figure 21: Other community social care services in England by region, 31 March 2012



Source: CQC

Figure 22: Proportion of other community social care services in England catering for specific needs of people who use services, 31 March 2012



Source: CQC

Supported living schemes provide accommodation through individual tenancies and tailored support such as help with shopping, cooking, cleaning, washing, dressing, personal care, laundry, and also help with claiming benefits, or finding suitable education, training and employment opportunities.

Shared Lives schemes arrange placements, enabling people to receive the support they need through living in a family home, and taking part in family life and related social and community activities.

The number of other community social care services in each region is shown in Figure 21, with the highest number found in the South East and the North West and the lowest in the North East.

Figure 22 shows the proportion of other community social care services in England catering for the different needs of people who use services. The most common types of provision are for those with a learning disability or autistic spectrum disorder, those with a physical disability and older people. A single service may be registered to provide care for more than one type of person.

> 2,034 other community social care services registered with CQC including extra care housing, supported living services and Shared Lives schemes.

02 Quality and safety of health and social care

In part 2 of this report, CQC gives an overview of the quality and safety of care in 2011/12 across each of the different care sectors. It reports on what is working well in each sector, as well as where it is finding issues of poor care, using the findings from its inspections, its themed inspection programmes and thematic reviews, as well as other published reports and statistics.

Read CQC's latest inspection reports at
www.cqc.org.uk/public/news/our-latest-reports

Every part of the health and care system in England has a role in improving standards of care for people. There are five main influences. Commissioners of care must make sure that they do not buy poor quality services. Providers have a legal duty to meet national standards of quality and safety. Frontline professionals and care staff have a responsibility to deliver high standards of care and tackle poor care when they see it. Regulators must promote, and enforce where necessary, standards of care among the organisations and professionals that they regulate. And the voices and experiences of people who use services must be encouraged and heard.

An overview of how CQC inspects care services, and the essential standards of quality and safety that it inspects against and which people have a right to expect, are set out in the appendix. CQC's inspectors use a range of methods to listen to and gather the views of people who use services – these include using Experts by Experience and sector experts on an inspection as well as tools like SOFI 2 (the Short Observational Framework for Inspection 2), which helps inspectors to capture the experiences of people who may not be able to express this for themselves.

The ageing population is putting ever more pressure on all types of health and social care services. In England, there are more than 400,000 people living in residential care. There are 800,000 people living with dementia in the UK and, over the next 30 years the number of people with dementia is expected to double.[21] About a third of all people with dementia live in care homes, while around a quarter of older people on acute wards in hospitals are estimated to have dementia, much of it undiagnosed.

In the light of this ageing demographic, CQC focuses in this report on those people who may not have mental capacity (and consequently are less able to speak up for themselves) and those who as a result of

> Across all sectors, the standards with the poorest performance related to record-keeping and medicines management.

their circumstances are more vulnerable – people with dementia, people with a learning disability and people with mental health problems.

And in particular, it reports on the extent to which these people – whether in the NHS, independent health care or social care – are treated with respect, dignity and compassion, and given the opportunity to be involved in and make decisions about their own care.

Although CQC inspectors check that services are meeting standards under a number of different headings – for example, whether there are enough staff and whether they are trained and supported effectively – ultimately failures in these areas all lead back to a poorer experience for the person receiving care and the risk that people's dignity is compromised.

Overall quality across all sectors in 2011/12

On 31 March 2012 most of the services (73%, 10,313 locations) that CQC had inspected across all health and social care sectors were meeting all the essential standards checked.[22]

Within this, there is much excellent care being provided. But this also means that 27% of services (3,617 locations) that CQC had inspected up to that date (including those inspected before 2011/12) were not meeting at least one standard on 31 March 2012. Any substandard care will ultimately impact on the experience of people who use services.

Across all sectors, the standards with the poorest performance related to record-keeping and medicines management. Proportionately, CQC took enforcement action in respect of medicines management more often than any other standard – the 'conversion rate' of non-compliance to enforcement for this standard was 8.2% in 2011/12, which compares with an average rate across all standards for the year of 4.0%.

The next highest conversion rates were for the standards on the care and welfare of people (5.3%), meeting people's nutritional needs (4.6%) and cleanliness and infection control (4.3%). In contrast, the conversion rate for the record-keeping standard was beneath the average at 2.9%.

Warning notices are by far the most common type of enforcement used by CQC. In 2011/12, CQC issued 638 warning notices to providers: 598 in adult social care, 20 in the NHS, 19 in independent health care and one to an independent ambulance provider. They were most often used to enforce compliance with the standard on care and welfare of people, with 145 notices being issued.

In adult social care, this standard was the one with the highest number of warning notices (134), closely followed by the standard on medicines management (120). The next most common use of warning notices in this sector related to the standards on assessing and monitoring the quality of provision (62 warning notices), supporting staff through supervision, training and appraisal (42) and staffing levels (41).

The standard on care and welfare of people was also the most commonly enforced standard in independent health care, with six warning notices out of the 19 issued.

In contrast, in the NHS it was the standard on assessing and monitoring the quality of provision that raised most concerns – six warning notices out of the 20 issued to NHS services related to this standard.

This is the beginning of an approach that looks at the impact that regulation has on driving improvement in services. CQC will be examining this in more detail in future reports, for example by looking at the length of time it takes providers to return to compliance with standards. We will also shortly be publishing information on whistleblowing, and the types of information most commonly raised with CQC.

NHS services

The NHS is currently experiencing the largest-scale structural change in its history, with the transfer of commissioning responsibility from PCTs to CCGs and the new NHS Commissioning Board, and responsibility for public health moving out of the NHS to local authorities. Meanwhile at local level, service re-organisations and reconfigurations continue as the NHS strives to improve care pathways, concentrate specialist services in centres of excellence, deliver more care in communities rather than acute hospitals, strengthen integration with social care, and provide more personalised services.

NHS funding has stayed broadly level in real terms since 2010 at over £121 billion. However, due to medical and technological advances, health cost inflation runs higher than general inflation. The NHS has been tasked with achieving £20 billion efficiency savings by 2015, while improving quality, innovation, productivity and prevention under the QIPP agenda.

With a rising population, pressures on NHS services continue to increase. By mid-2011, England's population had reached a record 53.1 million.[23]

There has been a continuing rise in live births since 2001, with 723,913 in England and Wales in 2011 – the highest number this century. At the same time, death rates have fallen to their lowest recorded level. There were 484,367 recorded deaths in England and Wales in 2011, a fall of 1.8% compared with the previous year.[24]

The patterns of disease and health need are changing, shaped by a rise in long-term and lifestyle-related conditions. Obesity is now recognised as a significant public health issue, associated with a range of diseases and poor health outcomes. In England in 2010, over a quarter of adults (26%) were obese, and around three in 10 children aged two to 15 were classified as overweight or obese.[25] More and more people are living with long-term conditions such as diabetes, coronary heart disease and respiratory diseases, and multiple co-morbidities. However, cancer death rates have fallen by 14% for men and 10% for women in the past decade [26]; more people are living with, and surviving, cancer for longer. The impact of these trends is greatest on older people and people living with co-morbidities.

As the population ages, we are also seeing a rise in conditions for which age is a major risk factor, such as dementia. In addition, one in four people experiences mental health problems at some point in their lifetime.

While NHS services are available for everyone, regardless of age or the care they require, older people are accounting for a bigger proportion of NHS hospital activity every year. This is particularly the case with inpatient care, with the number treated growing at a much faster rate compared to any other age group.

Hospital stays in England involving patients aged 75 and over rose by two thirds in the decade up to 2009/10. This compared to the overall growth rate in that period of 38%. The number involving 60 to 74-year-olds also rose rapidly, by nearly 50%.

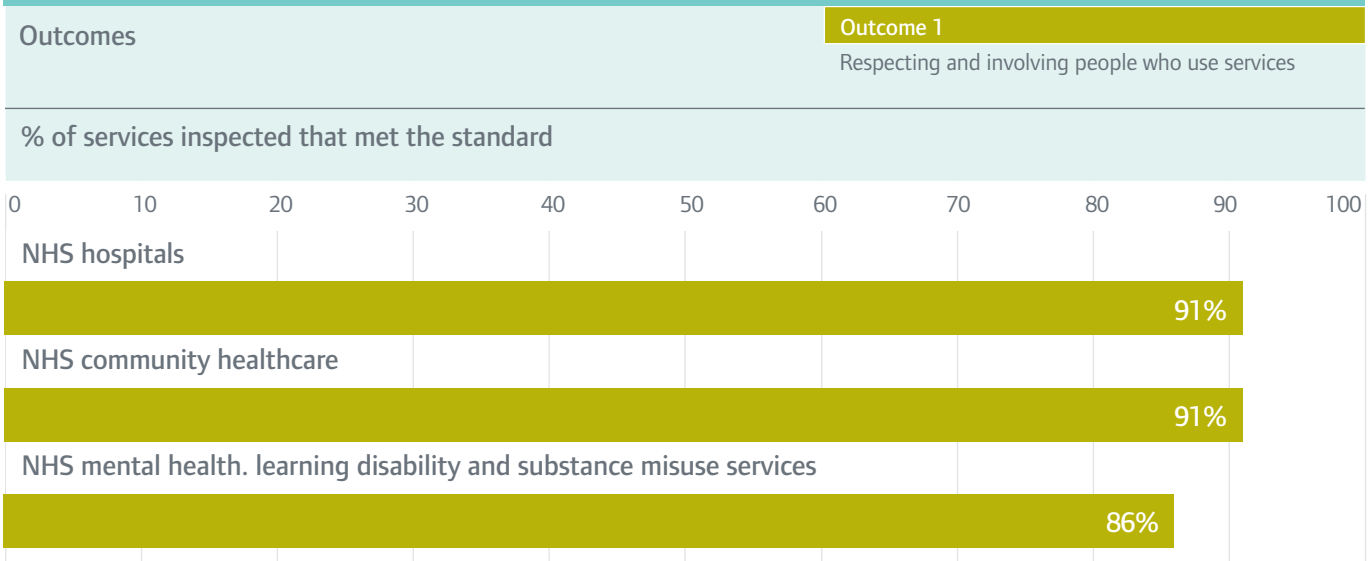
Older people also tend to stay in hospital much longer: the average length of stay for patients over 75 years of age is more than 10 days, compared with just over four days for those aged 15 to 59. And any problems with discharge arrangements, such as poor communication with care homes or carers, can increase the risk of emergency readmission back to hospital.

In this report, CQC has focused on issues of respect and dignity. Its key findings in respect of NHS services are as follows.

Key findings in the NHS

- In 2011/12, nine out of 10 NHS hospitals that CQC inspected (350 inspections) met the standard on treating people with respect and dignity, and involving them in their care. Those that did this had a high degree of consistency in the way they treated patients and respected their dignity.
- There were common themes in the other 10% that failed – a lack of privacy, call bells being out of reach, and staff speaking to patients in a condescending way.
- Three things underpin this poor care: cultures in which unacceptable care becomes the norm; an attitude to care that is 'task-based', not person-centred; and managing with high vacancy rates or poorly deployed staff.
- The performance of NHS community services was similar to hospitals, whereas 86% of NHS mental health, learning disability and substance misuse services that CQC inspected met the standard (243 and 160 inspections respectively).
- Following its targeted inspection programme, three-quarters of trusts told CQC they had made changes to the way they looked at dignity and nutrition.
- Inpatients reported feeling involved in decisions about their care and being given clear information about their treatment, although there has been no significant change in recent years. Outpatients, however, have seen improvements.
- 85% of hospitals (258 inspections) met the standard on making sure patients had the right food and drink and the help they needed – an issue closely linked to treating patients with respect. But the figures for community services and mental health, learning disability and substance misuse services were more positive – 90% and 97% (163 and 87 inspections) respectively.
- NHS staff were recruited effectively and checks were carried out to make sure they had the right skills and experience to do their jobs. But a number of NHS services struggled to make sure they had enough qualified and experienced staff on duty at all times, and then to make sure staff were properly trained and supervised – putting extra pressure on the ability to focus on the needs of each and every patient.
- Poor discharge arrangements on leaving hospital can lead to an increased risk of emergency readmission. CQC found that people discharged over a weekend are at significantly higher risk of this happening.

Figure 23:
Proportion of NHS services meeting standards on respect and involvement, 2011/12



Source: CQC

Airedale General Hospital

Inspection report June 2011

Example of
Good practice

"Patients we spoke with were very positive about their experiences of care and treatment.

We observed staff respecting the privacy and dignity of patients while talking to them and helping them in their daily activities."

"The staff members adjusted the volume of their voice to accommodate the individual needs of each patient. Curtains were drawn around beds and side room doors closed on each occasion where care interventions were being carried out. Patients were accommodated in same sex bays and single rooms; staff took care to knock before entering a single room.

Staff addressed each patient by name and we saw them frequently engaging the patients by asking them if they were comfortable and whether they needed anything. Call bells were within easy reach and audible. One patient had been provided with a hand bell because their electronic call bell was out of reach.

One of the wards was trialling a new scheme – the 'Butterfly Scheme' – which highlights the special needs of patients whose memory is permanently affected by dementia. The focus is on meeting the needs and views of people by displaying a butterfly symbol (with consent). This symbol prompts staff to follow a simple five-point plan, known as REACH: Remind, Explain, Arrange, Check, History. We saw evidence of staff following this plan during our visit and staff told us that they had received bespoke training on this scheme."

"We saw evidence of staff following this plan during our visit and staff told us that they had received bespoke training on this scheme."

Dignity and respect

Ensuring that people are treated with dignity and respect, and that they are treated as people – with lives, families, relationships and individual needs of their own, and not defined in terms of the 'illness' they have or the 'task' they represent ¬– is one of the most important features of a high quality care service.

When CQC inspects services, its inspectors check the extent to which people are treated with respect and involved in their care, and how their views and experiences are taken into account. Providers need to ensure the privacy, dignity and independence of people using their services. They should also ensure people using services can make, or participate in, decisions about their care and treatment, including providing appropriate information. They should encourage and support people in managing their own treatment and care, where appropriate.

During 2011/12, CQC carried out a programme of themed inspections, looking specifically at issues of dignity and respect in the care given to older people at 100 NHS acute hospitals in England. It used teams made up of CQC inspectors, a practising and experienced nurse, and an 'Expert by experience' – someone with experience of caring or receiving care – to look at the standard on respect and involvement (as well as the standard on food and drink) in respect of the care given to older people.

Of the 100 checks CQC made against the respect and involvement standard as part of this programme:

- 60 hospitals fully met the standard and a further 28 met the standard but CQC suggested they make improvements to make sure they continued to do so.
- 12 did not meet the standard and had to take action to improve.

This broadly matches the overall findings across all the NHS hospital-based services inspected in the year (350 inspections), where 91% of services met the standard (figure 23).

In the hospitals that did meet this standard in the themed inspection programme, there was a high degree of consistency in the way that they respected patients' dignity. Patients described staff as positive, sensitive and respectful. CQC's inspectors found many examples of good practice in respecting patients' privacy – most commonly staff closing curtains when care was being delivered and not discussing people's care out loud.

Across all 100 hospitals, the availability of single sex facilities was consistently good, with single sex accommodation and facilities available in all 87 locations where CQC's inspectors made a specific assessment of it. While overall wards were generally mixed, patients were usually accommodated in single sex bays or side rooms with single sex bathrooms available.

In contrast to this good practice, there were some common themes in those services where CQC did find problems:

- Curtains not being properly closed when personal care was given.
- Call bells being out of patients' reach, or not responded to in a reasonable time. This is a simple issue that matters a lot to patients, based on the comments and feedback we heard.
- Staff speaking to patients in a condescending or dismissive way.

In the national report that accompanied the findings, CQC highlighted three key themes that underpinned the poor care seen, and reiterates them here:

- That leaders in hospitals must create a culture in which good care can flourish. Often, CQC's inspectors saw significant differences within the same hospital – where one ward got it right, another in the same building was getting it wrong. They saw cases where there was clearly some fault in the hospital's culture that allowed unacceptable care to become the norm, where it should have been an exception.
- That staff attitudes to people are critical. Those who are responsible for the training and development of staff need to look hard at why 'care' often seems to be broken down into tasks to be completed – focusing on the unit of work, rather than the person who needs to be looked after. Task-focused care is not person-centred care. It is not good enough and it is not what people want and expect. Kindness and compassion costs nothing.
- That resources have a part to play. Many people told CQC about the wonderful nurses in their hospital, and then said how hard pressed they were to deliver care. Having plenty of staff does not guarantee good care (inspectors saw poor care on well-staffed wards, and good care on understaffed ones) but not having enough is a major ingredient of poor care.

Of the other NHS services inspected in the year (243 inspections), the performance of NHS community healthcare services was similar to hospitals – with 91% meeting the standard.

NHS mental health, learning disability and substance misuse services performed more poorly, with 86% meeting the standard (160 inspections). This is a concern. The results from CQC's review of services for people with a learning disability show that if the care system is to meet the needs of this group of vulnerable people it is vital to ensure that person-centred care is commissioned appropriately and delivered. If this were to happen systematically people would be much more in control and able to exercise choice about how and where care is delivered that best meets their needs.

This issue of patients being fully involved in decisions about their own care was something CQC also raised in its report *Monitoring the Mental Health Act in 2010/11*, which was published in December 2011.

Patients' perceptions of being treated with dignity and respect

The NHS national patient surveys provide valuable information about patients' experiences of various aspects of care and treatment. The ninth inpatient survey looked at the experiences of more than 70,000 people discharged from hospital between June and August 2011. All participants were adults who had spent at least one night in an NHS acute hospital in 2011. People using only mental health or maternity services were not included.

The fourth outpatient survey covered the experiences of more than 72,000 people aged 16 or over who attended outpatient departments during April or May 2011. This includes outpatient clinics run with A&E departments, such as fracture clinics.

The surveys include an in-depth look at whether patients are treated with dignity and respect, and show consistent findings over the last few years. In 2011:

South Tyneside District Hospital

Follow-up dignity and nutrition report November 2011

Example of
Good practice

Improvements following CQC inspection

"We returned to the same two wards as we had visited in April 2011. These were a large care of the elderly ward and the stroke unit. Patients were positive about their experiences of care and treatment, and told us that staff were caring, helpful and respectful.

They made the following comments: 'The staff spend time with me'; 'I am always asked for my view'; 'I was asked about my diet when I was admitted and the staff listened to what I told them'; 'I have plenty of time to eat my meals…'.

A change had been made to ensure that medication was no longer given out during mealtimes. This ensured that all staff were available to support patients with their eating and drinking needs during mealtimes. Where patients were slow eaters we noted that their main course was kept warm until they were ready for it.

Nurses on this unit told us that team relationships had improved and that everyone had become more aware of the importance of their actions and approach to the patients.

There were plans to change staff shift patterns. This would enable staff to work both day and night shifts so they could be involved in care provision across the 24-hour period.

Several staff referred to a recent situation where they had worked closely with a relative who wanted ongoing hands-on involvement with their partner, to share meals and be together overnight. The staff described a positive experience where their commitment to giving this couple assistance with their immediate and long term needs was clearly apparent.

The ward manager of the elderly care unit said he was looking to introduce 'This is me' leaflets, a form produced by the Alzheimer's Society that provides professionals with information about responding to the person with dementia as an individual. More training for staff on caring for people with dementia was being organised."

- 79% of NHS inpatients thought they were "always" treated with dignity and respect while in hospital.
- 18% thought they "sometimes" were.
- 3% thought they were not.

These proportions are unchanged since 2008.

For outpatients, the corresponding figures were 89% always treated with respect (2009: 87%), 10% sometimes (2009: 12%), and 1% who said they were not treated with dignity and respect (unchanged since 2009).

When asked whether doctors had talked in front of them as if they were not there, 73% of NHS inpatients in 2011 said it had not happened (72% in 2010), 20% said it happened "sometimes" (21% in 2010), and 6% said it happened "often" (6% in 2010). Overall, this is a slight improvement from 2010. Asked the same question about nurses, 78% said it had not happened, 17% said it happened sometimes, and 5% said it happened often - these figures are unchanged since 2009.

The corresponding figures for NHS outpatients were 88%, 8% and 4%, unchanged since 2009.

Taken together, these surveys highlight that a lack of dignity and respect is a persistent issue and one that has been hard to shift – with anywhere between 11% and 26% of patients reporting issues of dignity and respect that "sometimes" or "often" happen.

CQC's targeted inspection programme has focused attention on this crucial area and helped to drive improvements in practice. As a result of the programme, three-quarters of trusts said they had made changes to the way they looked at dignity and nutrition. In the first quarter of 2012/13, CQC inspected 35 NHS services in respect of the standard on respecting and involving people. Only one of these did not meet the standard and the CQC inspector judged that it had a minor impact on patients.

Experiences of people using community mental health services

The 2012 national survey of people using NHS community mental health services reported on the experiences of over 15,000 people aged 18 and above, who had received care or treatment for a mental health condition between July and September 2011. This included people receiving support under the Care Programme Approach (CPA) – the central approach for co-ordinating the care of people with the most complex mental health needs, who need the support of a multi-disciplinary team.

The majority of respondents were very positive about the health or social care worker that they had seen most recently for their mental health condition. The majority "definitely" agreed that: they had been treated with respect and dignity (87%); they had been listened to carefully (79%); they had enough time to discuss their condition or treatment (72%), and their views had been taken into account (73%).

The 2012 survey found that there is still scope for improving information provision around medications, with no changes since the 2011 survey. Fifty-six per cent said their views were "definitely" taken into account regarding decisions about which medication to take, and 32% said they were "to some extent". Of those who had been prescribed new medication in the previous 12 months, most said the purpose of the medication had been explained to them definitely (68%) or to some extent (26%). However, over a quarter (28%) said they were not told about possible side effects and 15% said they were not given information about new medication in a way that was easy to understand.

Respondents were asked about their NHS care plans. Of those on CPA, 13% said they did not have one. Of the remainder, almost half (48%) definitely understood their care plan, 31% did to some extent, and 8% said they did not understand it. A quarter (25%) of respondents on CPA had not been given or offered a written/printed copy of their care plan. Of those people who are not on CPA, 40% said they did not have an NHS care plan. Of the remainder, 27% said they definitely understood it, and 23% did to some extent, with 10% saying they did not understand it. Forty five per cent of respondent not on CPA said they had not been given or offered a written/printed copy of their care plan.

Of respondents who had an NHS care plan and understood it, the majority said their views were taken into account when deciding its contents definitely (54%) or to some extent (36%). Forty-three per cent said the care plan definitely set out their goals, compared with 40% in 2011. Most respondents on CPA said their NHS care plan covered what they should do if they have a crisis definitely (60%) or 'to some extent (26%). For people not on CPA, 49% said their care plans definitely covered this, and 28% said they did to some extent, leaving almost a quarter (23%) saying their care plan did not include this.

National guidelines recommend yearly reviews for those on CPA, but the survey found almost a quarter (24%) of people on CPA had not had a care review meeting in the previous 12 months, although this was an improvement on the 27% for whom this was the case in 2011. People not on CPA should receive ongoing reviews as their needs require. Almost half (48%) of those not on CPA said they had not had a care review in the previous 12 months.

Involving people in their treatment and care

Involving people in decisions about their own care and giving them the information they need to make good choices about their care, is just as important a factor in delivering dignified care.

The staff caring for them have a huge responsibility to see past the illness or condition and to the patient as a person. Those who provide dignified care constantly seek to involve the person in decisions, explaining what is happening and why, listening to and addressing concerns, and – above all – treating each person as someone deserving respect and understanding, empathy and kindness. In short, they recognise care as a partnership, instead of treating people as passive recipients.

In the hospital wards that performed well in our inspection programme of 100 acute hospitals, there was strong consistency in involving patients in decisions about their care, and a similar high level of good practice around explaining treatment options. This suggests that staff and management in these hospitals understood the importance of taking time to both involve patients in their care and explain what it means for them.

On the other hand, in those hospitals that performed poorly, a common complaint was that people received little or no information about what to expect from care delivered in the wards they were on.

In terms of patients feeling involved in decisions about their care and being given clear information about their treatment, the NHS surveys generally point to an unchanging picture in recent years for inpatients. Outpatients, however, have seen some improvements.

Asked how involved they felt in decisions about their care and treatment in 2011, slightly over half (52%) of NHS inpatients felt that they were "definitely" involved as much as they wanted; 37% said they were involved "to some extent", and 11% said that they were not involved as much as they wanted to be. These proportions were unchanged since 2008.

There was some improvement for NHS outpatients. In 2011, 72% said they definitely were involved as much as they wanted to be, up from 70% in 2009. Twenty-two per cent said they were to some extent (down from 24% in 2009), and 6% said they were not involved as much as they wanted (unchanged since 2009).

When inpatients were asked in 2011 whether doctors and nurses answered their questions in ways they could understand, there were no changes since 2009. Sixty-seven per cent said doctors "always" answered their questions in a way they could understand, and 27% said doctors did this "sometimes". Six per cent said doctors did not answer their questions in a way they could understand. The corresponding figures for nurses were 66%, 29% and 5%.

When NHS outpatients were asked if doctors answered their questions in ways they could understand, 73% of outpatients said they definitely had (up from 71% in 2009), and 23% said this had happened to some extent (down from 25% in 2009). The proportions saying doctors did not answer their questions in ways they could understand (3%) or that they did not get a chance to ask (1%) were unchanged since 2009.

✔ Spotlight on good practice in the NHS:

Involving patients in decisions about their care

The Northumbria Trust urology service serves a predominantly white working class population, including ex-mining communities. It is an outpatient service and the majority of patients who have lower urinary tract symptoms come through the service and are managed by nurse specialists.

The team used to provide a one-stop-shop, with assessment, diagnosis and treatment decisions all being undertaken on the day. However, they realised that in order to make a more informed decision, patients were likely to need more time to digest the information they had been given and fully consider their preferred course of action.

As part of the MAGIC (Making Good Decisions in Collaboration) programme, the team modified the patient pathway, so that rather than having their assessment, diagnosis and then making a treatment decision all at once, the patients now have their assessment and a discussion of the treatment options available, and the risks and benefits of each. Patients are given the NHS 'Enlarged Prostate' information booklet to take home, and read and then make a decision. The nurse calls them a week later to check whether they have made a decision about treatment. Patients are offered a face-to-face appointment if they prefer.

The booklet helps urology patients understand their treatment options and in some cases facilitates the involvement of spouses or partners who may be affected by the patients' symptoms or the chosen treatment options. Additionally, the questionnaire provided in the booklet allows the team at the clinic to check patients' understanding of the information provided to them during the clinic visit.

In addition to having more time to consider their options, patients have also benefited from an improvement in the quality of consultations delivered, in terms of interaction between clinicians and patients, and the structure, focus and content of conversations within these. The consultations are felt to flow better because of the use of the standard set of topics outlined in the NHS booklet. For the nurse practitioners, this has meant that consultations felt calmer because they were clearer about what they needed to cover and were less likely to 'jump about' in discussions.

One impact of this increased calmness and focus in consultations has been to give nurse practitioners the space to reflect on how they can best meet individual patients' needs. Ultimately, the team felt that patients are making better decisions.

Effective care, treatment and support

With the increasing number of older and more vulnerable people in hospital, making sure that they are able to eat and drink properly and are given help to do this when needed, is another cornerstone of dignified and respectful care. In addition, the food and drink must meet people's nutritional, religious and cultural needs.

CQC's themed inspection programme that looked at the care received by older people in acute NHS hospitals included the standard that covers food and drink. Of the 100 checks inspectors made against this standard:

- 51 hospitals fully met the standard and a further 31 met the standard but inspectors suggested they make improvements to make sure they continued to do so.
- 15 were not meeting the standard and had to take action to improve.
- Two were a cause of major concern and CQC had to take urgent action.

This broadly matches the aggregated findings across all the NHS hospital-based services CQC inspected in the year (258 inspections), where 85% of services met the standard (figure 24).

The impact on patients of good and poor practice in this area is clear. Where there was good practice, patients were helped to sit comfortably to eat their meals, staff sat with patients while they ate, and mealtimes were unrushed with staff reassuring and encouraging people. Meals were available for people who had missed set mealtimes, and snacks and drinks were available too.

An important element is identifying patients at risk of poor nutrition or hydration, and there was good practice here, with many wards using coloured (usually red) trays or jugs to do this.

The highest level of compliance we saw across hospitals in the themed inspection programme was in terms of food quality. We checked this at 77 hospitals of the 100 and 73 were found to be meeting this standard. In 66 cases, food was reported to be good across the board, with seven cases where opinion was mixed but acceptable.

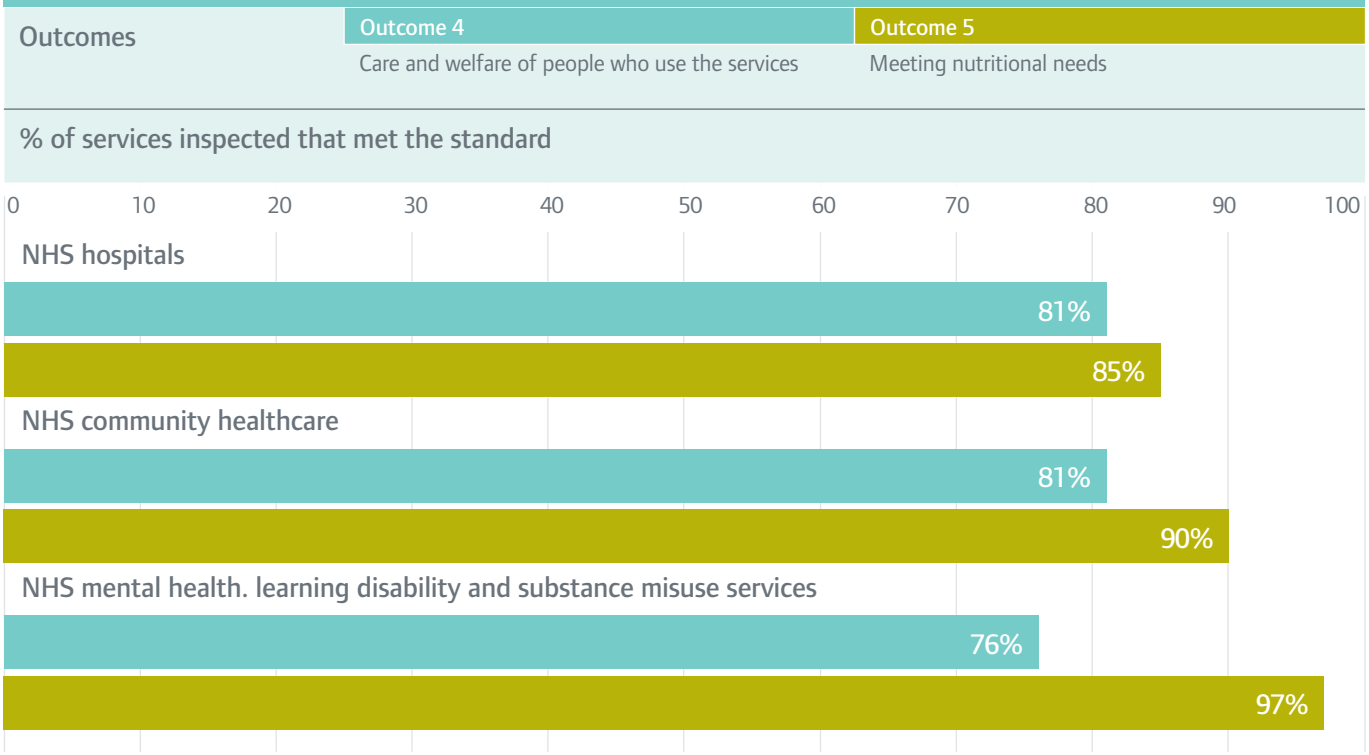
However, in hospitals where there was poor practice, patients received care that lacked dignity and respect:

- Patients not being given help with their food if they needed it.
- Mealtimes not being protected, so that patients were interrupted during meals and could not finish their food.
- Many patients not being able to wash their hands before meals.

Underpinning some of these issues was a lack of time to deliver care (due to short staffing, persistent high demand or excessive bureaucracy) – preventing staff from making sure that people's needs are assessed and giving them the right support to eat.

> 85% of NHS hospital services met the standard on food and drink in 2011/12

Figure 24: Proportion of NHS services meeting standards on effective care, treatment and support, 2011/12



Source: CQC

Poor care can also happen if there is a culture in a hospital that does not place an emphasis on treating people with dignity and respect. This might explain why needs assessments do not seem to be a priority in some hospitals, and the habit of talking across (rather than to) patients by staff.

CQC's inspection findings are mirrored by the NHS inpatients survey, which asks about patients' experiences of hospital food. In the 2011 survey, around two-thirds (62%) of inpatients said they "always" got enough help from staff to eat their meals (down from 64% in 2010), and 19% said they "sometimes" got enough help (18% in 2010). The proportion saying they did not get enough help was 19%, and this has increased slightly since 2010 (18%).

The other NHS services that CQC inspected in the year performed better in relation to this standard than hospitals. Ninety per cent of NHS community healthcare services met the standard (163 inspections); for NHS mental health, learning disability and substance misuse services the figure was 97% (87 inspections).

Across the different kinds of NHS service, there was poorer performance in relation to the standard on the care and welfare of people who use services.

To meet this standard, providers need to carry out an assessment of the needs of each person that uses their services, and plan and deliver their care and treatment in ways that meet the person's individual needs, ensure the person's welfare and safety, reflect good practice evidence and guidance, and avoid unlawful discrimination. Providers must also have arrangements in place for dealing with foreseeable emergencies.

CQC found that, of those inspected, 81% of NHS hospitals (355 inspections) and NHS community healthcare services (265 inspections) met the standard in 2011/12.

The poorest performance was in NHS mental health, learning disability and substance misuse, with 76% of services meeting the standard (254 inspections). CQC examined care and welfare issues in its 2011/12 review that looked specifically at NHS, independent healthcare and adult social care services for people with a learning disability.

The main concerns in relation to this standard (across all care settings) in the review related to care planning (38%), meaning that people with learning disabilities and their families were not involved in the design of the care and therefore were not in control of their own needs – a lack of person-centred planning was a significant feature.

Keeping people safe

The safety of people receiving care is paramount. This is particularly important when people are less able to speak up for themselves – an increasing feature of NHS services with the growing number of frail people and people with dementia.

When CQC inspects services, it looks at what providers do to make sure that people who use the services, staff and visitors are as safe as they can be, and that risks to people's safety are managed well.

Inspectors look particularly at what the provider is doing to respect people's human rights and protect them from the risk of abuse, and how they identify when people are in vulnerable situations and respond accordingly. They also check whether the environment is clean and people are protected from the risk of infections, and whether the medicines that patients need are prescribed and administered safely.

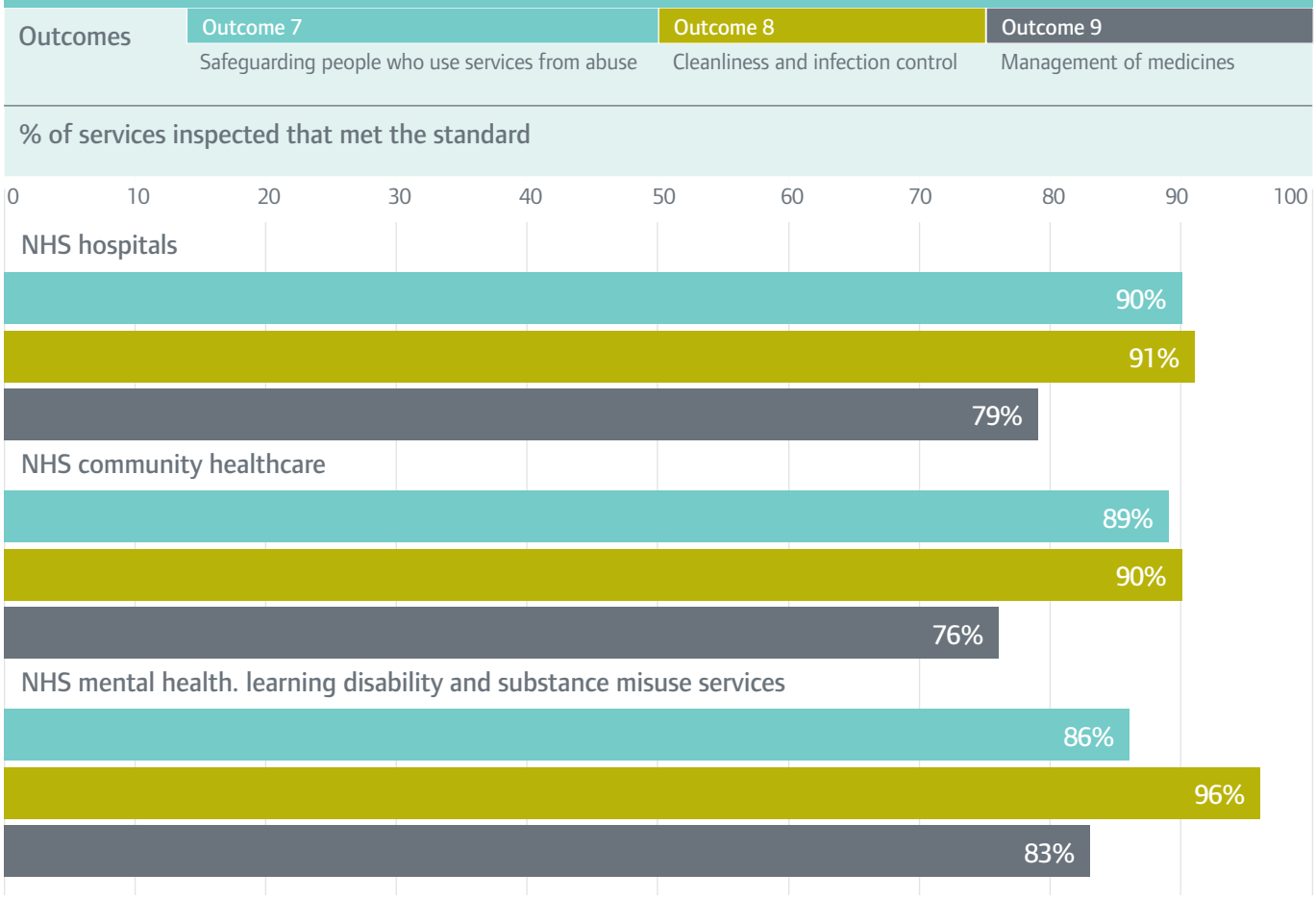
The standard on safeguarding requires providers to take action to identify and prevent abuse, and to respond appropriately when it is suspected that abuse has occurred or is at risk of occurring. Providers must also ensure that safeguarding guidance is followed, that people's human rights are respected and upheld, and that any use of restraint is appropriate, reasonable, proportionate and justifiable.

CQC's inspections in 2011/12 found that 90% of NHS hospital-based services (240 inspections) and 89% of community services (202 inspections) met the standard (figure 25).

Information-sharing in respect of safeguarding needs improvement in NHS services – there can sometimes be a lack of clarity about responsibilities and procedures, so that some cases are not referred to local authority safeguarding teams where it would have been appropriate to do so.

The NHS inpatient survey asks questions about people's own feelings of safety. Three per cent of participants in 2011 said they had felt threatened by other patients or visitors during their hospital stay, a fall from the 4% who answered yes to this question in 2008, 2009 and 2010.

Figure 25:
Proportion of NHS services meeting standards on safety and safeguarding, 2011/12



Source: CQC

NHS general hospital,

Inspection report March 2011

Example of
Good and bad practice

"The trust undertakes regular internal reviews to ensure that child protection resources meet the increasing demand. As a result of a recent review of its child protection staffing, the trust appointed an additional half-time child protection specialist nurse to the child protection team. The trust undertakes child protection and safeguarding training which is mandatory for all staff, and provides access to multi-agency and forensic courses where required.

"The number of child protection/safeguarding referrals has increased since this training became mandatory. The trust has also taken a lead in running regional multi-agency study days for senior medical and nursing staff, police and social workers.

Staff we spoke to understood that safeguarding refers to protecting vulnerable adults and children, and could list the different types of abuse. Staff were aware of their responsibilities, and knew what they would report and to whom. There is a safeguarding vulnerable adults alert process in place. Staff in Accident and Emergency and on the wards gave us examples where signs of abuse had been identified in adults and children on admission to hospital, and patients had been referred to Social Services appropriately. Staff did not mention examples of abuse which had occurred in hospital.

We asked staff what they would do if there was an allegation that a vulnerable adult had been abused by hospital staff. This could include neglect or a severe pressure ulcer which developed in hospital. Most staff showed no awareness that abuse by hospital staff could happen, or that these incidents should be reported as safeguarding alerts. We spoke to a matron who said the issue would be reported and investigated.

The trust is required to report allegations of abuse against the trust to the Care Quality Commission without delay (this is done through the National Patient Safety Agency). Trust staff were not clear that this should be done as soon as a safeguarding alert is raised, although the investigation may subsequently find the allegation to be unsubstantiated.

We judged that the hospital had effective processes for identifying and responding to signs of abuse in children and vulnerable adults at the point of admission, and staff have had training and know how to respond to this. However there was low staff awareness of recognising abuse which may have occurred to vulnerable adults in hospital, and of the action to be taken. We found that overall it was meeting this outcome but that there were some areas of concern where improvements needed to be made."

NHS mental health, learning disability and substance misuse services performed less well than other NHS services in 2011/12 – of those CQC inspected, 86% met the standard (224 inspections).

In its review of services for people with learning disabilities carried out in 2011/12, CQC looked at safeguarding issues at 68 NHS, 45 independent healthcare and 32 adult social care services. The main findings in respect of NHS services were:

- NHS providers had the highest proportion of locations meeting the standard (79%) compared to adult social care (59%) and independent health care (51%).
- The NHS services had the lowest levels of major concerns (2%, compared with 11% for independent healthcare services and 12% for adult social care services).
- The main concerns in relation to safeguarding, across all care settings, related to the use of restraint (25%), meaning that restraint was not recorded and monitored appropriately. Incidents that involved restraint were not reviewed systematically and there was no approach to learning lessons from them.

It is worth noting that in the review, while the proportion of assessment and treatment services

(both NHS and independent) that met both standards was 52%, there were more people using the non-compliant services (58%) than were using the compliant ones.

Similarly, while the proportion of secure units (both NHS and independent) that met both standards in the review was 57%, only 54% of people were living in these services. This is something that commissioners should take note of.

Learning from CQC action:

Cross-organisation learning at Cheshire and Wirral Partnership NHS Foundation Trust

This trust had three inspections as part of our themed inspection programme looking at services for people with a learning disability.

The first two, to Kent House and Greenways had major and moderate concerns and were inspected in September and October 2011 respectively. An inspection to a third location the Mary Dendy Unit in January 2012 showed they had implemented changes as a result of the other two inspections, therefore demonstrating good learning across the organisation.

Following the Greenways and Kent House inspections, the trust commissioned two independent reports. The independent report concerning Greenways related specifically to a particular person's needs and care that was raised at the inspection. The trust fully implemented the recommendations from this report, resulting in considerable improvement for that person.

The trust updated its policy on restraint and retrained all staff in appropriate ways of dealing with aggression and violence. Our inspectors have followed up the wider issues with the trust through two quarterly liaison meetings. As a result the trust has overhauled and improved its policy and approach to people with learning disabilities, with an emphasis on maximising learning from the inspection. It has been explicitly appreciative of CQC's role in enabling this to happen.

Cleanliness and hygiene

Providers must ensure that they have good procedures for cleanliness and infection control, and that people are protected from the risk of acquiring healthcare-associated infections (HCAIs) – infections acquired while people are receiving health care in hospitals, clinics or other settings. All providers registered with CQC must follow the Department of Health's *Code of Practice for health and adult social care on the prevention and control of infections and related guidance*.[27]

CQC's inspections found that, in 2011/12, 91% of NHS hospitals (165 inspections), 90% of community healthcare services (108 inspections), and 96% of mental health, learning disability and substance misuse services (75 inspections) met the standard on cleanliness and infection control.

A number of factors can increase the risk of acquiring a HCAI, but high standards of infection control minimise the risk. The most well-known HCAIs are meticillin-resistant *Staphylococcus aureus* (MRSA) and *Clostridium difficile (C. difficile)*. Cases of these rose dramatically in the 1990s, but have declined in recent years. Overall, the NHS continues to make good progress in tackling these infections.

Between April 2011 and March 2012 there were 1,114 reported cases of MRSA bacteraemia across the NHS. This represents a 25% reduction compared to 2010/11 (1,481 cases), and a 62% reduction on the number of cases reported in 2008/09 (2,935).[28]

There were 18,005 cases of *C. difficile* infection in the NHS reported between April 2011 and March 2012. This represents a 17% reduction compared to 2010/11 (21,707 cases) and 50% reduction compared to 2008/09 (36,095 cases).[29]

Well over half the cases of MRSA (58%) and *C. difficile* infection (57%) in 2011/12 were not attributable to the hospital where the patient was admitted.[30] Instead, the patient may have already had the infection when they entered hospital, or been transferred from another health care facility when the infection was first diagnosed.

The NHS inpatient survey asked a number of questions relating to cleanliness and hygiene, and the findings show there have been year-on-year improvements in patients' perceptions of hospital cleanliness since 2007. In 2011, over two-thirds (67%) of inpatients said their hospital room or ward was "very clean", an improvement from 53% in 2007, 60% in 2008, 64% in 2009 and 66% in 2010 (figure 26).

Management of medicines

As CQC reported in its first Market Report in June 2012, the management of medicines was the single most common reason for providers across the care sectors to fail to meet all the essential standards.

The standard says that providers should make appropriate arrangements for obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines. They should follow published guidance about using medicines safely. They should ensure that people have their medicines at the times they need them and in a safe way, and wherever possible have information about the medicines prescribed for them.

In 2011/12, 79% of NHS hospitals (150 inspections), 76% of NHS community healthcare services (121 inspections) and 83% of NHS mental health, learning disability and substance misuse services (76 inspections) met the standard when CQC inspected against it. However, note that CQC's risk-based approach means that it carried out many of these inspections in direct response to concerns it had about services – and therefore the figures may over-emphasise poor performance against this standard.

Common problems reported by CQC's inspectors related to the following.

- Arrangements for people to look after their own medicines: although services are usually able to show that they have a policy and procedure available to support this, this is often not translated into practice – for example people taking medicines when the staff supporting them are not aware that they are prescribed that medicine.
- Incomplete records of medicine administration: which also links to times when medicines are not available to be administered – either when a supply of the medicine has run out and not been replaced, or when an acute prescription is written and then supplies are not sought in a timely manner. Sometimes medicines are prescribed that that are not part of the usual medicine stock – without good planning, the supply can frequently run out at weekends when it is harder to restock.
- Inappropriate storage facilities: this may relate to either the lack of suitable arrangements to keep medicines secure, or the lack of provision to store medicines within the correct temperature range.

Figure 26: Inpatients' perceptions of cleanliness of hospitals and wards, 2002-2011

Source: CQC from NHS patient surveys

Staffing

The increasing pressure on NHS services from an increasing and ageing population – particularly caring for older people and people with dementia – has a direct impact on staffing levels, and whether providers are able to deliver dignified and respectful care with the resources they have.

When CQC inspects, it looks at whether there are enough staff in place, how they are supported to carry out their role, and whether the training they receive is sufficient and effective. It also examines whether the right checks have been made by employers when recruiting staff.

Most of the NHS services that CQC inspected met the standard on 'requirements relating to workers', which means that staff were recruited effectively and checks were carried out to make sure they were appropriately qualified and fit to do their jobs. Of the NHS hospital-based services and community healthcare services inspected in 2011/12, 97% and 95% respectively met the standard (86 and 56 inspections respectively) (figure 27). The performance of NHS mental health, learning disability and substance misuse services was less positive, however, at 89% (71 inspections).

This reflects the common framework for recruitment within the NHS, and the robust processes that NHS employers must go through.

On the other hand, CQC has seen a number of NHS services struggle with the requirements to have enough qualified and experienced staff on duty at all times and to make sure that staff are properly trained, supervised and appraised while on the job, and that they have opportunities for professional development.

In 2011/12, 84% of NHS hospitals (250 inspections) and 87% of NHS community healthcare services (167 inspections) met the standard on staffing levels when CQC inspected against it. For the standard on supporting staff, the corresponding figures were 85% and 86% (247 and 188 inspections respectively).

As CQC commented in its June 2012 Market Report, staffing emerges as a key driving factor in many instances where NHS services fail to meet all the standards. The non-availability of temporary staff and vacancies in qualified staff often led to compromises around the care and welfare of people using services and support for staff, including training and supervision. Often staff are being asked to do too many different roles at once.

Sometimes, formal staffing assessments had not been undertaken or, where they had, they had not been implemented. Continuity of care was also affected, leading to a poorer patient experience.

It is unsurprising that pressures on numbers of staff have a knock-on effect on the ability of organisations to train, support and supervise their staff effectively. This is compounded in community health care where the workforce is more dispersed.

Looking at the 2011 NHS inpatient survey, participants were asked whether, in their opinion, there were enough nurses on duty to care for them in hospital. In the survey 58% said there were "always" or "nearly always" enough nurses (down from 60% in 2010) and 31% said there were "sometimes" enough nurses (up slightly from 30% in 2010). Eleven per cent said that in their opinion there were "rarely" or "never enough" nurses, a slight increase from 2010 (10%).

NHS hospital

Inspection report January 2012

Example of
Poor practice

"All staff receive annual appraisals but there was a lack of an ongoing supervision system in place.

"Most of the staff we spoke to said they did not receive supervision. Only one nursing sister [of those we spoke to] said she did receive a weekly supervision meeting with her manager. This means that some staff may not feel adequately supported within their roles. The hospital said that clinical supervision is available to staff if requested or deemed required following annual individual performance review. They also said that staff are able to meet their managers for one to one support. However, there does not seem to be a recognised system, throughout the hospital, of regular ongoing supervision."

East of England Ambulance Service NHS Trust HQ

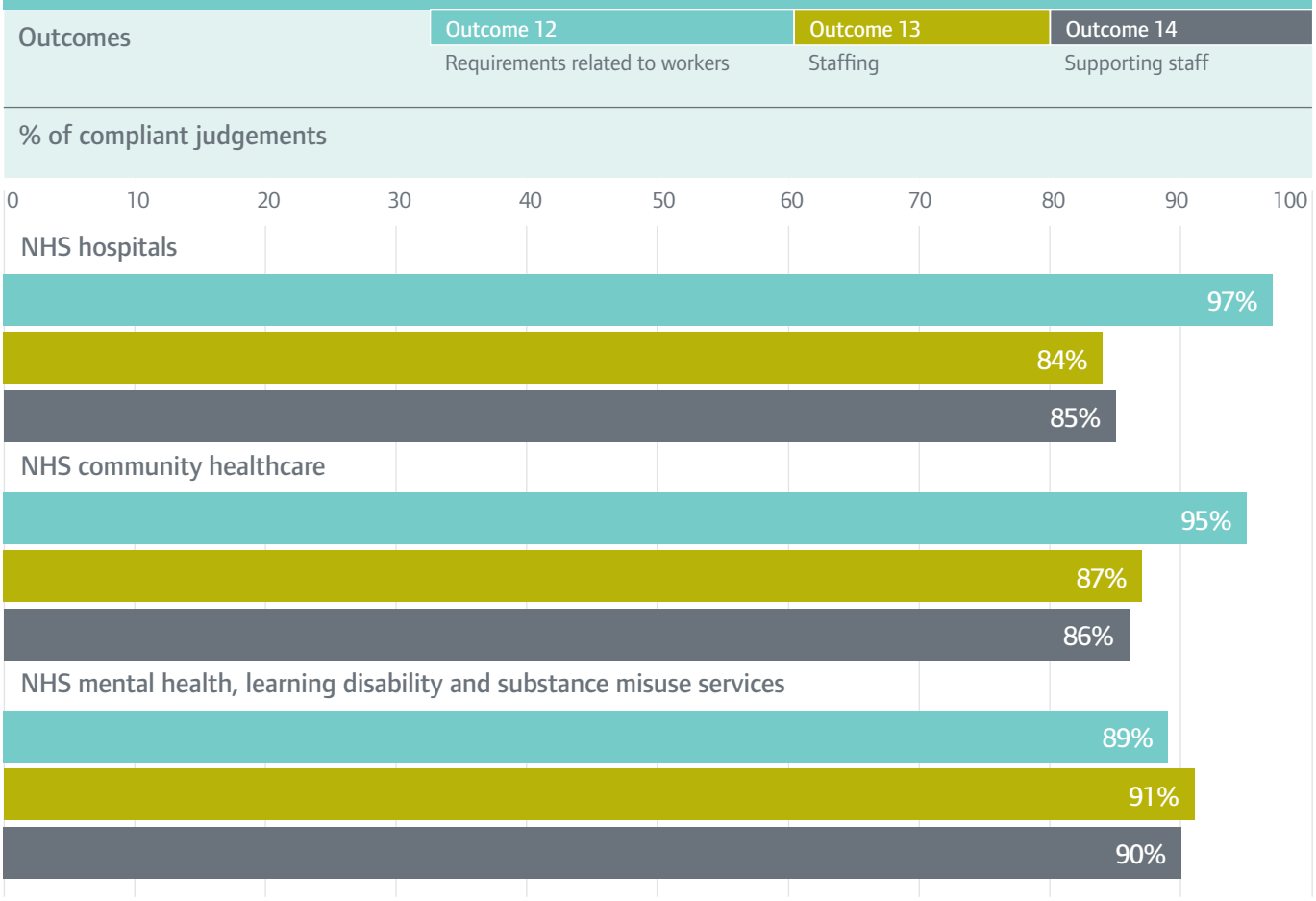
Inspection report May 2012 (inspected March 2012)

Example of
Good practice

"The personnel files for a range of the 20 most recently recruited staff contained good evidence that staff had been recruited safely."

"Appropriate references and CRB (criminal records bureau) checks had been obtained, and occupational health assessments had been undertaken, before staff had commenced their employment. In addition, the files contained clear and detailed job descriptions and signed employment contracts for staff. Every month a sample of recruitment check lists had been audited by the trust to ensure that their recruitment procedures were robust. We viewed records that showed that staff members' CRBs were regularly checked. The trust monitored staff's professional registrations and conducted monthly audits to ensure all staff had been registered with their relevant professional body."

Figure 27:
Proportion of NHS services meeting standards on staffing, 2011/12



Source: CQC

The pressures on staff are highlighted in the 2011 NHS staff survey, in which 30% of respondents said that there were enough staff in their organisation for them to do their job properly, down from 32% in 2010. [31]

In terms of ongoing support for staff and their ongoing training and supervision, the NHS staff survey encouragingly reported a rise in the percentage of staff who had had an appraisal, from 77% in 2010 to 80% in 2011. However, only 35% of all staff felt that their review was "well structured" in that it improved how they worked and set clear objectives.

Problems in relation to the standards on staffing levels and supporting staff were not as prevalent in NHS mental health, learning disability and substance misuse services in 2011/12. In that year, 91% of the services CQC inspected met the staffing standard (127 inspections) and 90% met the supporting staff standard (146 inspections). In the NHS staff survey, mental health staff had one of the highest appraisal rates (82% of staff said they had had one) and the highest proportion who felt their review was well-structured (39%).

Managing quality

Providers need to constantly monitor and check the quality of the services they are providing, to make sure that they continue to meet the essential standards and that people have a good experience of care.

The main standards that CQC inspects against relating to quality and management are: assessing and monitoring the quality of service provision; complaints handling; and record keeping.

Complaints in the NHS

Complaints are an important way for people to express concerns if something goes wrong or they are unhappy with the treatment and care received. For providers of health and social care, complaints should provide opportunities to respond to the concerns of individuals and their families, but also to identify and address more systemic problems.

In England, health and social care providers are legally responsible for investigating complaints about

Ipswich Hospital, Ipswich Hospital NHS Trust

Inspection report August 2012

Example of **Good practice**

"There was evidence that learning from incidents or investigations took place and appropriate changes were implemented. For example the hospital was not meeting the 18 week general surgery waiting time. Remedial action plans were put in place which had been agreed by Suffolk PCT. They planned not to exceed the waiting time by the end of August 2012.

Decisions about care and treatment were made by the appropriate staff at the appropriate level. During our visit to the service we spoke with the head of midwifery, who confirmed that the monitoring of maternity service had been heightened. The perinatal review was completed in November 2011. There was a detailed action plan and they told us that good progress was being made towards completing the plan. The increased monitoring included a clinical audit programme for the year, risk issues discussed at board level, an improved communication process throughout the maternity service, visible managers and supervision for all practitioners.

The wards we visited all held monthly ward meetings where staff could raise topics and hear about lessons learned, developments on the ward and in the service as a whole.

One ward had also piloted a series of 'Patient Workshops', involving staff putting themselves in the shoes of people using the service to see how their experience in the ward could be improved.

One ward had audited the time it took for the lunch to be served, in order to make sure there was no undue delay in people getting their meal. The ward had also given out questionnaires to people, and relatives for their views. These were displayed on the ward for all to see. This ward had been awarded the trophy for Team of the Year 2012."

their service. If the complainant is not satisfied with the response they get, they are able to go to the Parliamentary and Health Service Ombudsman or the Local Government Ombudsman. In the case of a safeguarding incident, the complainant should go to the Police or the Local Authority. These organisations are the relevant authorities with the legal responsibility for investigating and resolving complaints. CQC does not have this responsibility to resolve complaints.

In discussions with the public and stakeholders, it has emerged that there is frustration at the current system of complaints handling, and they have requested a clear explanation of our role. CQC agrees and is undertaking work with the Department of Health to explore how to resolve the confusion about the overall system of managing complaints.

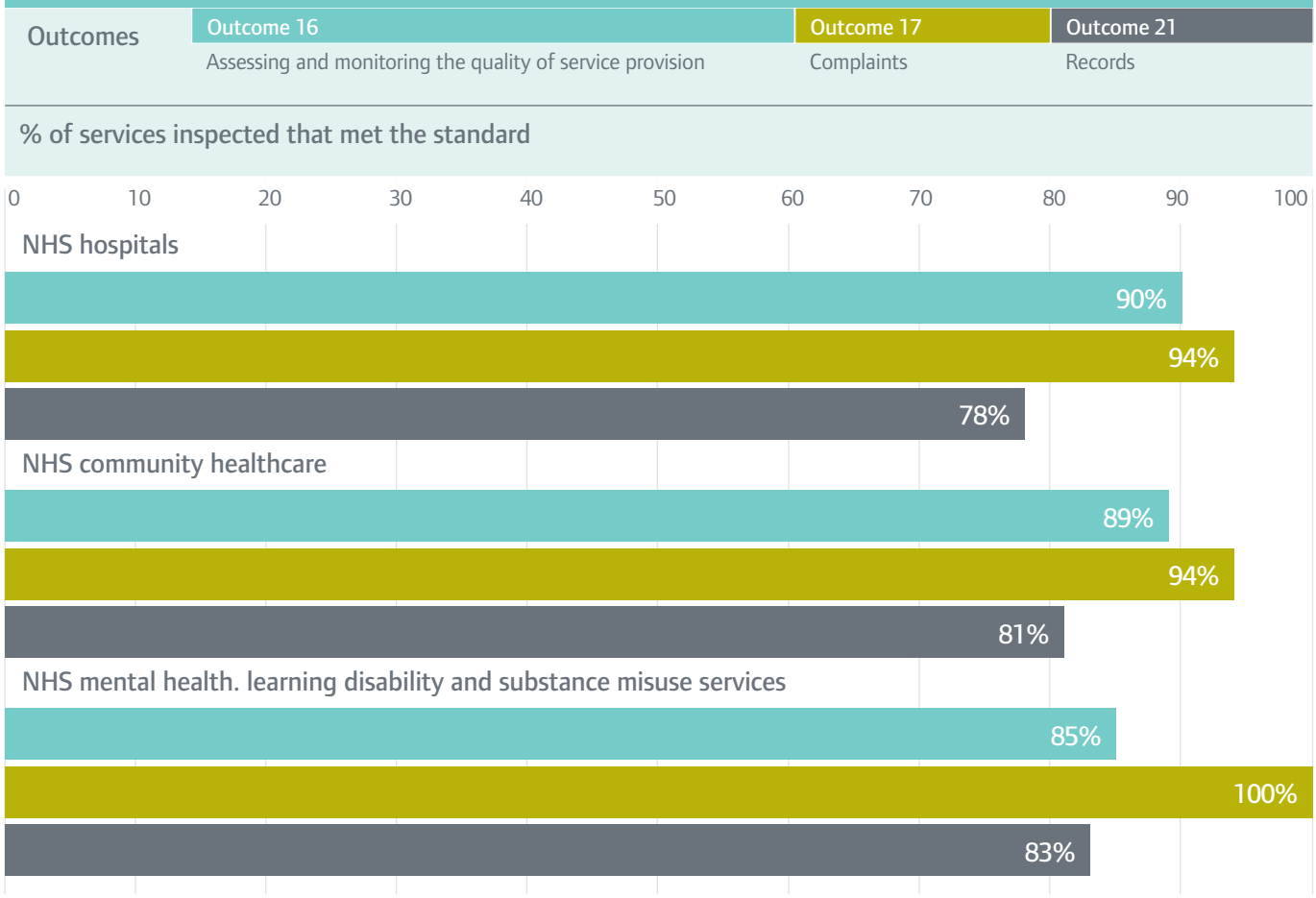
We continue to do two important things when we are made aware of complaints. When we receive complaints about a particular service we first ensure that the complainant is fully briefed on the appropriate procedure for pursuing their individual complaint against that provider. Secondly, we obtain as much information as we can from the complainant to help us judge the quality of care being provided, and whether we should consider the need to take action against the provider concerned.

The number of complaints a provider receives is not necessarily an indication of poor care; it could also reflect an organisational culture that encourages complaints – making it easy for people to complain – and then uses the information to improve.

The Information Centre for Health and Social Care publishes annual statistics on complaints in the NHS.[32] There were 162,129 NHS written complaints in England in 2011/12, an increase of 8.3% on the previous year. However, some foundation trusts did not have to submit data in the earlier year. For organisations that provided data in both years, the increase was 1.3%.

There were 107,259 written complaints about NHS hospital and community health services in England,

Figure 28:
Proportion of NHS services meeting standards on managing quality, 2011/12



Source: CQC

an increase of 8.3% taking into account all data. However for organisations that provided data in both years, there was a decrease of 2.3%.

Analysed by service area, the greatest number of complaints in 2011/12 related to inpatient hospital services (31%), followed by outpatient services (27%), mental health services (10%), other community health services (6%) and A&E hospital services (9%).

The highest number of complaints (46%, compared with 44% in 2010/11) related to "all aspects of clinical treatment" followed by "attitude of staff' (12%, unchanged since the previous year). Ten per cent were about "communication/information to patients (written and oral)" (unchanged since the previous year) and 8% about "delay/cancellation of outpatient appointments" (9% in 2010/11).

Providers should have effective systems in place for identifying, receiving, handling and responding appropriately to complaints and comments. They should make people who use their services, and those acting on their behalf, aware of their complaints system, and give support to people to use it where necessary. People should know that they will not be discriminated against for making a complaint.

In the locations CQC inspected in 2011/12, 94% of both NHS hospitals and community healthcare services met the standard on complaints handling (114 and 78 inspections respectively), and 100% of the NHS mental health, learning disability and substance misuse services inspected met it (66 inspections) (figure 28).

The Parliamentary and Health Service Ombudsman noted a significant rise in 2011/12 in the number of complaints where the NHS had failed to provide an adequate remedy or proper apology. Overall they received 16,337 complaints from the public wanting to complain about the NHS or NHS-funded services, an 8% increase on the previous year.[33]

Monitoring the quality of care being provided

Providers must have in place effective quality monitoring and risk management systems. This requires them to have good governance arrangements. They must also regularly seek the views and experiences of people who use their services and others acting on their behalf, and of staff, to inform providers' views on standards of care. Providers should take account of comments and complaints, investigations into poor practice or untoward incidents, CQC reports and other relevant external reports and reviews.

This standard is one of the ones that CQC checks most frequently on inspections. It can be a good indicator of the quality of the care being provided overall and will sometimes help inspectors to look in more detail at other standards.

In its NHS inspections in 2011/12, CQC found that performance was mixed. Ninety per cent of NHS hospitals (258 inspections), 89% of NHS community

Whiston Hospital, St Helens and Knowsley Teaching Hospitals NHS Trust,

Inspection report November 2011

Example of
Good practice

Example of good learning from public feedback

"We received several concerns from the public stating that their complaints had not been dealt with appropriately or with a result that satisfied them. In general they told us that the service was 'defensive', 'gave little information' and was 'unwilling to fully communicate with us'.

We also looked at information we held that indicated that not all concerns were being appropriately reported to CQC or addressed in an appropriate manner. Management in the hospital agreed with this, stating that they had identified in early April that complaints were not being appropriately addressed. The system that they had in place at the time was giving misleading information and at an initial glance it looked as though complaints were being addressed rapidly. Once it was identified by the management team that several complaints had remained unresolved for considerable time, a priority was made to contact those whose complaint was outstanding and address this as a matter of urgency. We saw records that showed some complaints had remained unexplored earlier this year for over two months.

A computer system was put into place that gave all staff the opportunity to log any concerns or incidents. The management team had identified a number of areas that needed to be further developed, including better communication with people using the service and a better attitude from staff when concerns were raised. We spoke to staff on the wards who told us that they had been training in using this system and felt it captured information easily.

We were shown how the system can monitor the progress of any concerns and this allows management to question the relevant people if complaints are not rapidly responded to. We saw information that showed very few complaints remained unacknowledged after 25 days and where an extensive investigation was needed the complainant had been contacted to discuss this.

The complaints team spoke with passion and gave us information about their own personal experience of raising concerns over care of loved ones. It was evident that they intended to significantly improve the previous approach and to use the monitoring of complaints to improve practice. A number of areas of training had been identified and staff in all areas were being supported to actively seek feedback both positive and negative regarding their experience in the service."

healthcare services (193 inspections) and 85% of NHS mental health, learning disability and substance misuse services (169 inspections) met the standard in 2011/12. While CQC's inspectors have seen much good practice in this area (see example below), problems with this standard can often indicate problems elsewhere in the service and undermine providers' ability to assure themselves of the quality of care they are delivering.

Record-keeping

Providers must maintain an accurate, confidential and fit-for-purpose record for each person using their services, including information about the individual's care and treatment. Records should be kept securely, and located promptly when required.

Across NHS services, this was the poorest area of performance out of the standards dealing with quality management. CQC found that, of the services inspected in 2011/12, 78% of NHS hospitals (153 inspections), 81% of NHS community healthcare services (111 inspections) and 83% of NHS mental health, learning disability and substance misuse services (95 inspections) met the standard on records and record-keeping.

It is common for failings in other standards to be repeated for this standard, as a problem elsewhere is likely to be reflected in the quality of records. CQC's inspectors also report that poor record-keeping can be an early sign of strains on an organisation's ability to perform – for instance, as a consequence of a shortage of staff and the resulting lack of time they have to complete all their tasks.

Special focus: NHS hospital discharge arrangements

Going into and coming out of hospital can be an uncertain and sometimes emotional experience for people and their families or friends. Key to effective hospital discharges (that is, those that are timely and appropriate) is effective joint working both across the NHS and between agencies and genuine involvement of patients and carers.

There can be a number of different problems concerning hospital discharge, including discharges that occur too soon, are delayed, are poorly managed from the patient/carer perspective, or are to unsafe environments.

In 2011, CQC carried out a thematic review, looking at the data it held to check where hospital discharge arrangements were affecting patients' experiences and putting patients at risk. In particular, it examined data on delayed transfers of care and hospital emergency readmissions.

Of those trusts that were not meeting at least one essential standard in 2011/12 due to issues with discharge arrangements, the most common concerns related to insufficient discharge planning, incomplete discharge plans, poor communication with patients or carers, and patients having to wait for medicines.

The following case study typifies the kinds of problems found regarding discharge arrangements.

> A number of different problems can affect hospital discharge – they occur too soon, are delayed, are poorly managed, or are to unsafe environments.

Case study: Hospital discharge

In February 2011 CQC took the decision to inspect an NHS trust prior to its merger with community services transferred from the PCT. This was to establish a baseline of its performance against the essential standards.

Inspectors visited the trust's two main acute hospitals in addition to three smaller community services. The visit highlighted shortfalls in a number of the essential standards. Among these was the recording of discharge planning. There was also an indication that successive moves of patients within hospital were leading to delays in discharge decisions. CQC issued the trust with a warning notice. The trust acknowledged these problems and provided an action plan of how they intended to improve discharge planning.

At a subsequent visit in September 2011, CQC noted improvements to the overall delivery of patient care – this included discharge planning. The trust had implemented spot checks and weekly audits of patient records, but CQC found that the improvements were variable across different wards, and further work was needed to improve consistency.

It was agreed that the trust would continue to embed improvements and CQC's inspectors would visit again in early 2012.

In November 2011, the local LINk carried out its own review of 'leaving hospital for patients' using both acute hospitals and community hospitals run by the trust. They concluded that discharge arrangements were better planned and managed within the community hospitals. They highlighted a number of areas for improvement including consistency in documentation, improved communication between wards and other services such as pharmacy, transport and social services input that often impact on discharge dates. They also recommended a review of the discharge policy to better reflect the arrangement within community hospitals. They suggested that patients' feedback upon discharge should be captured to inform improvements to the service.

In the thematic review of hospital discharge arrangements, the trust scored 'about the same as expected' when compared to national average figures for inpatient survey information. Similarly data indicated that delayed transfers, although slightly above average, were about the same as the national average.

However, more detailed and current information available to us for January to March 2012 seemed to indicate a mixed picture with regard to delayed transfers. This appeared to be as a result of factors attributable to both the trust and local social care services.

In April 2012, CQC inspected both acute hospitals again and found the discharge planning process much improved. Staff said that they discussed discharge arrangements at weekly multidisciplinary meetings. CQC's inspectors noted that the arrangements for discharge planning were not always recorded in the same place in the patient notes for easy reference. CQC highlighted this to the trust; along with the observation that there was no one single record that pulled together all the relevant arrangements around discharge. The trust said that they were piloting a 'holistic record of needs' prior to discharge and that they hoped to roll this out across the trust once its effectiveness had been assessed.

2,000

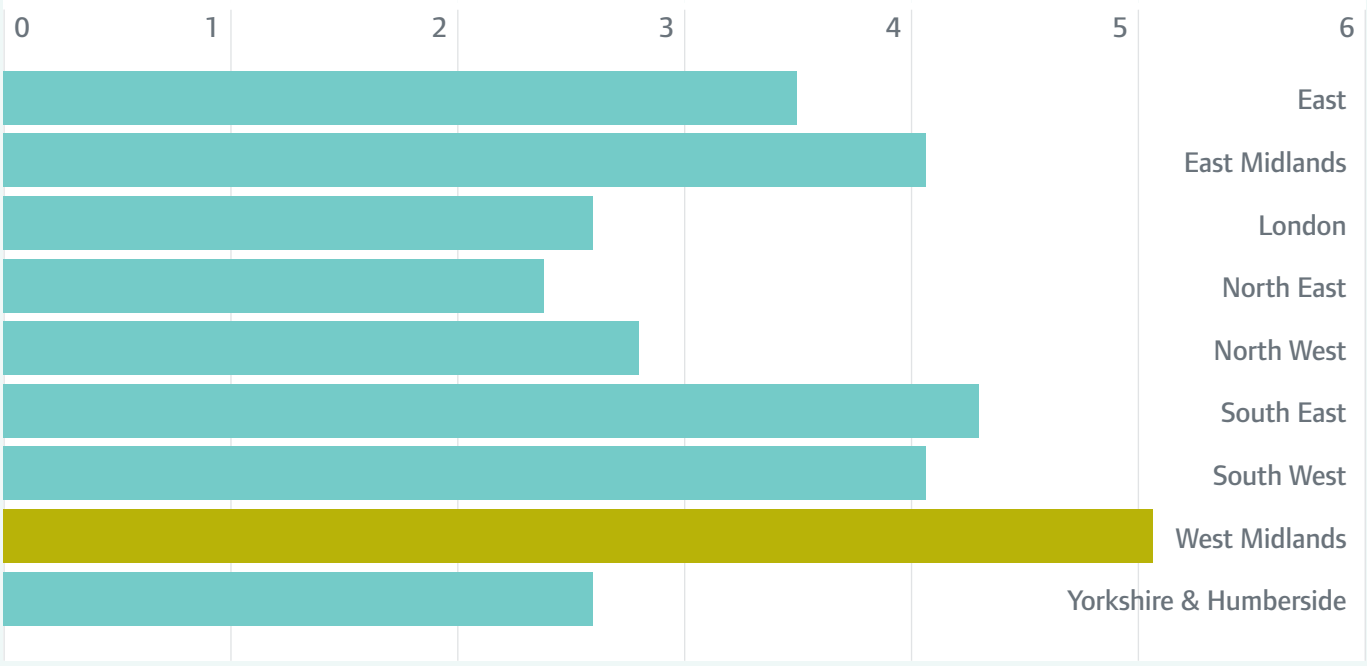
Acute NHS patients on any given Thursday evening whose discharge from hospital is delayed

Delayed transfers of care

Reducing delayed transfers of care continues to be a significant challenge for the health and social care sector. On any given Thursday evening, there are approximately 2,000 acute NHS patients and 1,500 non-acute NHS patients reported with delayed discharge. The total numbers of delayed days reported each month remains consistently above 100,000. There are many reasons why discharges may be delayed and there is variation between and within regions.

The causes of these problems are diverse and may be due to internal hospital arrangements, coordination between health and social care providers, capacity or resource issues, lack of communication with

Figure 29: Regional comparison of the proportion of delayed discharges between April-Dec 2011



Source: CQC

out-of-area social care providers or simply a lack of patient/carer involvement when making decisions around discharge planning.

Of those patients who said in the 2011 NHS inpatient survey that their discharge was delayed, most had to wait more than an hour; nearly a quarter said they had to wait four hours or more:

- 0 -1 hour, 16%
- 1 - 2 hours, 28%
- 2 - 4 hours, 33%
- 4 hours or more, 23%

In the survey, patients said that the main reasons for the delays were:

- Waiting for medicines - 60%
- Waiting for doctors - 15%
- Waiting for an ambulance - 10%
- Something else - 14%

In terms of the organisation responsible for all reported delayed discharges, the figures for April to December 2011 show that the NHS was the biggest contributor nationally in that period:

- NHS - 62%
- Social care - 31%
- Both - 7%

Analysing by region, the West Midlands had the highest proportion of delayed discharges, compared to the relatively lower proportions observed in London and the northern regions (see figure 29).

Emergency readmissions

If discharge arrangements and planning for discharge are not sufficient, there is an increased risk of emergency readmission to hospital. The national average for emergency readmissions within 0-7 days of discharge that required at least an overnight stay was 2.5%, but this increased to 3.8% for emergency readmissions within 8-30 days that required at least

an overnight stay (where external factors are more likely to contribute to the readmission).

Analysing by region, the three northern regions performed relatively poorly on both emergency readmission indicators, which is in contrast to their performance on the delayed discharges measure (see figure 30).

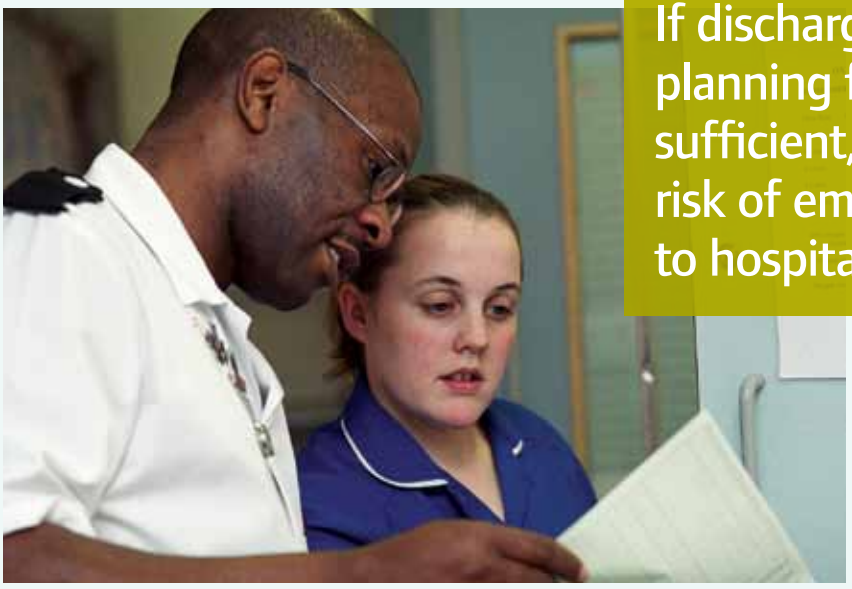
Published research has indicated that patients admitted as an emergency at weekends have a higher risk of death, reflecting potentially different levels of service provision on particular days. In a similar fashion, emergency readmission rates are higher for patients discharged during weekends (see figure 31).

While the number of patients discharged over the weekend is much reduced compared to weekday figures, an analysis of national data shows that those patients discharged over the weekend are at significantly higher risk of readmitting as an emergency (even after adjusting for any differences in patient case-mix). This again illustrates potentially different levels of service provision over the weekend, either in the hospital setting or the available community services, or both. While the trend is observed in a large number of trusts across the country, there are examples of a number of trusts that are able to maintain their emergency readmission rates throughout the whole week and avoid an increase in patients discharged over the course of the weekend.

Analysis of national data shows that patients with higher risk of emergency readmission (for example, older people, patients with complex conditions and/or co-morbidities) are generally discharged proportionately less over the weekend.

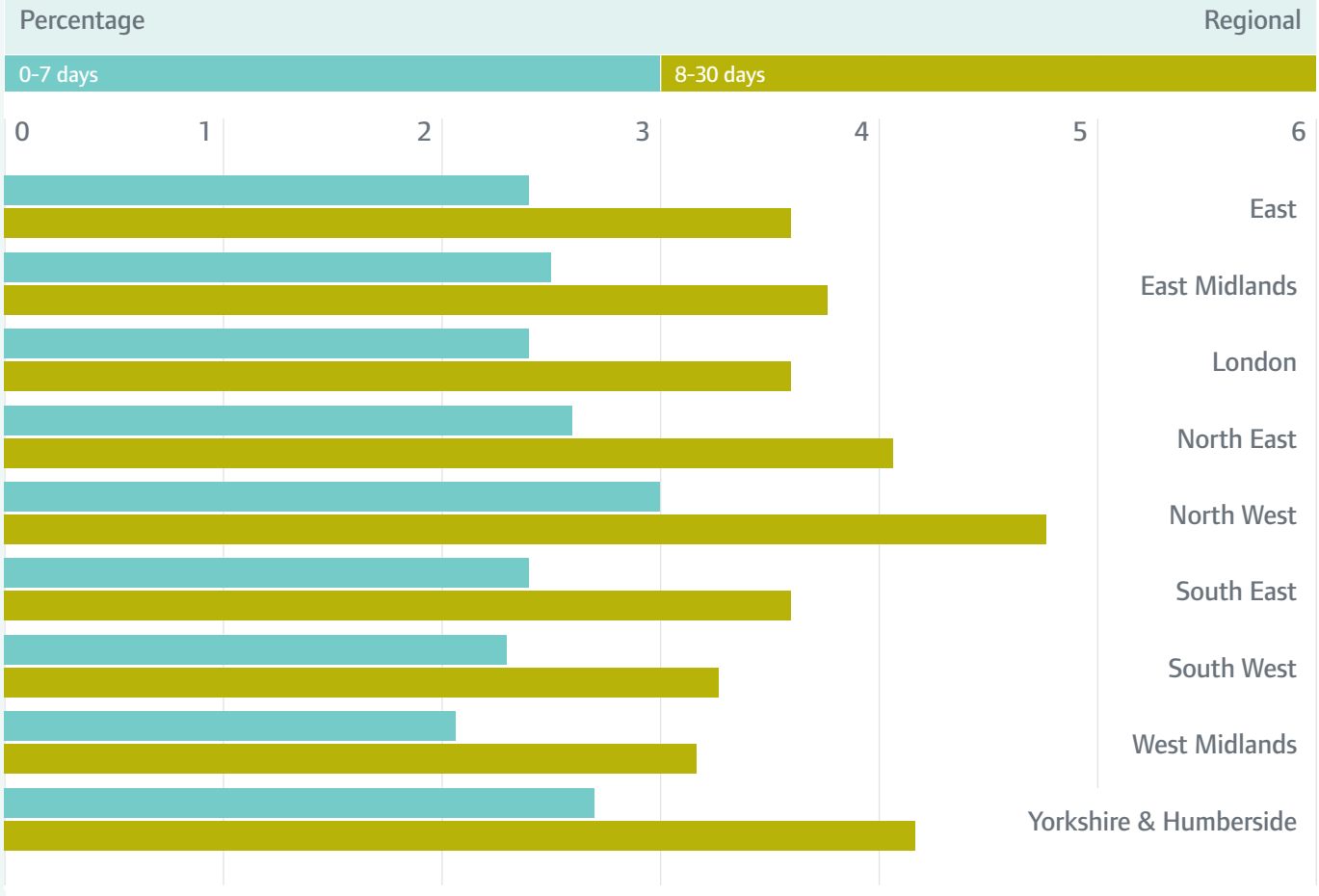
However, there are certain groups of people at higher risk of emergency readmission that are more likely to be discharged over the weekend (where the risk of emergency readmission is potentially higher). This includes new mothers and young babies, as well as those patients who discharge themselves. While weekend discharge might be expected more for these people, consideration needs to be given to whether it carries an increased risk of emergency readmission.

This issue adds to the debate about the NHS moving in future to a seven-day working pattern for essential hospital services.



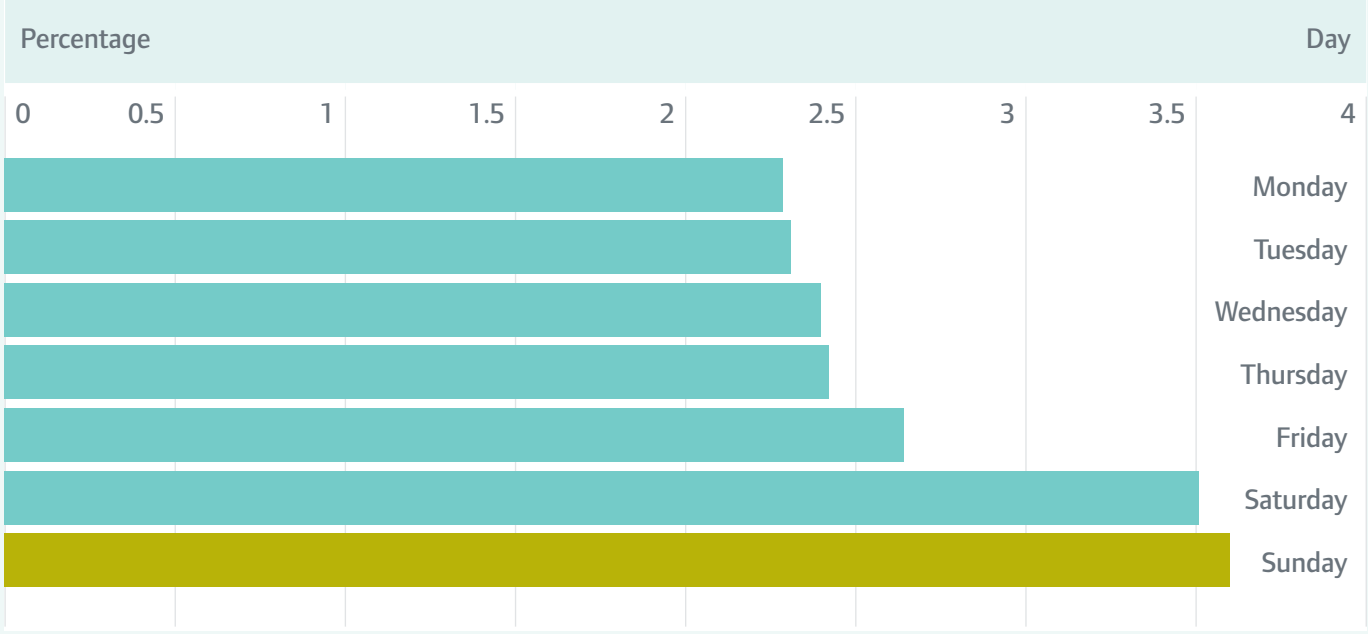
> If discharge arrangements and planning for discharge are not sufficient, there is an increased risk of emergency readmission to hospital.

Figure 30: Regional comparison of emergency readmissions within 0-7 days and 8-30 days (that required at least an overnight stay) between April-November 2011



Source: CQC

Figure 31: Emergency readmission within 0-7 days (that require at least an overnight stay) by day of the week patients were discharged on



Source: CQC

Independent health care

The independent healthcare sector provides a wide variety of services across a whole range of interventions and packages of care, from specialised surgical procedures in acute settings to care for people with learning disabilities and mental health problems.

The main changes affecting the independent sector in recent years have been economic and political, rather than demographic. The sector was negatively affected by the economic downturn in 2008, but by 2011 many independent providers were reporting an increase in business.

Acute medical hospitals make up the largest part of the independent healthcare sector, and were valued collectively at £6.3 billion in 2011. Although major hospital groups and London private hospitals dominate, market analysts Laing and Buisson note that "there is also a burgeoning cache of smaller players (including day clinics and private medical surgeries) which are supplying acute medical services away from fully fledged hospital settings".[34]

The NHS is a significant purchaser of independent health care. The current health reforms are likely to see both for-profit and not-for-profit independent providers increasingly competing to win tenders and be commissioned to provide NHS-funded services. The policy drive to see more care provided 'closer to home' in community settings may see growth in both private and voluntary sector provision of community-based health services, and we will monitor this going forward.

We may see further development of independent providers partnering with foundation trusts to create new services and more private patient units (PPUs), and getting involved in running large-scale acute services in areas where NHS trusts are placed in administration under the NHS failure regime.

85%

Proportion of mental health and learning disability services that met the standard on respecting and involving people

The independent sector has been involved for many years in delivering NHS-funded services; however, the degree to which this will increase in light of current health reforms, and the scale and pace of any such expansion, remains highly uncertain.[35]

Independent services play a particularly prominent role in providing care for people with mental health problems and people with a learning disability.

CQC's focus on ensuring people are treated with dignity and respect means that it has paid particular attention to how these services are performing and which areas need to improve. CQC's key findings are as follows.

Key findings in independent health care

- Independent hospitals and community services performed well in treating people with dignity and respect: 98% and 96% respectively met the standard in 2011/12 (365 and 380 inspections respectively).
- However, the performance of mental health, learning disability and substance misuse services was less positive: 85% met the standard (148 inspections). A recurring issue was a lack of patients' involvement in their care plans, and not always having the opportunity to express their views about how they would like their care delivered.
- In CQC's learning disability review, 49% of the 45 independent services inspected were meeting the general standard on ensuring people's care and welfare, compared with 71% of NHS providers.
- Many people had been in assessment and treatment services for disproportionate periods of time, with no clear plans for discharge arrangements in place and too many people had been in services away from their families and homes. In too many cases care was not person-centred.
- In contrast to NHS services, independent hospitals and community services had good staffing levels. However, they struggled with the requirement to carry out checks on prospective employees – increasing the risk of poor care for patients.
- Mental health, learning disability and substance misuse services had problems in having adequate levels of staff – which clearly puts pressure on the ability of staff to deliver respectful and dignified care.

Care Sheffield

Inspection report Decemnber 2011

Example of
Good practice

"The service operated a patient survey and these indicated high degrees of satisfaction with the service.

Comments received included 'All aspects of treatment from start to finish always explained and easy to understand' and 'Very efficient method of scanning and blood taking. Easy to fit around work…'.

People were given a patient guide that described the service, an overview of in vitro fertilisation (IVF) funding, costs, selection criteria, counselling and support, legal parenthood, consent, explanations of stages of treatment and outcomes and the complaints procedure.

The consent procedure included ensuring patients understood the stages of treatment, the implications in terms of success rates and how lifestyle can affect outcomes and where applicable the costs involved.

The service provided a patient survey and we were shown the analysis for 2011 to date. There had been 226 questionnaires returned and people had commented on: arrival, administration services, procedures, facilities and environment, consultation, professional services and communication. The results were very positive, averaging 3.91 out of 4 in terms of how the service scored answers.

We were told of instances of comments in patient surveys being used to change or improve practice, such as organisation of blood taking and scans between 8.00am and 9.00am to help those with work commitments. The clinic considered comments about waiting to be seen and started using a nurse 'runner' to prioritise people into the correct area for their treatment.

The service provided information evenings for groups of people or one-to-one information sessions if people preferred."

"Independent hospitals and community services had good staffing levels

Dignity, respect and involving people

Independent hospitals performed well in respect of both standards in this area in 2011/12. Of those hospitals CQC inspected, 98% met the standard on respecting and involving people (365 inspections) and 98% met the standard on consent to care and treatment) (139 inspections) (figure 32). Independent community healthcare services performed equally well against the standard on respecting and involving people, with 96% of locations meeting it (380 inspections).

However, the performance of independent mental health, learning disability and substance misuse services against the standard on respecting and involving people was less positive, with 85% of services meeting the standard when CQC inspected against it (148 inspections). These services also struggled with the standard on consent to treatment, where 84% met the standard when inspected (67 inspections).

Given the nature of these services, this is clearly a cause for concern. A recurring issue was a lack of patients' involvement in their care plans, and not always having the opportunity to express their views about how they would like their care delivered.

Effective care, treatment and support

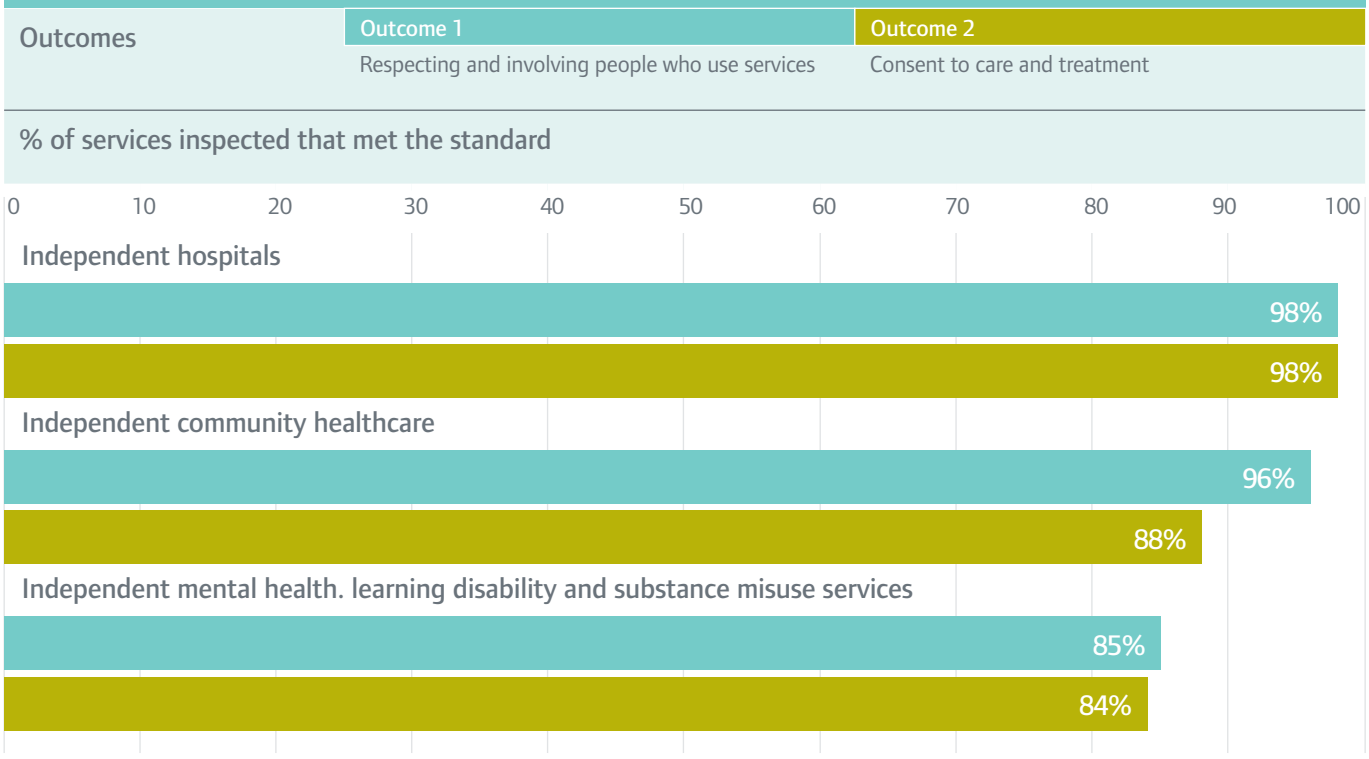
Providers are required to ensure that people experience effective, safe and appropriate care. Many of the issues that our inspectors find can result in a provider not meeting this standard.

Concerns in relation to this standard are apparent across all sectors, and in this regard independent hospitals and community services performed comparatively well when compared to other sectors. In hospital-based settings, 93% of services met the standard during the year (482 inspections) (figure 33). In community services, the figure was 88% (492 inspections).

However, CQC's inspectors found significant problems in independent mental health, learning disability and substance misuse services, with 69% of services meeting the standard in 2011/12 (224 inspections). This is clearly a huge concern given that these services care for many people who are vulnerable as a result of their circumstances.

CQC looked at this area in detail in the year, in respect of services for people with learning disabilities and challenging behaviours. It carried out unannounced inspections at 150 locations in England, consisting

Figure 32: Proportion of independent healthcare services meeting standards on respect and involvement, 2011/12



Source: CQC

of NHS, independent healthcare and adult social care services.

Overall, CQC found that, while there is a good deal of evidence available as to what constitutes good care, there remains a significant shortfall between policy and practice. Nearly half the locations CQC inspected were not meeting the essential standards that people should expect. In too many cases care was not person-centred: people were fitted into services rather than the service being designed and delivered around them.

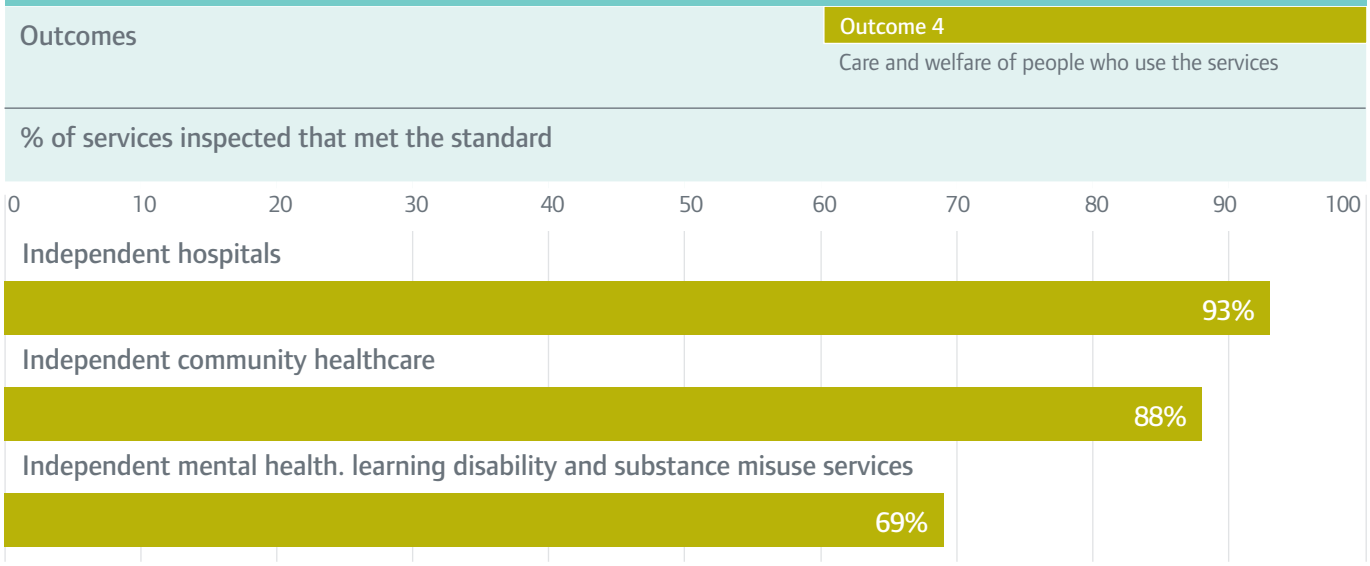
Many people had been in assessment and treatment services for disproportionate periods of time, with no clear plans for discharge arrangements in place and too many people were in services away from their families and homes. Overall, there remains much to be done to ensure that people with learning disabilities are not discriminated against and that expectations are raised about the type of services that can be commissioned and provided for people and their families.

The main concerns in respect of the standard relating to care and welfare of people, across all care settings, related to care planning: meaning that people and their families were not involved in the design of the care and therefore were not in control of their own needs. A lack of person-centred planning was a significant feature.

Specifically in relation to independent healthcare services:

- Assessment and treatment services and secure services run by the NHS were significantly less likely to have patients resident for longer than two and three years respectively (45% and 58%), compared to assessment and treatment and secure services run by independent healthcare providers (75% and 88%).
- 49% of the 45 independent services inspected were meeting the relevant standard, compared with 71% of NHS providers.

Figure 33: Proportion of independent healthcare services meeting standards on effective care, treatment ansd support, 2011/12



Source: CQC

Independent mental health hospital

Inspection report January 2012

Example of
Poor practice

Outcome 1: "There was little evidence in care plans of patients' own views and people had not been given copies of their own care plans. Patient survey results indicated that only 39% had a copy of their care plan; many said that their named nurse had not gone through their care plan with them, felt they did not have a say in their care plan and said that their care plans were not reviewed.

Detained patients we spoke to were not clear about what was required for them to be discharged from the hospital back into the community, or of their rights under the Mental Health Act, and people were not being given copies of their leave forms.

The hospital has an appointed independent advocacy service; however, the survey indicated that only 28% of patients had met with the service and 60% of respondents said they did not fully understand the role of an advocate. Survey results also showed that many people said they had not been given a copy of the patient handbook or been supported by staff to understanding its contents.

There was limited evidence available of patients being involved in their own care planning, or of consistent regular care plan reviews taking place. Patients had asked for more help with accessing training and work opportunities and for improvements in meeting their food and cultural requirements, but there was no evidence available to us of how these issues were being systematically addressed.

There were gaps and omissions in some of the Mental Health Act documentation and records; there was no evidence that all detained patients had been given information on their rights in a timely manner or that staff were regularly reinforcing rights information; outline Approved Mental Health Professionals reports, detailing the reasons for the application for detentions and patient circumstances, were not being requested routinely when patients were transferred into the hospital and/or when applications for detention were completed at the hospital; and there was no consistent system to provide evidence that patients were routinely given a copy of their Section 17 leave forms."

Outcome 2: "Detained patients we spoke to were not clear about their rights under the Mental Health Act. Most detained patients we spoke to knew what medications they were taking and why these had been prescribed. Patient survey results indicated that 11% of people said they did not know the medications they were prescribed or the reasons for taking them.

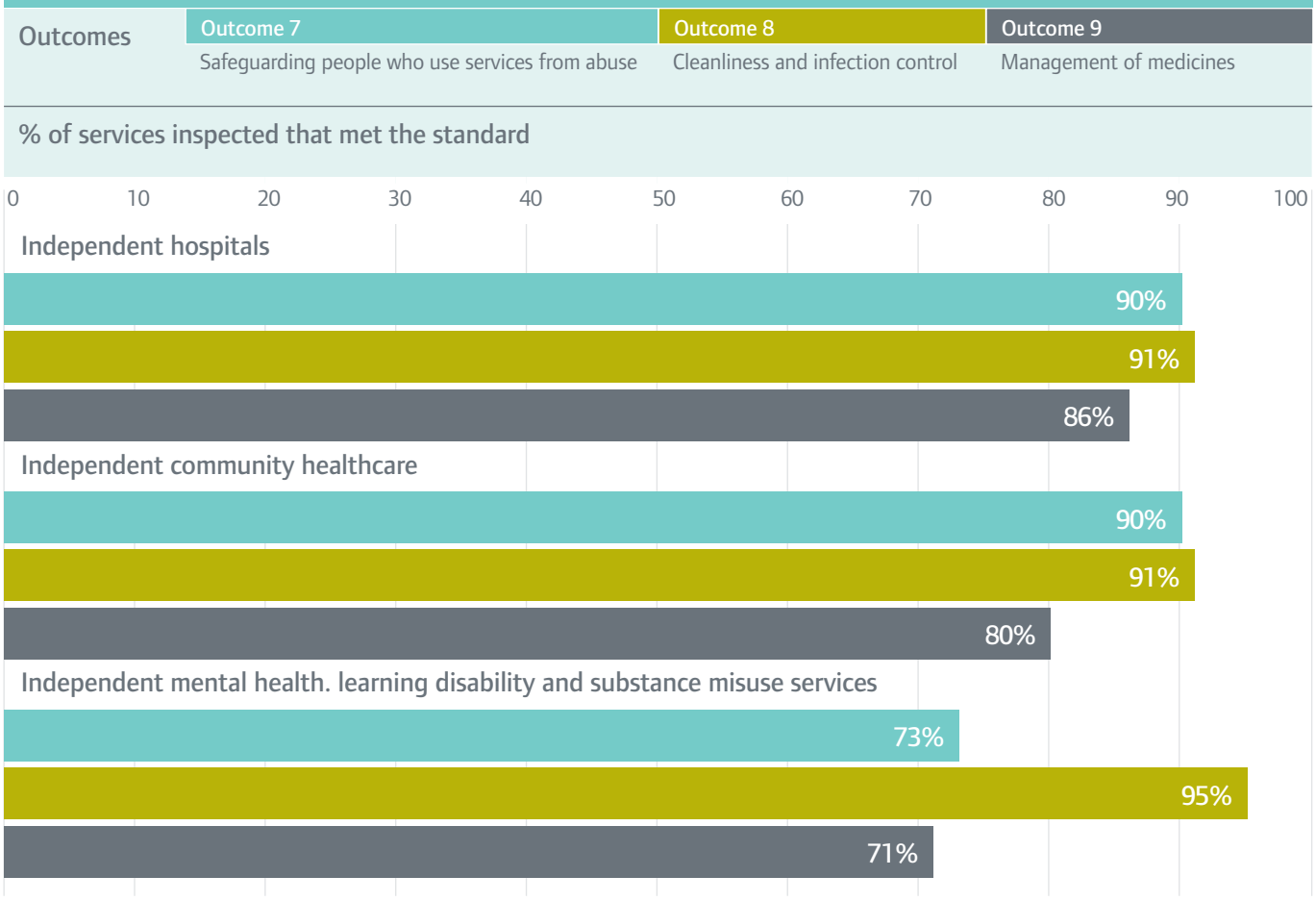
We found a number of gaps, errors and omissions in the systems and individual records relating to medication consent for patients detained under the Mental Health Act, including that there was no evidence that reviews of capacity and consent to treatment having always taken place in a timely manner or being fully recorded, or that second opinion appointed doctors (SOADs) had been requested in a timely manner in order to safeguard the views and rights of patients who refused treatment or were deemed incapable of consenting."

Keeping people safe

Independent healthcare services performed well in relation to cleanliness and infection control. Of those CQC inspected, 91% of independent hospitals and community healthcare services (161 and 138 inspections respectively) and 95% of independent mental health, learning disability and substance misuse services (44 inspections) met the standard on cleanliness and infection control (figure 34).

Independent sector hospitals began reporting cases of MRSA bacteraemia and *C. difficile* infection to the Health Protection Agency in January 2008. This extended to surveillance of MSSA bacteraemia in January 2011, and *E. coli* bacteraemia in June 2011. The figures for 2010/11 show that there were eight reported cases of MRSA in independent hospitals, representing 0.39 per 100,000 inpatient bed-days[36], and 76 cases of *C. difficile* or 3.54 per 100,000 inpatient bed-days.[37] This data cannot be directly compared with NHS figures, due to the different ways the data is collected.

Figure 34: Proportion of independent healthcare services meeting standards on safety and safeguarding, 2011/12



Source: CQC

Spotlight on good practice

Independent health care: Infection prevention and control

BMI Healthcare is committed to ensuring that all its hospitals have the correct resources and a developed workforce with access to specialist knowledge at all times.

Managing infection prevention and control (IPC) practice across 64 geographically spread sites presents a significant challenge. Regardless of the size of the hospital, IPC competency must be available to the same level in each hospital to ensure standards of care are consistent across the organisation.

BMI has set a minimum requirement for all hospitals; this guides the time resource and competency level for each hospital. In 2012, all hospitals carried out a self-assessment and established plans to move towards the objective of a minimum number of IPC competent specialists available across the group.

BMI also registered with the World Health Organisation's (WHO) global challenge of continual improvement in hand hygiene. All hospitals undertook the WHO self-assessment to set a baseline for future improvement and introduced the WHO's 'Five moments for hand hygiene' initiative. Training all staff in this concept is integral to their annual mandatory training.

All hospitals have an appropriate hand hygiene strategy in place and are developing long-term plans to ensure that improvement is continual and sustained.

Some independent healthcare services performed fairly well in 2011/12 in respect of safeguarding people from abuse – of those CQC inspected, 90% of independent hospitals and community services met the standard in the year (375 and 401 inspections respectively).

However, this was not replicated in independent mental health, learning disability and substance misuse services – here 73% of the services inspected met the standard (193 inspections).

This is clearly of concern, given the vulnerable circumstances that many people being cared for by these services are in. It is something CQC has already raised in the context of services for people with a learning disability, following its programme of inspections looking at these services that ran from September 2011 to February 2012.

As mentioned above, this involved unannounced inspections at 150 locations in England. The NHS and independent services consisted of 'assessment and treatment' services and 'secure' services. CQC's inspectors were supported by a professional advisor and two experts by experience – one who was a person who had used services accompanied by their support worker, and a second expert who was a family carer.

CQC found that many people had been in assessment and treatment services for disproportionate periods of time, with no clear plans for discharge arrangements in place and too many people had been in services away from their families and homes. One of the most significant findings was that in too many cases care was not person-centred: people were fitted into services rather than the service being designed and delivered around them.

The main findings in relation to the 45 independent healthcare services inspected were:

- Independent healthcare providers had the lowest proportion of locations that were meeting the safeguarding standard (51%) compared with adult social care (59%) and NHS services (79%).
- The main concerns in relation to safeguarding, across all care settings, related to the use of restraint (25%), meaning that restraint was not recorded and monitored appropriately. Incidents that involved restraint were not reviewed systematically and there was no approach to learning lessons from them.
- Although there were independent advocacy services at most locations, the quality of that provision needs to be reviewed, given that advocacy was also available in those services that did not meet the standards.
- Providers were sometimes unclear about deprivation of liberty and the safeguards needed, and those that were unclear did not have internal or external mechanisms in place to address that knowledge gap.

Management of medicines

On management of medicines, CQC found a varied picture in independent health care. Of those inspected, 86% of independent hospitals (111 inspections), 80% of independent community healthcare services (164 inspections), and 71% of independent mental health, learning disability and substance misuse services (80 inspections) met the standard 2011/12.

The poor performance across many sectors is something CQC raised in its first Market Report published in June 2012, and is a concern, particularly in respect of mental health, learning disability and substance misuse services. One of the things that became apparent to inspectors in CQC's review of learning disability services is that staff in some services do not appreciate that they are a hospital rather than a care home, and responsibilities for having audit trails of prescription and documented reasons for why a particular medicine is needed are not clear.

86%

Independent hospitals that did not meet the standard on medicines management in 2011/12

Hospital for people with mental health needs

Example of
Poor practice

Inspection report September 2011

"We found that people's medical needs were provided for by specialist doctors and a GP who visited the hospital once a week, as well as by suitably qualified nurses.

"Managers told us that they had recently introduced an annual medicines competency assessment to help ensure that medicines were handled safely. We saw that one person administered some of their own medicines. But no risk assessment or care plan was in place to support this. Managers explained that new procedures were being introduced to help ensure that self-administration was better assessed. We saw that two patients were currently working through a medicines booklet as part of the new process.

Medicines for people's physical health needs were administered from supplies prescribed and labelled for them. We found examples where the instructions on the pharmacy label differed from those on the hospital prescription chart. We saw that nurses followed the instructions on the prescription chart but had not confirmed which of these instructions was correct.

We looked at medicines stock control. We found it difficult to account for people's medicines because there was no clear system in place for recording quantities of medicines brought onto the ward. Additionally, there was no standard code for recording when medicine doses were missed. This means when recording errors were made, such as not signing the medicines charts, nursing staff could not assess whether medicines had been given correctly.

Managers explained that they were testing a new ordering system where the supplying pharmacy would check stock levels and order all the medicines needed for that ward. And a new stock record book was being rolled out to help account for medicines received into the hospital and improve stock control."

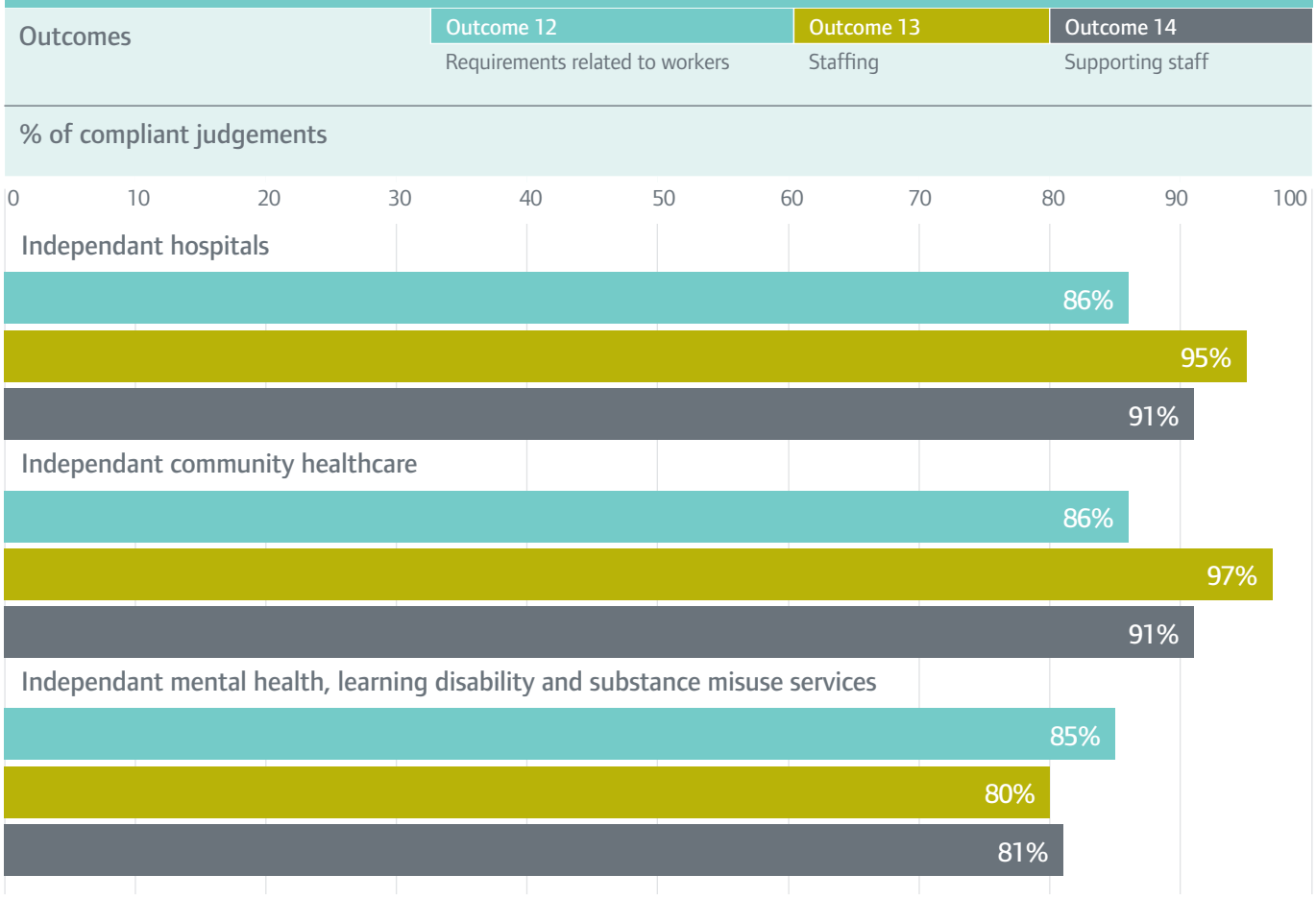
Staffing

In contrast to NHS services, independent hospitals and community healthcare services performed well in respect of the standard relating to staffing levels, with 95% and 97% respectively of the inspected services meeting the standard in our 2011/12 inspections (130 and 147 inspections respectively) (figure 35). These providers are usually able to hire staff quickly and establish staffing levels that are in line with their commercial requirements. Support and training for staff in these settings was also good, with 91% meeting the relevant standard (340 and 334 inspections respectively).

In independent hospitals and community services, it was the standard relating to having effective recruitment policies and checking prospective employees that proved to be a bigger challenge for providers. In both types of service, 86% met the standard when CQC inspected against it in 2011/12 (123 and 135 inspections respectively).

For independent mental health, learning disability and substance misuse services, the early signs from CQC's inspections are that there are concerns in all three of the staffing standards – in particular the standards on staffing levels (80% of inspected services met the standard in 2011/12, 105 inspections) and supporting staff (81%, 151 inspections).

Figure 35:
Proportion of independent healthcare services meeting standards on staffing, 2011/12



Source: CQC

80%

Mental health, learning disability and substance misuse services that met the standard on staffing levels

Nuffield Health Shrewsbury Hospital

Inspection report October 2011

Example of
Good practice

"We talked with a number of the people who were receiving treatment in this hospital when we visited. All of them were very complimentary about the staff making comments such as: 'All staff are attentive – they always remember requests', 'Staff are excellent' and 'Staff are very pleasant'.

"We also saw comments made in the hospital's patient satisfaction surveys that echoed this such as 'All the staff were superb' and 'All the staff were excellent and friendly'.

We talked to the matron and she told us how new staff received a full induction when they started working at the hospital. We saw from the records that the hospital maintains that this was part of a corporate e-learning system that the hospital group has developed. The records that we saw also confirmed that a more local orientation programme was followed.

During our conversations with the various members of staff they showed a clear understanding of how each aspect of the organisation worked in relation to the others so that they knew who to approach to ensure that each of the patients needs were met.

The hospital's e-learning system also contains courses on infection control, health and safety, fire prevention, adult protection and a range of other topics. We talked to a number of the staff who were on duty when we visited and they told us that the courses that they need to complete are identified by the company and they are sent reminders by the training coordinator when they become due. Their completion of each course is recorded and so that it can be monitored by the hospital's management.

We saw one of the staff completing one part of the required training and we also saw the computer records that showed who had completed what courses."

Managing quality

CQC's inspectors have found so far that independent hospitals and independent community healthcare services perform well against the standards dealing with complaints handling and monitoring the quality of care being provided.

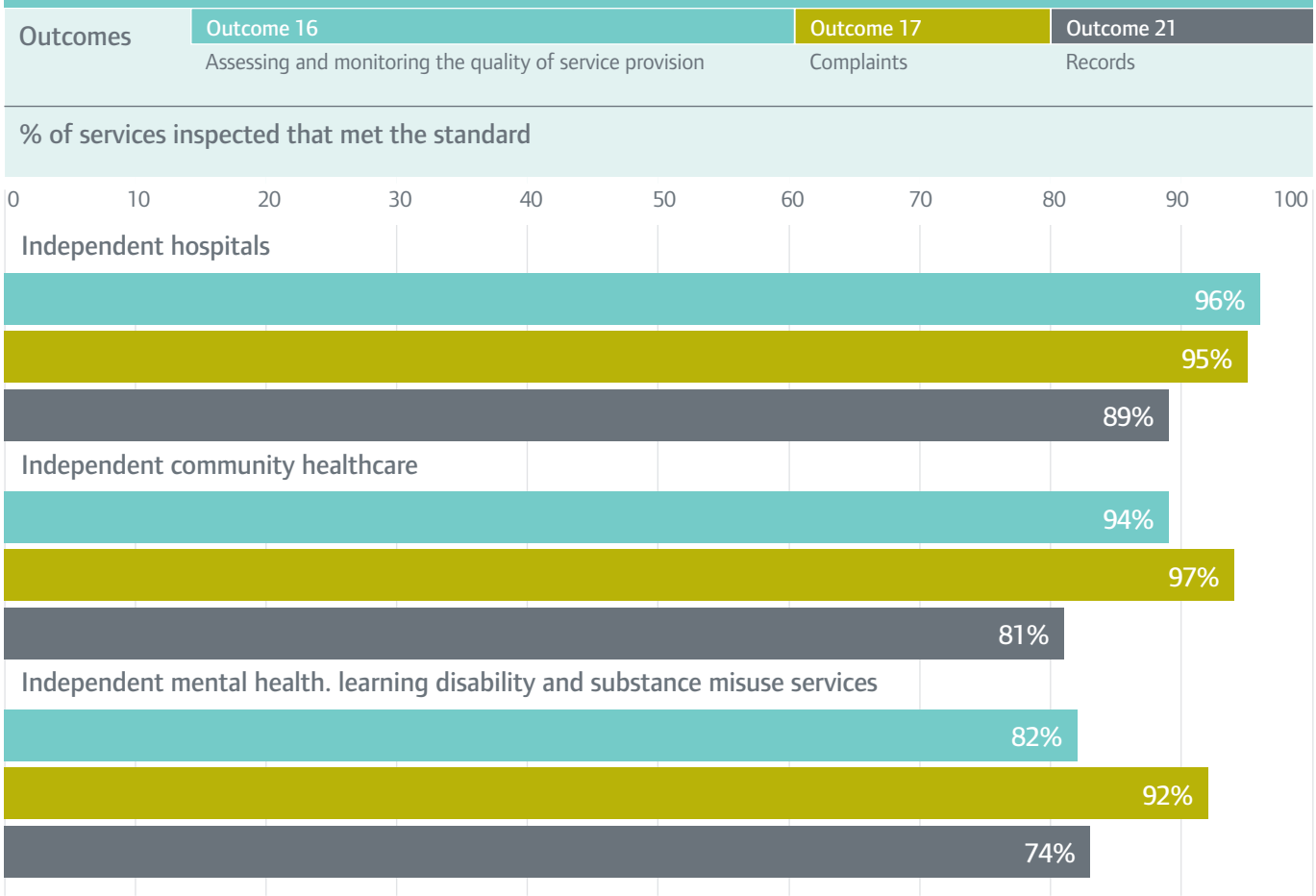
On complaints, of those locations inspected in 2011/12, 95% of independent hospitals (97 inspections) and 97% of independent community healthcare services (98 inspections) met the standard (figure 36).

There are no national figures for the total number and types of complaints received within the independent healthcare sector. Many complaints are resolved directly by providers, and therefore not brought to the attention of any external body. The Independent Sector Complaints Adjudication Service (ISCAS) operates a code of practice for handling complaints across the independent health sector. This is managed by Independent Healthcare Advisory Services.

The number of people who contacted ISCAS to access its complaints procedures during the period from January 2011 to March 2012 was 367 compared to 321 in 2010 and 184 in 2009. Comparatively this is similar to 2010 contacts due to the extended reporting year. In line with other complaints handling processes, the ISCAS code of practice promotes local resolution of complaints as best practice, encouraging providers to take ownership of complaints and resolve them at an early stage. In 2011 (also including January to March 2012), ISCAS managed external adjudication of 28 cases that had passed beyond local resolution, a small rise from 22 in 2010.

In its annual report, ISCAS reiterated its continuing concern that private patients treated in the NHS have no ability to complain to an external body, as the NHS Complaints Ombudsman has no jurisdiction and no NHS private patient facility is a member of ISCAS. An important milestone for 2011 was establishing the ISCAS Governance Board with an independent Chair.[38]

Figure 36: Proportion of independent healthcare services meeting standards on managing quality, 2011/12



Source: CQC

Mental health hospital

Inspection report November 2011

Example of
Poor practice

"The provider sent us a report in response to our previous inspection report telling us how the service would meet outcome 13 by 15 August 2011.

"On 19 August 2011, the service notified us that a serious untoward incident, leading to a safeguarding alert. This incident involved patients who required enhanced observations; at the time the incident took place, staff required to conduct the one-to-one observations were not present, in breach of their allocated duties. The incident raised serious concerns about the numbers, skills and mix of staff available on the ward, which had impacted not only on the personal and therapeutic care and treatment of people using the service but also on their safety and wellbeing.

We told the provider to submit a full investigation report into the incident. This demonstrated that on the day of the incident there were 15 patients on the ward, two requiring two-to-one observation and one requiring one-to-one observation; other patients were on 15 minute checks. On the day, there were three permanent and six agency nursing staff on the ward; there was little evidence that agency staff had been properly inducted to the ward, specifically around engagement and observation.

The provider report stated that staff had been allocated unreasonable amounts of observation tasks, that these were not allocated fairly or in line with policy and procedure, and that staff were allocated more than two hours on observation in a row, not following policy and good practice. Issues raised by ward staff about this with the shift co-ordinator were ignored. One member of staff said they had not been carrying out the observations allocated to them because they were afraid to do so; this person had also been allocated 12 hours of observations without a break.

In addition, staff did not immediately recognise the incident as a safeguarding matter and therefore their immediate actions did not reflect the seriousness of the incident.

Overall, the report noted several examples of staff having been unable to undertake the tasks allocated to them, due to insufficient numbers and/or to a lack of skill or experience, or due poorly inducted and supported staff."

In view of the seriousness of the concerns, we issued a warning notice on the provider.

"Overall, the report noted several examples of staff having been unable to undertake the tasks allocated to them, due to insufficient numbers and/or to a lack of skill or experience."

Learning from complaints:

Closing the loop on the complaints process

Listening to complainants, learning from their feedback and, crucially, closing the loop by communicating how the organisation is improving services as a result, is fundamental to the management of complaints from patients.

Often it is not made clear to the complainant how the organisation has learned from the issues raised. On some occasions, it is not clear to the Adjudicator how, or whether, any actions are being taken internally to improve services.

For example, in one case before the ISCAS, Mrs Jones had complained about the care she received during her admission to hospital for an operation. There were five heads of complaint: two related to nursing care provided on the ward following surgery and at a follow-up appointment to remove her stitches. The other three concerned whether Mrs Jones' priority on the theatre list had taken into account a pre-existing medical condition, difficulties arranging a follow-up appointment, and comments made about her lifestyle behaviours.

The hospital had been swift to apologise to Mrs Jones for inconvenience or distress caused to her, but it had not indicated any learning as a result of the issues raised by her complaint, or outlined any steps taken to improve service quality. The Adjudicator upheld all five heads of complaint and requested that the hospital provide details of any actions it planned to take in response to her feedback. These included actions to ensure that theatre staff receive information that may impact on a patient's priority for surgery; steps taken to ensure that patients are not left waiting in pain for medication; reviewing patient information to ensure that it covers the risk of stitches being inadvertently left behind; and any learning about the routes by which follow-up appointments are arranged.

The Adjudicator also addressed Mrs Jones' ongoing care needs. She had experienced considerable difficulties in arranging a follow-up appointment, and the hospital had apologised but it was not clear what changes, if any, were planned as a result of the difficulties she had experienced, or whether arranging an appointment would be made any easier. The Adjudicator therefore asked the hospital to assist Mrs Jones in rearranging her follow-up appointment.

The hospital responded very positively to the adjudication and shared their action plan with the Adjudicator and Mrs Jones. This outlined a number of measurable improvements to services, including training sessions with staff to address the outcomes of the complaint and reviewing the content of patient information materials. The hospital pointed out that actions such as these were routinely agreed following a complaint. The missing piece of the jigsaw in this case was making this transparent to the complainant and, by doing so, reassuring Mrs Jones that steps were being taken to prevent other patients from experiencing the same problems.

In relation to assessing and monitoring the quality of service provision, 96% of independent hospitals (461 inspections) and 94% of independent community healthcare services (451 inspections) met the standard in the year. In this respect, there is more of a direct link between the payments that independent services receive and their monitoring of the quality of care they provide.

However, in line with other sectors, CQC's inspectors found early indications that independent hospitals and independent community healthcare services were struggling to meet the standard on records and record-keeping – of those inspected, 89% of hospitals and 81% of community healthcare services met the standard in 2011/12 (92 and 124 inspections respectively).

Independent mental health, learning disability and substance misuse services had notably poorer performance than other independent healthcare providers against the standards relating to monitoring the quality of service provision and record-keeping.

In relation to assessing and monitoring the quality of service provision, 82% of independent mental health, learning disability and substance misuse services met the standard in 2011/12 (155 inspections).

For records and record-keeping, 74% of independent mental health, learning disability and substance misuse services met the standard (76 inspections). As we mentioned above in respect of NHS services, poor record-keeping can be one of the first indicators of an early sign of strains on an organisation's ability to perform, for example because of the shortage in staff in these services.

Independent doctors treatment service

Inspection report December 2011

Example of
Poor practice

"There was a lack of supporting documentation to show that staff had been appropriately recruited.

"Minutes of a focus group meeting stated that counselling services were being offered to people who used the service. There were no records to show that the counsellor had been CRB checked. Two staff members told us they did not have a CRB check, but said that they were in the process of applying for one. One staff member had been employed for over a year."

Primary dental care

The oral health of adults in England has improved significantly over recent decades. Successive national Adult Dental Health Surveys show that between 1998 and 2009, the proportion of adults in England with visible coronal caries fell from 46% to 28%.[39] According to World Health Organisation measures of oral health, England stands alongside Germany and Denmark as the best in Europe.[40]

Key to this transformation has been the provision of high quality dentistry services. An independent review of dental services in 2009 for the Department of Health (the Steele review) noted that "the two common dental diseases, dental decay and gum disease, are chronic and the damage they cause is cumulative and costly. The NHS... is still dealing with, and paying for, the consequences of disease that developed more than 50 years ago."[41]

As the population's oral health continues to improve, demand for restorative dentistry is likely to reduce, but demand for preventative dentistry is anticipated to increase.

The dentistry market grew rapidly in the decade between 2000 and 2010, and is now worth an estimated £5.7 billion a year across the UK (excluding cosmetic dentistry). Of this, around £3.3 billion (58%) is spent on NHS dental treatment, and £2.4 billion (42%) on private dentistry.

98%

Dental care providers that met the standard relating to the care and welfare of patients

However, more recently the economic downturn has affected dentistry. Market growth slowed in 2008/09 and 2009/10, mainly due to weakening demand for private dentistry. Spending on private dentistry fell in real terms by 4% in 2008/09 and 3% in 2009/10. Along with other health and social care services, NHS dental services are likely to face increasing financial pressures in the coming years.

In addition to the Steele review, a Health Select Committee report in 2008[42] and a report by the Office of Fair Trading in May 2012 have highlighted issues including: geographic variability in access to NHS dental services; the need for greater consistency

ADP Dental Company, Basingstoke

Inspected February 2012, inspection report April 2012

Example of
Good practice

"People we spoke with told us that any questions they may have were always answered fully and politely.

"This was because staff explained things in a way that made them less apprehensive. This approach had also encouraged them to attend regularly.

One person told us how the dentist had described a particular aspect of their treatment. The dentist had explained things very well and had drawn a diagram to make sure the person understood what was involved.

We spoke with two people whose children were patients at this practice. Both people said that the staff included the children in conversations about their dental care. Any treatment they needed was explained at a level they could understand and carried out only with their full cooperation.

We gained consent from one person to observe and listen to one of the dentists explaining a treatment plan. The result of x-rays and treatment options were discussed. When the person did not understand something the dentist took time to reword his explanation. The dental nurse was also involved by explaining the cost involved. A written treatment plan was signed by the person and a copy given to them to take away. We saw that all the people who had attended for examinations that day left with a copy of their treatment plan."

in quality; the need for better information for the public, including on pricing and how to access services; the need for better commissioning of urgent dental care; and the need to shift focus from activity to outcomes, and more preventative work.[43]

By 31 March 2012, CQC had completed and published inspection reports relating to 796 locations (out of a total of 10,130 dental care services registered with CQC at that date).

In the first dental care inspections, CQC's inspectors focused on the standards relating to respect and involvement of patients, their care and welfare, safeguarding patients from abuse, and cleanliness and infection control.

They found that 99.7% of the services inspected met the standard relating to respect and involvement of patients (584 inspections).

Of the 796 inspections published up to 31 March 2012, 729 included inspection of performance against the standard relating to the care and welfare of patients. Of these, 98% met the standard.

The first dental care inspections included looking at two standards relevant to safe care: safeguarding people from abuse and cleanliness and infection control.

In both cases, 93% of the dental services we inspected met the standard up to 31 March 2012 (601 inspections for safeguarding, and 735 inspections for cleanliness and infection control).

The safeguarding standard was the one that dental providers most commonly declared themselves to be not meeting at the point they registered with CQC. Although in general inspectors have found good performance overall in respect of this standard and awareness of child protection issues is generally good, they report that providers' understanding of safeguarding vulnerable adults is patchy.

There were two areas where inspectors only inspected a small number of services but the early results suggest that dental services may be encountering some problems:

- 30 inspections looked at the safety and suitability of premises. Seven of these were not meeting the standard on 31 March 2012.
- 34 inspections looked at the standard relating to recruiting staff who are properly qualified and able to do their job. Eleven of these did not meet the standard.

CQC's inspectors will be monitoring these carefully as they carry out more inspections.

Central Dental Practice, Carlisle

Inspection report February 2012

Example of
Good practice

"We spoke with people who use the service. They were very happy with the care and treatment provided and also said the practice always managed to fit them in if they needed to see a dentist urgently.

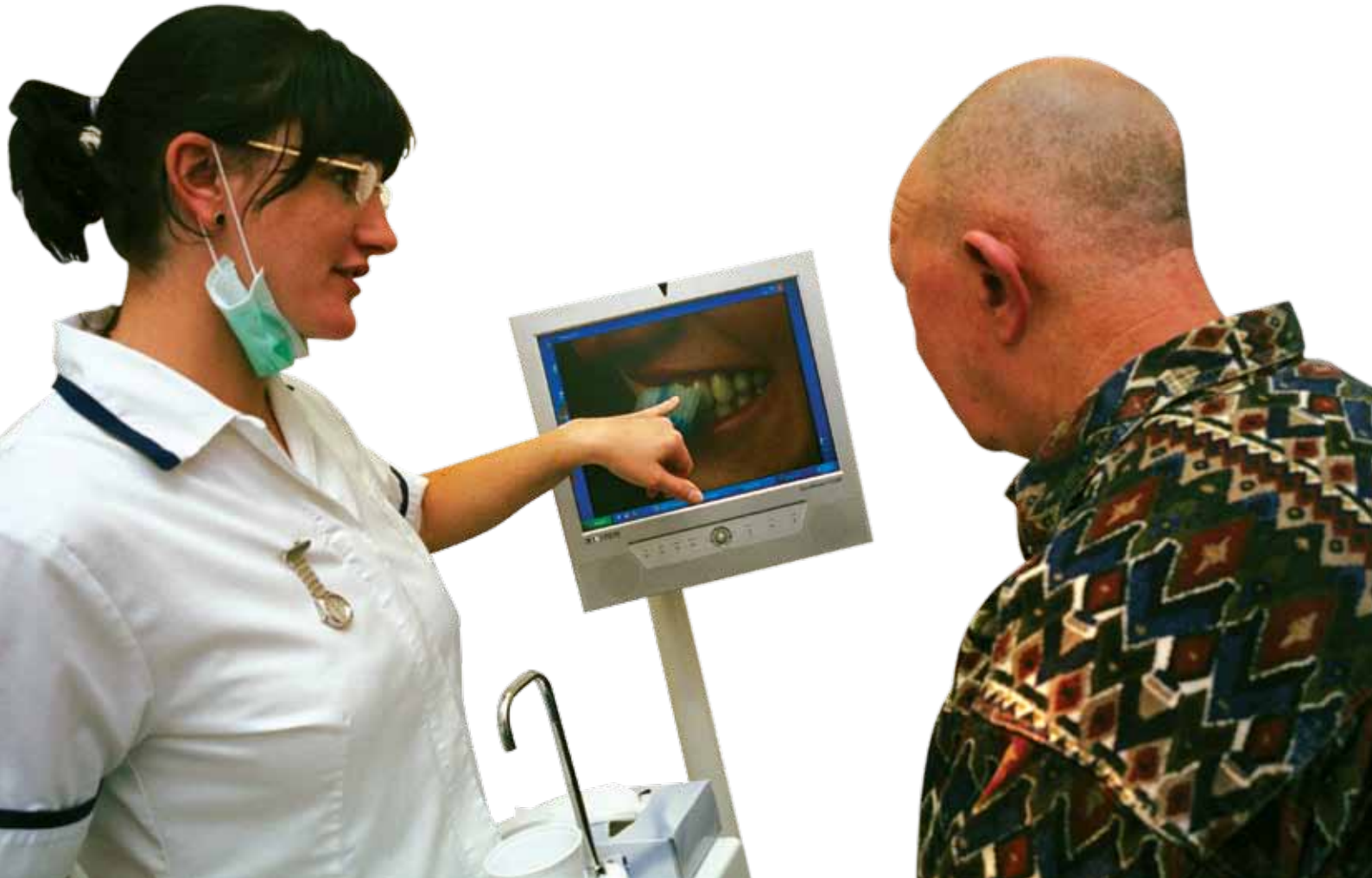
"We saw further evidence of satisfaction with the care in the patient surveys from last year. Patients had recorded that they were very happy with the care and that the treatment was excellent. Another wrote 'there has been a noticeable improvement in the practice, treatment and the professional attitude of staff since the new company took over'.

We checked patients' records and saw that relevant information regarding dental examinations was recorded. There was recorded evidence of oral health education. We found evidence of completed records in respect of patient examination, treatment planning, evaluation and assessment of x-rays; preventative dental care and advice, appropriately completed personal treatment plans and information given.

The practice has extended surgery hours on a Monday and Wednesday and there were five emergency appointments available each day. Patients who required treatment out of the practice's opening hours would be referred to the NHS emergency service.

We saw that there was a report for the current year that demonstrated compliance with radiological safety and local rules were in place for each x-ray machine. The practice sought radiological advice from the clinical director of the company and all the dentists had received appropriate training in the use of x-ray equipment. We saw evidence that machines were regularly serviced and maintained.

We were told by staff that it was a 'brilliant practice to work for'. They confirmed they had appraisals, regular staff meetings where any concerns, alerts or changes to practice were discussed. One member of staff told us 'I feel very well supported and I really enjoy working here'."



Dental practice

Inspection report March 2012

Example of
Poor practice

Although staff at a dental practice in the South West understood their role and responsibilities in safeguarding, they had not had training in safeguarding vulnerable adults or in the Mental Capacity Act, and they did not have access to contact details to make a referral if they identified a safeguarding concern.

We imposed a 'compliance action' on the provider, and asked them to send us a report outlining their actions within 28 days.

General Dental Council guidance is that all registrants must be aware of the procedures involved in raising concerns about the possible abuse or neglect of children and vulnerable adults. However until recently there has been very limited training available for dentists in safeguarding vulnerable adults and the Mental Capacity Act. We have discussed this issue with our stakeholders in the dental sector, including the British Dental Association, postgraduate deaneries and dental membership organisations. They have reacted quickly to this gap in training provision, and are now offering appropriate courses specifically tailored for dental professionals, as are some private providers.

The provider in the South West was able to identify safeguarding training quickly and arranged for staff to attend a course within the 28-day timeframe.

> "Inspectors found good awareness of child protection issues; however dental care providers' understanding of safeguarding vulnerable adults is patchy.

Adult social care

England's population is both growing and ageing, as people live longer than ever before. Latest figures show that by mid-2011 England's population was at its highest ever level, at an estimated 53.1 million.[44] Within this, 8.7 million people are aged 65 or over, and 1.2 million are 85 or over.

More than 400,000 people in England live in residential care, 1.1 million people receive care at home, and around five million people care for a relative or friend. The majority of people now aged 65 will need some form of social care and support in their later years. Of people currently aged 65:

- Around a fifth of men (19%) and a third of women (34%) will need residential care at some point in their lives.
- Just under half of men (48%) and just over half (51%) of women will need domiciliary care only.
- Only a third of men (33%) and 15% of women will never need social care.[45]

A significant minority of older people who enter hospital from their own homes are discharged to care homes. There has also been an increase in people moving from hospital services into social care more quickly, to help with their recuperation and rehabilitation.

These demographic pressures are increasing at a time when resources are constrained. Expenditure by councils on adult social care has not decreased: in 2010/11 (the latest available figures), there was a 1% rise in cash terms from £16.8 billion to £17.0 billion.[46] However, a survey of directors of adult social care services said that £1.9 billion has been taken out of adult social care budgets over the past two years.[47]

These financial constraints have already resulted in many local authorities freezing fees that they pay to care homes and domiciliary care providers. At the same time, care homes have experienced increases in energy and food costs, while domiciliary care providers have faced rising fuel prices.

This means there are significant challenges throughout the adult social care system in maintaining and improving quality in the face of growing demand pressures and tighter resources.

As we said in the introduction to part 2 of this report, ensuring that people are treated with dignity and respect, and that they are treated as people – with lives, families, relationships and individual needs of their own, and not defined in terms of the 'illness' they have or the 'task' they represent – is one of the most important, if not the most important, feature of a high quality care service.

Nowhere is this more important than in social care services, where the majority of people are older, where they generally have greater co-morbidity than in the past, and where their care requirements are becoming more complex. We therefore have focused in this section on issues of dignity and respect. The key findings are as follows.

1.1 million

Number of people in England who receive care at home

Key findings in adult social care

- Of the adult social care services CQC inspected in 2011/12, 93% of residential care homes and 95% of domiciliary care agencies met the standard relating to respect and dignity (5,984 and 1,680 inspections respectively). The performance of nursing homes was rather poorer at 85% (2,502 inspections).
- In residential care, CQC's inspectors report that the more complex caseload being seen has an impact in a number of areas, including ongoing support and training for care staff.
- In CQC's review of learning disability services, 63% of the 32 care homes inspected met the general standard on care and welfare.
- In the review, inspectors saw some very positive examples of people being given control over the care planning process. Where they found problems, the most common issue was a lack of person-centred planning with little information about people's individual preferences, including likes and dislikes about how care is delivered.
- In terms of ensuring that the people in their care are given the food and drink they need and help to eat and drink, there were some concerns in nursing homes and residential care homes: 80% of nursing homes (1,362 inspections) and 89% of residential care homes (2,114 inspections) met this standard in 2011/12.
- On providers' assessment and monitoring of the quality of care, CQC found varied performance – 80% of nursing homes (2,772 inspections), 84% of residential care homes (6,612 inspections) and 87% of domiciliary care services (1,981 inspections) met the standard.
- Cooperation with other providers was good across all types of adult social care: 96% of nursing homes, 95% of residential care homes and 96% of domiciliary care agencies met the relevant standard in 2011/12 (640, 1,299 and 376 inspections respectively).
- A common problem in social care was the lack of a good manager in place at the service, or even the absecnce of one altogether. Very often, a change of registered manager following action by CQC was followed by dramatic changes in the quality of care provided.

> The more complex caseload in social care is having an impact in a number of areas, including support and training for care staff.

Dignity, respect and involving people

In its report on dignity and nutrition in hospitals (which it is now following up in 2012/13 with a targeted programme of inspections of 500 care homes), CQC stressed that care providers need to look long and hard at why care often seems to be broken down into tasks to be completed, focusing on the unit of work, rather than the person who needs to be looked after. Task-focused care is not person-centred care. It is not good enough and it is not what people want and expect.

This was something that was reiterated by the Commission on Dignity in Care – a joint initiative of Age UK, the Local Government Association and the NHS Confederation set up to help improve dignity in care for older people in hospitals and care homes – when it published its final report in June 2012 called *Delivering Dignity*:

"The overarching commitment should be to help keep people mentally and physically well, to involve them in decisions about their care, to help them get better when they are ill and, when they cannot fully recover, to stay as well as they can and live as independently as they can until the end of their lives. And it said that a major cultural shift is needed in the way people throughout the system think about dignity – to make sure that the care that is delivered is person-centred, not task-focused." [48]

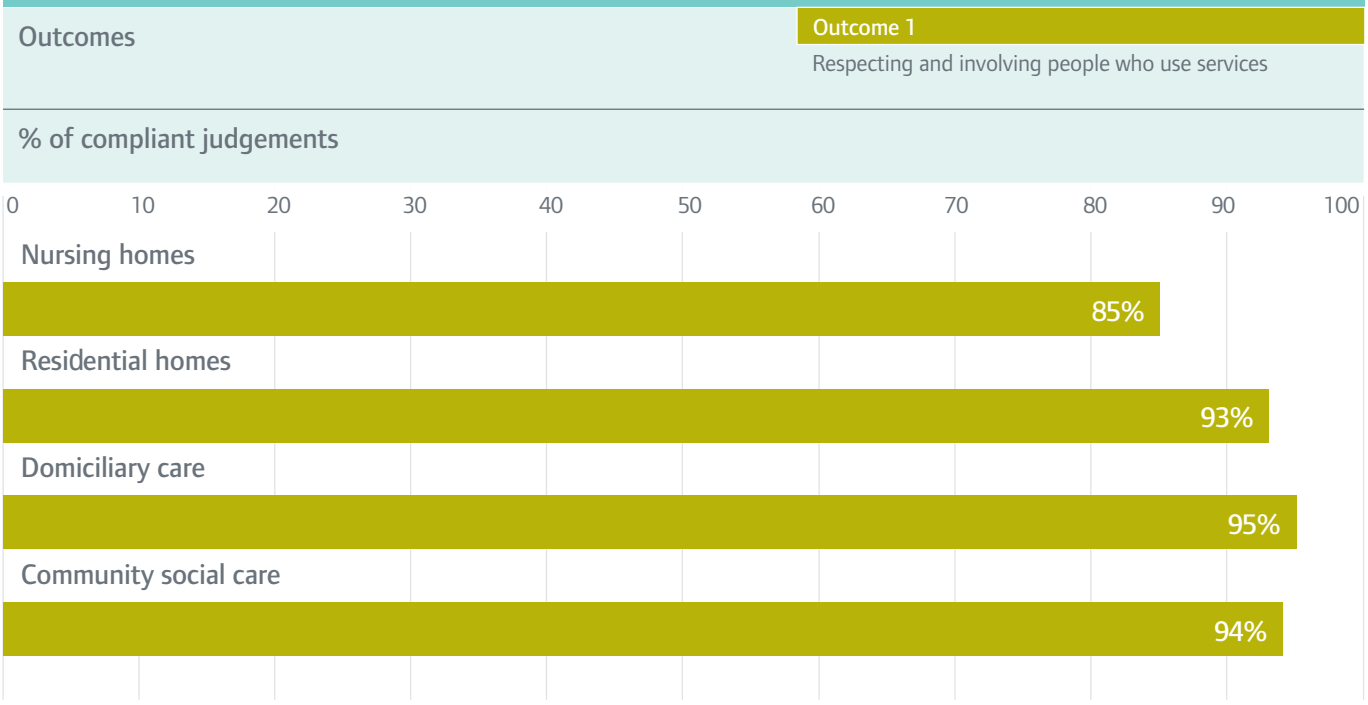
When CQC inspects services to look into these issues, it checks carefully to see the extent to which people and patients are treated with respect and involved in their care, and how their views and experiences are taken into account.

Of the adult social care services inspected in 2011/12, 93% of residential care homes (5,984 inspections), 95% of domiciliary care agencies (1,680 inspections), and 94% of other community adult social care services (524 inspections) met the relevant standard (figure 37). The performance of nursing homes was rather poorer at 85% (2,502 inspections).

In the second annual survey of people who receive council-funded care services (either wholly or partly), 30% reported they have as much control as they want over their daily life – which is linked to the extent to which people are treated with dignity and respect and involved in their care. Another 45% said they have adequate control and 20% said they have some control but not enough. Five per cent reported they had no control at all. All of these figures are the same as 2010/11.[49]

Also in the survey, 63% of people who responded said they were extremely or very satisfied with the care and support services they received. This was similar to 2010/11. Twenty-seven per cent said they were quite satisfied, 6% said they were neither

Figure 37: Proportion of adult social care services meeting standards on respect and involvement, 2011/12



Source: CQC

Spotlight on good practice

Social care: Changing the culture of dementia care

Merevale House promotes community-based living and provides high quality and innovative care for people with dementia. It has 38 residents across four different settings.

Over the years, Merevale House has tried to develop a way of living called 'active co-existence'. This overturns conventional passive relationships between service users and providers, and works to recognise and develop people's abilities as a community. Togetherness is crucial: people live and work together in the home so that there is no longer a distinction between carers and users, and both can thrive.

The approach has evolved over the years and has worked to take person-centred care one step further. Merevale promotes social interaction and a community that accepts diversity and differences. This involves breaking down barriers, sharing emotions, and removing hierarchies.

Fundamentally this involves close relationships between employees and residents. Merevale works to promote a community that has the freedom to exist in a safe, warm and loving environment, and it does this through focusing on what people can do and contribute, rather than on what they can't do. For example through 'positive risk assessments' which involve looking at how people can live normally and exercise control over their lives through what they are able to do, rather than what they can't do – recognising people's strengths and abilities.

The approach involves allowing people to make daily decisions and to live flexibly so that individual preferences dictate events; at Merevale there are no institutional activities or regimes, for example no drink trolleys and no bath lists. Instead people are involved in activities associated with the daily running of the community such as shopping, washing up or walking the dog.

Key to the success of Merevale is a leadership that gets everyone on board. Changing the culture of dementia care is a challenge and all members of staff need to understand the philosophy and what the community is aiming to achieve. The home provides training to all staff; the recruitment process is important. Every member of staff is expected to provide meaningful occupation throughout the day.

Their hope is that other homes will start to develop communities in the future and change their way of dealing with people with dementia to focus on making a difference to people's lives.

satisfied nor dissatisfied and the remaining 4% said they were dissatisfied.

CQC's inspections show that those delivering care that maintains people's dignity and treats them with respect have a number of things in common:

- Recognising the individuality of each person in their care, and helping them to retain their sense of identity and self-worth.
- Taking time to listen to what people say.
- Being alert to people's emotional needs as much as their physical needs.
- Maintaining people's independence as much as possible, and giving them more control over their care and the environment around them.

This is evident in many of CQC's inspection reports, and in the following good practice example.

85%

Proportion of nursing homes that met the standard on respecting and involving people

However, too often inspectors see care that doesn't live up to this. This is often characterised by things such as:

- Care staff talking over the person, as if they were not there.
- Having things 'done' to them, rather than 'with' them – for example, cutting up someone's food without asking to save time, rather than taking the time to find out what help they need – which can undermine self-confidence and independence.
- Not explaining the steps of a task, preventing the person from raising any anxieties they may have, and therefore giving them less control over the care they are receiving.
- Getting people ready for bed at a time that suits the staff rather than the individual people being cared for.

While such poor care is very much in the minority, CQC is focused on driving improvement in this crucial area. It began a programme of inspections at the end of 2011/12 looking at issues of dignity and nutrition in 500 care homes – this following the success of its similar programme in the NHS. It is due to report on the care home inspections in early 2013.

Respecting the human rights of older people using home care

CQC also began a themed inspection programme in spring 2012 looking at 250 domiciliary care providers; one of the areas included in this programme is the respect and involvement of the people being cared for. It will publish a national report on this programme in early 2013.

A report by the Equalitiy and Human Rights Commission (EHRC) in November 2011 found that home care providers are too often failing to meet older people's human rights.[50] Research for the report revealed many examples of older people's human rights being breached, including physical or financial abuse, disregarding their privacy and dignity, failing to support them with eating or drinking, treating them as if they were invisible, and paying little attention to what they want. Some older people were surprised to discover that they were meant to have any choice about their care, as in practice they had been given so little say in how their care was arranged.

> "The overarching commitment of care services should be to help keep people mentally and physically well.

Nursing home

Inspection report December 2011

Example of
Poor practice

"Eight people remained in bed throughout the day in one building. Staff told us that this was what people wanted. We observed that the people being cared for in their bedrooms mostly slept or dozed whilst watching television. When we tried to engage with people, they appeared disinterested in their surroundings and did not engage with us. From the care plans it was not clear why people were being cared for in bed other than it was their 'personal choice' to stay in bed.

"We asked people what activities they took part in during the day. We were told that mostly they watched television, read or had family visiting. We asked staff what activities were offered. They said that the activities co-ordinator offered bingo on a Tuesday and colouring on Thursdays. The co-ordinator also visited people in their bedroom for a chat. Occasionally there was an afternoon tea party. We could not see any activity timetable displayed in the home. We were told that activities were held only in one building, across a courtyard. This meant that people who were in bed in the other building would need support to join in.

There was little staff observation of people in the sitting rooms. Members of staff occasionally visited the sitting rooms to give people drinks. We saw that there were two call alarms at opposite ends of one sitting room. They were not accessible to the people sitting there because they could not walk unaided.

We saw one person in one sitting room looking at a magazine for 15 minutes, without turning the page. We asked them what they liked to do and they said, 'I like to go into the garden' and asked if they could go outside. At no time during the day did we hear staff asking people what they wanted to do or supporting the person to go outside. We saw that staff were very busy and did not sit and chat to the people in the sitting rooms at any time during the day. We observed that staff did not always knock on people's doors before entering.

People's dignity was not respected because staff were concerned with carrying out tasks, with little consideration of people's needs. We heard one person in their room saying they did not want their lunch. When we looked into the room, a cleaner was standing directly behind the person who was sat in the chair and had their lunch on a tray on their lap. The staff member was cleaning the window frame. The room smelt of cleaning products.

People did not have access to comfortable bedding or freshly laundered clothing. We observed that people were clean but that their clothes were faded and did not look ironed. On all the beds we looked at, we saw that the bedding was threadbare, thinning sheets and washed out blankets. We did not feel that there was adequate bedding with only one sheet and a thin blanket on beds.

In the sitting room there was a television and a book case with a few puzzles and books. There was a white board for writing up activities but it was blank."

The EHRC questioned commissioning practices that focus on rigid lists of tasks, rather than what older people actually want, and that give more weight to cost than to quality of care. The report highlighted that very few local authority contracts for home care currently specify that the provider must comply with the Human Rights Act, and said that this undermines the quality of care received by older people. However, where human rights are embedded into the way home care is provided – from commissioning to service delivery – the EHRC found that high quality care can be delivered without necessarily increasing costs.

The EHRC inquiry found age discrimination was a significant barrier to older people getting home care - people over 65 are getting less money towards their care than younger people with similar care needs, and are offered a more limited range of services. The report also highlighted that the low rates paid by some local authorities to providers for home care, and the resulting low wages and poor conditions for staff, as well as high turnover, can all have a detrimental effect on the quality of home care for older people.

Effective care, treatment and support

With the ageing population, the social care system has to respond effectively to the increasingly complex care that people need, across all its many different services. We have therefore looked at the extent to which services link up with each other and plan together, so as to ensure a good experience of care for people.

This means cooperating effectively – particularly when the person moves from one service to another – sharing information and supporting people to access other services when they need them.

Generally, cooperation with other providers was good across all types of adult social care. Ninety-six per cent of nursing homes, 95% of residential care homes, 96% of domiciliary care agencies and 98% of other community adult social care services met this standard in 2011/12 (640, 1,299, 376 and 129 inspections respectively) (figure 38).

In terms of the standard ensuring that people are given the food and drink they need and any help they need, there were some concerns in nursing homes and residential care homes. CQC's inspections found that 80% of nursing homes (1,362 inspections) and 89% of residential care homes (2,114 inspections) met this standard in 2011/12.

In the 2011/12 annual survey of people who receive council-funded care services, 4% of respondents said they didn't always get adequate or timely food and drink and 1% felt that there was a risk to their health – figures that were unchanged from 2010/11. However, 95% either got all the food and drink they liked when they wanted (64%) or they got "adequate food and drink at OK times" (31%).[51]

Given that this is so central to good care for people receiving social care – particularly older people – this is a real concern. As mentioned above, this issue is a focus of CQC's targeted inspection programme of 500 care homes, and it will report its findings in early 2013.

Overall, the area of poorest performance across all types of adult social care was in relation to the standard on ensuring the care and welfare of people who use services: 72% of nursing homes, 82% of residential care homes, 86% of domiciliary care agencies and 84% of other community adult social care services met the standard when inspected against it in 2011/12 (3,544, 7,617, 2,118 and 672 inspections respectively).

Lorna House, residential home

Inspection report July 2011

Example of **Good practice**

"People living at Lorna House can receive care from a number of community services, including medical, nursing, dieticians, occupational therapists, physiotherapists, and palliative care support teams.

"Information about the person's needs is transferred safely and some members of the community teams also write in the home's care plans and notes, which helps to ensure information is transferred safely and understood by both agencies.

We were told that when people transfer between services, such as when being admitted to hospital in an emergency, information from their care plans regarding their needs and contact details for important people is photocopied and sent to the hospital with them. This also includes copies of risk assessments, including those for nutrition or infection control.

Discussions with the manager indicated that she ensures that when people are admitted to or discharged from the home she ensures that all relevant information is supplied to the appropriate agencies responsible for their care. If a person is discharged from hospital without full information she will endeavour to obtain this via their GP or the hospital ward. When people are being admitted from hospital the manager visits the person on the ward and talks to the staff as well as the individual and their relative to ensure all information is available as to their needs prior to admission.

In the home, information that is required on a daily basis is in files in the dining room. These are identified only by a room number and are used by staff for recording on a shift by shift basis. Other more confidential or sensitive information, such as information about finances, is available in the full care plans which are kept in the main office."

Figure 38: Proportion of adult social care services meeting standards on effective care, treatment and support, 2011/12

Source: CQC

The review of services for people with learning disabilities that CQC carried out in 2011/12 looked at the care and treatment given to people with a learning disability as well as whether people were safeguarded from the risk of abuse. Only 63% of the 32 adult social care services inspected met the standard on care and welfare.

Person-centred planning is not a new concept; therefore we expected this to be embedded in practice. While inspectors did see some very positive examples of people being given control over the care planning process, the most common issue was a lack of person-centred planning with little information about people's individual preferences, including likes and dislikes about how care is delivered. Many of the issues of concern would have been managed better if high-quality person-centred planning had been in place.

In the report, CQC stressed that further work is required by commissioners and providers to understand why person-centred planning is not embedded into all care for people using services and to make sure that it is in place. CQC will continue to assess this as part of the inspections it routinely carries out.

However, it is important to note that while less than half (48%) of the residential care homes in the review met both standards, in fact the majority of people using these services (63%) were actually resident in the compliant services.

Generally, the annual survey of people who receive council-funded care services pointed to a significant proportion of people who did not have a good quality of life. Twenty seven per cent of respondents reported

Figure 39: Proportion of domiciliary care services meeting standards on safety and safeguarding, 2011/12

Source: CQC

their quality of life was so good, it could not be better or very good (up 1% from 2010/11), 31% said it was good and 31% said it was alright. However, 7% reported their quality of life was bad and the remaining 3% reported their quality of their life was very bad or so bad, it could not be worse.[52]

Furthermore, while 31% of people were able to spend their time as they wanted doing things they valued or enjoyed (up 2% from 2010/11) and 34% said they were able to do enough of the things they valued or enjoyed, 28% did only some of the things they valued or enjoyed and 7% did nothing they valued or enjoyed with their time.

Keeping people safe

The safety of people receiving care is paramount, particularly in social care where the some people are more vulnerable because of their circumstances – this includes people with dementia and people with a learning disability.

Care home

Inspection reports 2012

Example of
Poor practice

CQC inspectors found a care home in Birmingham to have a number of serious issues that were affecting the care people at the service received.

We received information from a whistleblower about the management of medicines in the home and carried out a visit with a pharmacist to look into the issues. We talked to staff and were told that the service had recently changed GP and some medicines had not been prescribed: four people did not have some of their prescribed medicines.

We also found problems with the recording of medicine use through the Medication Administration Record (MAR) and some issues with training of staff. We issued a warning notice straight away.

We spoke to the manager who had been working in the service for four weeks. He told us that they were speaking to the new GP practice and also with the supplying pharmacy in order to make medicines safe in the service.

When we returned to the home to follow-up there had been significant improvements. Appropriate arrangements were in place for all aspects of medicines management. We found that systems were followed by staff which ensured people's medicines were handled safely. An improved system of medicine audits and checks were in place, which helped identify problems quickly. MAR charts were clear and easy to follow and documented and medicines prescribed to people were being reviewed and checked by the GP on a regular basis.

When CQC inspects services, it looks at what providers do to make sure that people who use the services, staff and visitors are as safe as they can be, and that risks to people's safety are managed well. It looks particularly at what the provider is doing to respect people's human rights and protect them from the risk of abuse, and how they identify when people are in vulnerable situations and respond accordingly.

Overall, in the 2011/12 annual survey of people who receive council-funded care services, 64% felt as safe as they wanted (up 1 percentage point from 2010/11) and 29% felt adequately safe but not as safe as they would like. However, 5% of respondents felt less than adequately safe and 2% did not feel safe at all.[53]

Domiciliary care

For domiciliary care, of the services inspected, 90% met the safeguarding standard (1,946 inspections) in 2011/12 (figure 39).

As mentioned above, CQC began a themed inspection programme of 250 domiciliary care services in spring 2012, looking at a number of standards including safeguarding. It will publish a national report on this programme in early 2013, but the early findings (based on a small number of inspections) show that generally the comments from people about safety have been positive. On the whole, people who use services have provided more positive responses to questions about care provision than informal carers, relatives and friends. The exception to this is with regard to clients feeling safe when care workers visit. Although the majority of clients (86%) said they always felt safe, a higher proportion of informal carers/friends/relatives thought that they did, at 95%.

CQC has been told that specialised safeguarding training for domiciliary care workers can be difficult to obtain, but that there are excellent examples from many parts of the country where councils have delivered their training by their own specialists and made it available to providers at low cost or for free.

Another issue for domiciliary care providers is that their policies and procedures must interface with those of local authorities. This can present challenges for providers who work with more than one local authority, in integrating their own policies with those of each council to whom they supply services.

Performance in respect of medicines management was poor in domiciliary care, reflecting the position seen in the rest of social care and across health care too. Of the locations inspected, 77% met the standard in 2011/12 (689 inspections). However, note that CQC's risk-based approach means that it carried out many of these inspections in direct response to concerns it had about services – and therefore the figures may over-emphasise poor performance against this standard.

Given the nature of domiciliary care, the training of careworkers is fundamental, as there are fewer opportunities for double-checking administration with another person (because usually only one careworker is present) or for administration errors to be spotted.

Also important is a clear understanding of where the responsibility for medicines management rests, so that staff know what degree of support they need to give.

There are sometimes exceptions to a policy created to meet the needs of specific people – for example, the domiciliary care agency only prompts people to

Example of
Good practice

Aaron Park Mews, domiciliary care service

Inspection report December 2011

"The manager maintained and displayed a staff rota. This was completed in advance to ensure that all shifts were covered and any shortfalls could be identified and cover arranged.

"The manager had access to bank staff both from within the home and from the provider's other homes in the local area to cover sickness and holidays if required.

Some of the daily staffing provision was shared with a nearby care home owned by the same provider. The staffing was arranged in this way so staff spent time throughout day shifts alternating between intensive one-to-one support and group support. All parties thought this approach worked well for them and they were happy with the arrangements. Where one person required short periods of care on different days over the week the same carer provided their service."

take their medicine, but for one person there is an arrangement for specifically trained careworkers to administer their insulin. These exceptions need to be carefully documented in the care plan.

Care homes

There were less positive findings in relation to safeguarding in nursing homes and residential care homes. Of the locations inspected, 83% of nursing homes (2,858 inspections) and 88% of residential care homes (6,749 inspections) met the standard in 2011/12 (figure 40).

In line with other sectors, management of medicines was the standard with the poorest performance across the adult social care sector. Of the locations inspected in 2011/12, 67% of nursing homes and 74% of residential care homes met this standard (1,611 and 2,920 inspections respectively).

As CQwC set out in its first Market Report in June 2102, inspectors report a number of recurrent issues concerning medicines management.

Often these impact on other standards. For example, the issue with 'when required' medicines – where there is often a lack of a clear plan to show how the decision to administer the medicines is to be made – is just as much an issue of poor care planning, which we could take as evidence for a failure to meet the standard on ensuring the care and welfare of people.

Similarly, gaps in recording of medicines administration and storage – another of the common findings of CQC's inspectors – could be an issue in relation to the standard on record-keeping.

Staffing

As with healthcare services, so rising levels of demand and the increasing complexity of people's care needs are having a direct impact on staffing levels in social care settings, and the ability of providers to deliver dignified and respectful care.

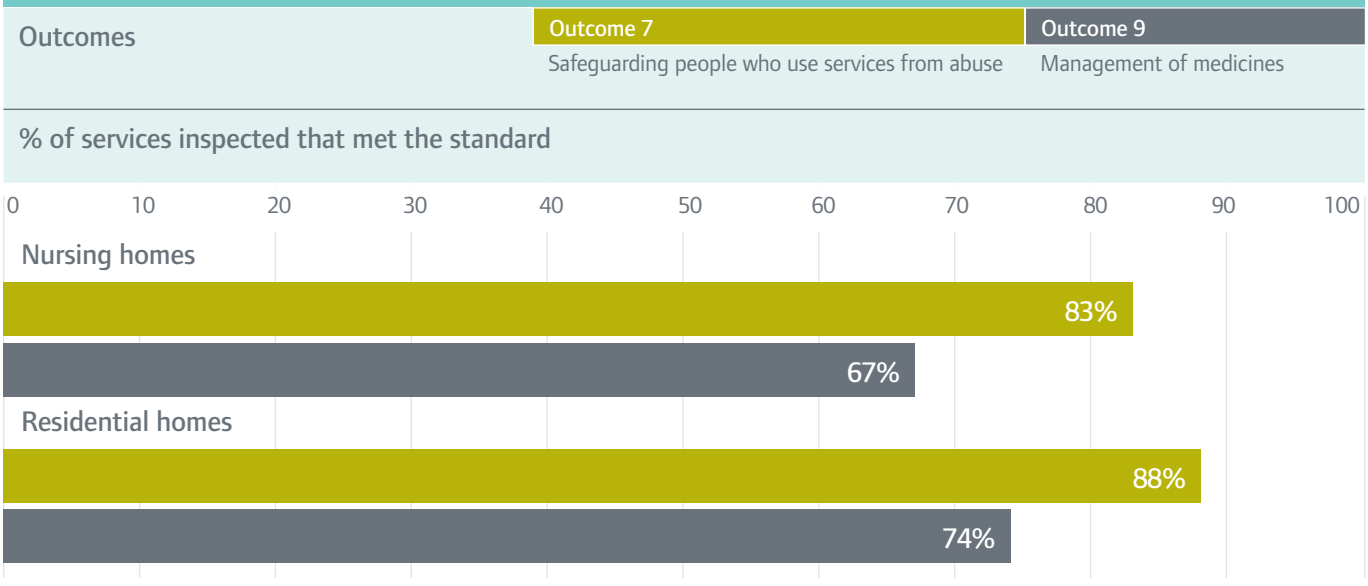
There were a range of issues relating to staffing across the different types of adult social care.

Best performing in respect of having adequate staffing levels were domiciliary care services, where 90% of services inspected (718 inspections) met the standard in 2011/12, and other community social care (235 inspections), where 89% met the standard (figure 41).

However, ensuring there are enough staff to provide a good service is a significant issue in care homes, with 77% of nursing homes (2,031 inspections) and 84% of residential care homes (3,771 inspections) meeting this standard when inspected against it in 2011/12.

In addition, a number of services across the social care sector, including domiciliary care, were not able to support staff with proper training, supervision, appraisals and development opportunities in line with the relevant standard. Of those inspected in

Figure 40: Proportion of care homes and nursing homes meeting standards on safety and safeguarding, 2011/12



Source: CQC

Figure 41: Proportion of adult social care services meeting standards on staffing, 2011/12

Source: CQC

Residential care home

Inspection report October 2011

Example of
Poor practice

"During our visits, we spoke with managers and staff about staff induction and training provided at the home.

"The managers informed us that the Skills for Care common induction standards were not used at the home. We were shown a new induction programme that was in the process of being drawn up.

Staff referred to their induction as being shown around the home, shown the fire and emergency procedures and people's care records.

We spoke with a number of staff regarding their training. Three of them informed us that they had not undertaken any training in respect of managing challenging behaviours. One of these people was an agency member of staff.

We looked at the records kept by the home for six of the agency staff they were using. The records showed us that only two of these staff had any training in managing challenging behaviours. One of the agency staff in question told us that they had already been working at the home for a period of one month."

2011/12, 76% of nursing homes, 84% of residential care homes, 85% of domiciliary care agencies and 85% of other community social care services met the standard (2,283, 4,944, 1,721 and 519 inspections respectively).

In residential care, CQC's inspectors report that the more complex caseload being seen has an impact in a number of areas, including ongoing support and training for care staff.

The nature of domiciliary care means that the workforce is mobile, and staff often work in a different area to where their office if located. Employers therefore need to put extra effort into how and where they meet staff to carry out their supervision, and arranging access to training programmes.

In the very earliest inspection reports published of the themed inspection programme mentioned above, performance was generally good. The main issues were the variability in quality of staff, with some respondents saying that they did not feel new carers had received sufficient training and some raising concerns about particular workers (although generally if they had complained, that staff member had not come again). There were, however, a large number of positive responses praising their regular care worker.

Where inspectors did find problems, they related to training or supervision and appraisals not taking place according the provider's policy or records not being maintained. In addition, there were some comments from people using services that staff were not knowledgeable or familiar with equipment required as part of the care.

Spotlight on good practice

Social care: Supporting staff and staff training

Westview House care home, Isle of Wight provides residential accommodation for 36 people with varying degrees and types of dementia.

Around four years ago, the management team decided that a change in culture and ways of working were needed to ensure that the home was delivering individualised care. They realised that they needed to move away from regiments, timetables and task-driven routines. Kate Hall, the home manager, recalls that *"when I joined as activities coordinator the activities were very regimented and only between certain hours during the week, so nothing at night or on the weekends. A team of us realised that the activities coordinator role is old and it's just not working anymore, that we needed to change things, it can't be regimented, it has to be a 24 hour thing, it has to be spontaneous."*

From this the concept of VITAL was developed – Valuing individuals, Inspiring them to keep Treasured memories and Active Lives. Kate says that VITAL is based on *"the fact that this is very much their home, not ours"* and describes the ways of working that VITAL promotes:

"It's about everyday life, from when they get up to the minute they go to bed. It's about choice, it's about person-centred care. For example, even just asking them what they would like to wear in the morning. We don't have regimented activities, things are very spontaneous. Like they like to dance, so I often find myself boogying. I'll go down and think 'I like that track' and start dancing and a few ladies will start dancing as well. Music plays a big part at Westview. If it's a nice day we may get out to the beach. The staff don't wear uniforms. It's all about bright colours, there's lots of orange, lots of light. The television isn't on unless it's something like a big football match and then we put it on."

To embed the VITAL approach, the care home developed a training programme for all staff working in the home, including kitchen and domestic staff. All new staff learn about VITAL in their induction training. They also receive more in-depth VITAL training before they start work at the home and this is regularly refreshed. Kate says it takes time for people to understand the concept and it's important to spend time with staff to ensure that they fully understand. The staff also receive communication training which is *"about understanding the illness, the different stages, how to communicate with clients in those different stages and how to deal with clients that are volatile or upset."*

The care provided at Westview House is also very much guided by the residents' 'life books': *"A lot of our work surrounds their life books which includes their history, what they like to do and what they don't like. The life book is key to understanding our clients and a key part of how we care for our clients. Knowing the history of clients helps to make them feel safe."*

Managing quality

Complaints handling was the best performing standard in this area for adult social care services. Of those services inspected, 94% of nursing homes (769 inspections), 95% of residential care homes (1,412 inspections), 92% of domiciliary care services (524 inspections) and 92% of other community social care services (159 inspections) met the standard in 2011/12.

It should be noted that, in contrast to the NHS, there is no national data available showing the total number and types of complaints received within the adult social care sector. Many complaints are resolved directly by service providers, and therefore not brought to the attention of any external body. There are no statutory reporting requirements for complaints in this sector, although individual local authorities do report on complaints they have received regarding adult social care that they fund.

When it comes to the standard on assessing and monitoring the quality of care provided however, there was notably varied performance – of the locations inspected, 80% of nursing homes (2,772 inspections), 84% of residential care homes (6,612 inspections), 87% of domiciliary care services (1,981 inspections) and 88% of other community social care services (620 inspections) met the standard.

Perhaps the most common problem in this area in social care was the lack of a good manager in place at the service, or even the absence of a manager altogether as in the example below. Very often, a change of registered manager following action by CQC can result in dramatic changes in the quality of care provided.

Across all types of adult social care, the poorest performance for this group of standards was in relation to records and record-keeping. For records and record-keeping, 70% of nursing homes, 78% of residential care homes, 81% of domiciliary care services and 86% of other community social care services inspected in 2011/12 met the standard (1,007, 1,792, 505 and 149 inspections respectively). As with other sectors, problems with this standard are often early signs of a service's ability to perform in other areas. The increasing complexity of the care required for people and pressures on numbers of staff can impact on services' performance in respect of this standard.

Example of
Poor practice

Domiciliary care service

Inspection report December 2011

"There is no manager in post at the Lancaster location. There is a field care supervisor who covers the Lancaster area. This member of staff is now based at the Preston office, in order to get management guidance and oversight from the registered manager of the Preston location.

"The field care supervisor spends one day each week at the Lancaster office, some time overseeing the care workers in that area and some time at the Preston office.

The registered manager of the Preston office is currently overseeing both locations and is working hard to address shortfalls at the Lancaster service. Service user records have been audited to identify those people who have not had their care plan reviewed and staff files have also been checked for shortfalls, such as no appraisal, no spot checks or gaps in training.

A manager must be appointed and must be registered with the CQC. It is difficult to see how important quality assurance measures can be put in place, monitored and sustained, without a dedicated manager to oversee the service."

87%

Domiciliary care services that met the standard on assessing and monitoring the quality of care provided.

Special focus: Hospital admissions from care homes towards the end of life

The quality of care that people receive at the end of their life is just as important as the care they receive at other times. Everyone as they approach the end of their life should receive high quality, person-centred care and have the opportunity to choose where they die.

CQC regulates the quality of end of life care provision under a number of the essential standards, in particular:

- Respecting and involving people who use services
- Care and welfare of people who use services
- Co-operating with other providers

Also important is the standard covering the training and supervision that care staff are given in carrying out their day-to-day duties.

Registered health and social care providers caring for people approaching the end of their lives are expected to observe relevant evidence-based guidance about good practice and alerts published by expert and professional bodies including the medical royal colleges, faculties and professional associations. In particular, a national End of Life Care Strategy was developed by the Department of Health in 2008, followed up in 2009 with a set of quality markers, which outline the standards that patients and carers can expect of service providers.[54] There is also a relevant NICE quality standard for end of life care.[55]

Many people express the desire to die in their own home. It is important to remember that for a large number of older adults their 'own home' is a nursing or residential care home. In May 2012, the National End of Life Care Intelligence Network (NEoLCIN) reported that 18% of people died in care homes in 2010. However, for people on an Electronic Palliative Care Co-Ordination System (EPaCCS), 29% recorded a preference to die in a care home and 76% were able to die in their preferred place of care.[56]

Analysis of hospital admissions from care homes towards the end of life

CQC conducted a thematic review in 2011 to examine whether care homes were sending people to hospital in the last days or hours of their lives, and also whether people from care homes were spending extended periods of time in hospital before they died.

The review was carried out because current good practice guidance encourages close joint working between care homes, hospitals and primary medical providers to ensure that people are not admitted to

hospital when they could be cared for in their place of residence. NEoLCIN report that 16% of care home residents are still admitted to hospital within the last week of their life, and die there. CQC worked with a wide range of stakeholders including the Department of Health, NEoLCIN, academics and other experts in the field.

The QIPP (Quality Innovation Productivity and Prevention) agenda for end of life care is focusing on identifying people as they approach the end of life, and then ensuring all relevant services jointly plan their care as early as possible, to enable people to avoid unnecessary hospital admissions and supporting them to die in the place of their choosing.

This is also likely to have cost-benefits. Hospital care is estimated to cost twice as much as social care towards the end of life.[57] The length of time somebody stays in hospital before they die can therefore have significant cost implications for hospitals and commissioners. If all people who died in hospital stayed no longer than eight days, then the total estimated cost to commissioners would be lower by approximately £357 million per year.[58]

✓ Spotlight on good practice

Social care: End of life care

Mrs C was 99 years old and had lived independently supported by her son. But her physical condition and cognitive function started to deteriorate, making it very difficult for her to maintain herself at home. Mrs C, her social worker and her son therefore agreed that her needs would be best met in a nursing care home. She had multiple co-morbidities.

On admission, Mrs C and her son were asked about their wishes regarding end of life care. A DNACPR (Do Not Attempt Cardio Pulmonary Resuscitation) form was completed. It was agreed that Mrs C would not receive inappropriate resuscitation attempts and her wish to stay in the care home during her last days was acknowledged.

Mrs C's health deteriorated further and the staff held weekly meetings to review and monitor her needs. Her son was involved and was kept informed about her condition throughout. The care home informed the GP about Mrs C's condition and other healthcare professionals were kept informed, such as the district nurses. Out-of-hours services were informed about her deteriorating condition and that it was her wish to be cared for in the care home in her final days, thereby avoiding inappropriate hospitalisation. She received symptom control and anticipatory prescribing. Through the Namaste care programme in her room, Mrs C received relaxing and relieving measures like massage and the provision of a calming and soothing environment.

There was an occasion when Mrs C was identified as probably being in the last days of her life and she was placed on the Liverpool Care Pathway (LCP), following discussion with her son. Information about the pathway and what to expect was given to him. However after a while, her condition improved and she started to increase her food and fluid intake. At this stage, the LCP was discontinued and her care needs reviewed.

When it was felt that Mrs C was dying, the nurse on duty discussed this with the GP and her son and the LCP was recommenced. Designated staff attended to Mrs C and made sure that all care needs were met and ensured that respect and dignity were maintained at all times. The appropriate spiritual care was given with respect to Mrs C's religious affiliation.

Mrs C's son was involved in her care. He made use of the quiet room where he could rest and take refreshments. He was also encouraged to ask questions about his mother and her care, and was supported by the staff.

After Mrs C died, the staff continued to discuss the quality improvement of end of life care. They completed the action plan and Significant Event Analysis form (SCR6) in the care of the dying. A team discussion revealed that Mrs C's son highly appreciated the care that she was given throughout and identified that some areas of documentation could have been more detailed. Further education and training was provided to improve the awareness of the care staff involved in providing palliative care.

Queens Oak Care Centre, London

What CQC looked at

In the review, CQC used Hospital Episode Statistics (HES) and Office of National Statistics (ONS) data collected in 2010 that contained details of people who were admitted as emergencies to a hospital from a care home and had either died following that admission (either in a hospital or elsewhere) or had been discharged.

The review looked at the number of people in NHS acute trusts who had died shortly after admission as well as those who had remained in hospital for more than a week before they died. It also looked at people who had died outside hospital within three months of their last admission.

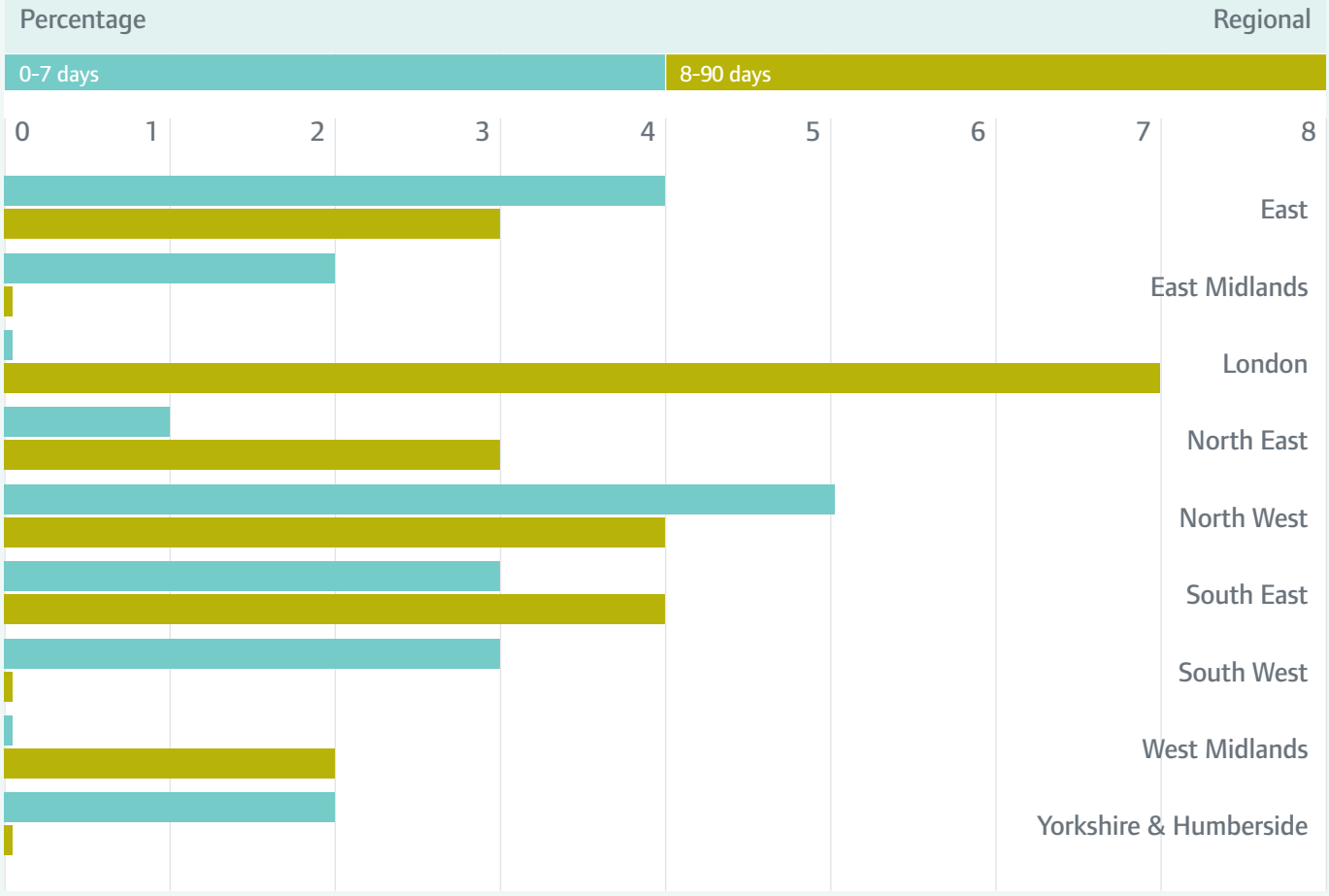
Due to the nature of HES data, CQC was only able to look at people who had recently been admitted to hospital because the HES only record details of people who interact with hospital services. The review did not cover elective (planned) admissions, nor did it include people under the age of 18. We identified admissions from care homes by looking at the patient's postcode at the time of admission. It is important to note that some postcodes, particularly in urban areas, may cover a number of properties in one street, and therefore would not have matched 100% to care homes.

CQC's findings

CQC's data sample contained details of 290,225 admissions from care home postcodes in England (these may include multiple admissions of the same person). Of these admissions, 57,886 people (20% of admissions) died within the three months following admission. Of the people who died, 32,630 (56%) died in hospital and 25,256 (44%) died elsewhere. This compares with the 53% of the general population who die in hospital.[59]

Over half (56%) of the hospital deaths occurred within seven days of admission. More than a third (36%) died with three days. Although there may be sound clinical reasons why people die in hospital, these figures are relevant because a death so soon after entering hospital could mean that the admission was unnecessary; the person may have been reaching the end of their life and could have been cared for in their care home.

Figure 42: Regional comparison of admission periods in NHS trusts with higher than expected rates of deaths in hospital following admission from a care home postcode, 2010



Source: CQC

The other hospital deaths (44%) occurred after longer periods of admission, between eight and 90 days. These figures are relevant for a different reason: if a person spends a long time in hospital before dying, it could indicate that the trust's arrangements for end of life care and its links back to social care services are poor.

For the majority of trusts, the rate of deaths in hospital of care home residents (as a proportion of all deaths of care home residents) was similar to the average across all trusts, with a small number of trusts with lower or higher rates than the average would lead us to expect. Of the 157 trusts included in the review, when looking at the rate of deaths in hospital of people with care home postcodes, 68% were statistically similar to the average across all trusts, 14% were higher and 18% were lower.

There were some regional variations: the North East had the highest proportion of trusts with higher than average rates of hospital deaths for people admitted from care homes, followed by London and the West Midlands; while the South West had the smallest proportion. However, it should be noted that these proportions are based on very small actual numbers of trusts: there were between one and six trusts per region with higher than average rates, and between zero and eight trusts per region with lower than average rates.

Where deaths of people admitted from care homes occurred in hospital, there were regional variations in the length of time those people stayed in hospital before they died. All regions had some trusts where the rate of hospital deaths of people from care homes was higher than expected (expectation based on the average across all trusts). When we looked at how long such people stayed in hospital before they died, there were differences between regions – for example, London had seven trusts with higher than expected rates of death in the 8-90 day period but none in the 0-7 day period; whereas the North West had five trusts with higher than expected rates of death in the 0-7 day period and four trusts in the 8-90 period (figure 42).

Our analysis also looked at causes of death. Almost two-thirds of those people admitted from care homes who died from respiratory disease died in hospital (64% of deaths from respiratory disease). In contrast, just under 40% of those admitted from care homes who died from cancer died in hospital (table 2). When looking at all those admitted from care homes who died in hospital, people with cancer formed the lowest proportion of people dying in hospital (8%), followed by people with respiratory disease (21%), people with circulatory disease (30%), and people whose cause of death was 'other' (40%).

NEoLCIN report that, for the population overall, respiratory diseases are the 'underlying' cause of death category for which the highest proportion of patients dies in hospital (69%).

Table 2:
Place and cause of death for people admitted from care homes in England, 2010

	Place of death				Total deaths		Proportion of all hospital deaths of people with care home postcodes
	In hospital		Out of hospital				
	N	%	N	%	N	%	%
Cancer	2,727	39	4,230	61	6,957	12	8
Respiratory disease	6,788	64	3,753	36	10,541	18	21
Circulatory disease	9,931	58	7,243	42	17,174	30	30
Other	13,184	57	10,030	43	23,214	40	40
Total	**32,630**	**56**	**25,256**	**44**	**57,886**	**100**	**100**

Source: CQC
Note: percentage figures have been rounded to nearest whole number

Special focus: Key learning on restrictive practices in mental health and mental capacity

CQC's statutory responsibilities under the Mental Health Act (MHA) and the Mental Capacity Act Deprivation of Liberty Safeguards (DoLS) were established to protect the human rights of some of the people who are the most vulnerable due to their circumstances in the health and social care system. CQC's role is to monitor, report, comment and ensure that the appropriate legal frameworks operate effectively to safeguard people's welfare.

CQC shares intelligence between its compliance inspection activity (under the Health and Social Care Act) and its MHA and DoLS monitoring. Its findings in respect of compliance with the essential standards, as far as they relate to affect mental health and learning disability services, are included in the different sector chapters above.

The poor care and abusive practices uncovered at Winterbourne View Hospital in 2011 showed that there remains much to be done to ensure that people with learning disabilities, mental health needs and challenging behaviours are not discriminated against, and their human rights respected.

CQC's review of services for people with learning disabilities – which looked across sectors at NHS, independent healthcare and adult social care services – found that, while progress has been made to improve the lives of people, challenges still remain in making further positive changes that give people back their independence and control. People are admitted to these services because they need help and support – for some this will have been at a time of crisis. But in too many cases care is not person-centred; people are fitted into services rather than the service being designed and delivered around them.

The review said that, in some instances, there was a failure by care staff to understand the potential negative impact of restrictive and institutional practices. This arose from a poor understanding of restraint and a lack of monitoring of when and how it was used, leading to an increased risk of restraint being used inappropriately.

This section is a brief overview of some of CQC's specific findings in respect of the operation of the MHA and DoLS, and in particular work on raising awareness of restrictive practices in services for people with mental health and/or mental capacity problems.

People whose rights are restricted under the Mental Health Act

CQC has a duty under the Mental Health Act 1983 to monitor how services exercise their powers and discharge their duties in relation to patients who are detained in hospital, or subject to community treatment orders or guardianship under the MHA.

CQC's MHA Commissioners meet patients in private to discuss their experiences and concerns, to make sure they understand their rights and check that staff are using the Act correctly. The MHA Commissioners also talk to staff and review legal documents and patients' notes. Their main aim is to identify where the Act is not being used correctly and where patients have concerns about their care and treatment.

CQC's annual report covering the 2011/12 year will be published in early 2013. (The aim is to publish future MHA annual reports earlier in the year.) In its most recent report, covering 2010/11, CQC noted some good examples of patients having significant input into planning their care. But equally, a lack of patient involvement continued to be one of the issues most frequently raised by MHA Commissioners.

The MHA Commissioners saw a number of good examples of hospitals helping current and former patients get involved in how the ward is run. And they confirmed that patients had an opportunity to influence this, for example through community meetings or patient councils, on 90% of the wards where they checked this.

They looked at access to independent mental health advocacy services and found that detained patients had regular access to an independent advocate (IMHA) on 65% of wards visited. IMHAs would come when requested on 85% of wards. Problems continued with commissioning arrangements for some IMHA services, particularly for patients placed out of area.

The assessing and recording of capacity and consent was an issue where CQC had previously identified the need for significant improvement. Again, MHA Commissioners saw some examples of good practice, but there was still significant scope for improvement in some hospitals.

MHA Commissioners continued to meet with patients who raised issues about feeling bored or wanting more to do while they were in hospital – often with a sense that meaningful activities came some way down the list of considerations in their treatment or care plan.

The vast majority of patients (90%) said that there were activities available on the ward, though fewer (78%) reported access to activities available off the ward. Around a third of patients said there wasn't enough for them to do on weekdays, a figure that rose to more than half of patients during the evening and almost two-thirds at weekends.

Overall, a wide range of therapeutic activities were available on most wards, and these were advertised reasonably well and reviewed on a regular basis. However, the analysis did raise questions about how well activities were tailored to individual needs and interests, and how effectively patients were encouraged and motivated to take part.

Use of the Deprivation of Liberty Safeguards

The Deprivation of Liberty Safeguards (DoLS) provide a legal framework to ensure people are deprived of their liberty only when it is in their best interests and there is no other way to care for them or provide treatment safely. The Safeguards apply to all people aged 18 and over who lack mental capacity to give consent to the arrangements for their care or treatment, for example because of dementia, brain injury or a severe learning disability.

All care homes and hospitals in England must apply for authorisation if they propose to deprive someone of their liberty by, for example: keeping them locked in; physically restraining them; placing them under high levels of supervision; forcibly giving them medicines; or preventing them from seeing relatives and friends.

CQC published its second report on the Safeguards in March 2012, covering the period 2010/11.[60] It found that many providers had developed positive practice, notably in involving people and carers in the decision-making process. However, there remained some confusion about what constitutes a deprivation of liberty, and this can cause inconsistent practice. CQC also found that staff training and awareness of the Safeguards varied a great deal, and some providers had still not trained their staff in the Safeguards.

Around a third of care homes that CQC inspectors asked about DoLS training had not provided it. The level and grade of staff receiving training varied, and there was some evidence that where training had taken place, staff were not confident in their understanding. In all the NHS hospitals asked about DoLS training there was evidence that at least some staff had received this; however there was variation in the proportion of staff trained. Across all relevant health and social care providers, training and guidance, including updates, are likely to be key to developing consistent practice.

In the year to 31 March 2012 there were 11,393 applications in England for a Deprivation of Liberty assessment, an increase of 27% over the previous year (8,982 applications).[61] More than half the applications (56% or 6,343) resulted in an authorisation being granted (that is, the deprivation of liberty was allowed).

The proportion of applications from hospitals to primary care trusts rose from 25% in the previous year to 28% in 2011/12, and the proportion from care homes to local authorities fell from 75% to 72%. Local authorities granted a higher proportion (57%) of applications than PCTs (52%). This suggests that someone in a care home is more likely to have a DoLS authorisation granted than someone in hospital.

Restrictive practices in mental health and learning disability settings

Taken together, CQC's themed inspection programme of services for people with a learning disability and MHA visits in 2011/12 have highlighted a range of concerns about the enduring use of restrictive practices in services for people with mental health and/or mental capacity problems. CQC joined with partners in a Restrictions on Liberty symposium in October 2012 to discuss the following issues, and raise awareness of them among providers and their staff.

Concerns about restrictive practices

- **Physical restraint**

CQC saw much variation in the frequency and intensity of use of physical restraint. However, one problem for our inspectors and MHA Commissioners was that sometimes it was difficult to work out from patients' records how often, and for how long, restraint had been applied, and what actually happened during the restraint – raising questions of how decisions about care are accounted for and monitored.

Sometimes more holistic concerns were raised, such as the lack of information about what might have triggered the behaviour that challenged staff, or no indication that any learning might have come out of the event. It was rarely evident that staff were working with the person and their family to explore ways to avoid crisis and ways that the person would prefer to be cared for during a crisis.

- **Seclusion and segregation**

There were a significant number of concerns about the use of seclusion to manage challenging behaviours. Safeguards were not always implemented and, in particular, poor recording did not give a clear picture of the use of seclusion and longer-term segregation.

A range of different terms were used to describe circumstances in which people might effectively be detained in seclusion: "Nursed in his room", "Placed in the low-stimulus area for a sustained period" or "Chose to be in the safe-care suite".

MHA Commissioners noted that seclusion was sometimes unavoidable, and managed in accordance with the Mental Health Act Code of Practice. But sometimes there was not enough information about the use of seclusion as a form of restraint.

There were not always individual care plans with guidance on avoiding restraint or seclusion, or a clear account of which less restrictive practices were considered, how long the seclusion lasted, and how the person's safety was monitored during and after it.

- **'Blanket rules' governing life in a ward, unit or care home**

Typically, blanket rules related to access to communal rooms, kitchens, the person's own bedroom (whether locking them out of their bedroom during the day, or insisting on a general and often early bedtime), and gardens and outdoor space. There were also rules in some settings about when a patient or resident might have a drink or a snack, or go for a cigarette. This happened in all types of care setting.

Such rules can rarely be justified in terms of a person's individual care plan. They were often explained as having arisen as a response to a particular incident, but may have continued long after the event.

Blanket rules can be triggers for challenging behaviour. They may be for the convenience of staff, or responses to concerns about the unhealthy choices

made by some patients, but their effect is to limit autonomy and make people feel overly controlled or even unable to exercise their own choices.

In some settings, staff members told people that their takeaway meal, or outing, would not be allowed as a punishment for certain behaviour. Such 'contingency rewards' are concerning, and often perceived by patients and residents as 'blackmail'. As a patient explained: "If you do not do x then you will be refused section 17 leave, cigarette time or have your own music removed."

- **Lack of understanding of the Mental Health Act**

CQC's MHA Commissioners and inspectors were concerned about the confusion over the rights and treatment of informal patients – that is, those who are voluntary patients and therefore not detained under the Mental Health Act. Examples included informal or voluntary patients being subjected to the same restrictions as detained patients, or subject to de facto detention – for example when they know they will be detained if they try to leave the ward. MHA Commissioners noted, on a ward where only a small proportion of patients were detained under the MHA: "Staff were not sure who was 'allowed out' and with which members of staff. We did not see any risk assessments on this or consideration to the deprivation of liberty that this may impose on those patients not formally detained."

- **Poor staff patient relationships; staffing difficulties**

There were concerns in a number of visits and inspections about poor relations with staff, or other staffing problems. Sometimes this was staff speaking in a derogatory way to, or about, people, or exercising petty and arbitrary controls over diet, smoking, privacy and contact with family and friends.

Staffing shortages were also a contributor to other restrictions – for example, where there are few staff on duty, smoking or other outdoor activities tend to be restricted.

Where people who use services appeared isolated, it was likely that staff were also separated from support from their managers and other professionals, and also from the support and cooperation of people's relatives and friends. Risk factors that are associated with overly restrictive practice include geographical isolation and an introspective culture, quantitative and qualitative staffing difficulties (not enough staff, of not high enough quality), a lack of training and supervision, and weak leadership both locally and within the organisation.

Next steps

In line with its proposed strategic direction over the next three years, set out in its consultation document *The next phase* published in September 2012, CQC's intention is to make more use of its unique sources of information, and the information held by others, to drive improvement in how services are provided and promote best practice. Its discussions with the public and stakeholders have strongly indicated that they would welcome CQC using its voice in this way.

CQC will do this by:

- Being clear about good care (what works well) and poor care.
- Reporting on the state of the different sectors, identifying problems and challenges in how services are provided and commissioned and recommending action.

The State of Care report for 2012/13 will incorporate and synthesise CQC's findings from the following pieces of work that it will be publishing in the coming months:

- The themed inspection programme examining the care given to people in their own homes by 250 domiciliary care providers.
- The themed inspections of dignity and nutrition in 500 care homes and nursing homes.
- The follow-up inspection programme looking at issues of dignity and nutrition in 50 NHS hospitals.
- Reviews of information and data on three topic areas:
  - Dementia care during admissions to hospital
  - The experiences of people waiting for NHS treatment
  - The physical health needs of people with a learning disability.

In addition, CQC will be able to include the findings of some of the first inspections it carries out in GP surgeries and practices.

Appendix: The essential standards

The Health and Social Care Act 2008 introduced for the first time a common set of standards – the essential standards of quality and safety – that apply across all regulated health care and adult social care services in England. Working to this new regime, CQC registered all NHS trusts and hospitals from April 2010 and independent healthcare and social care providers from October 2010.

Therefore, 2011/12 was the first full year in which the standards had been in place across both health care and adult social care.

CQC also registered primary dental care and independent ambulance providers from April 2011. It began to inspect these services later in the year; therefore, its picture of these sectors is based on very early findings. It will be able to present a much fuller analysis in the next State of Care report.

In April 2013, GP practices and primary medical care services will also come into this regulatory system.

Once providers are registered, CQC inspectors check that the essential standards of quality and safety are being met. There are 28 standards in total but, of these, they focus on 16 standards that most directly relate to the quality and safety of care. CQC produces guidance for providers that helps them understand what meeting the essential standards looks like. The guidance sets out the outcomes that a person using the service can expect to experience if the provider is meeting the essential standards – with each essential standard having a corresponding outcome. Table 3 shows the 16 outcomes and what each of them means.

Each of CQC's inspections looks at a different range of outcomes, so not every outcome is assessed at every inspection. CQC inspectors carry out a mixture of planned inspections (conducted as part of CQC's ongoing programme), responsive inspections (conducted in response to a problem or concern being raised with CQC) and themed inspections (looking at a particular issue or type of care). Almost all of these inspections are unannounced.

Table 3: The 16 essential standards – outcome numbers and titles and what they mean for people who use services

Outcome		What people have a right to expect
1	Respecting and involving people who use services	People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run
2	Consent to care and treatment	Before people are given any examination, care, treatment or support, they should be asked if they agree to it
4	Care and welfare of people who use services	People should get safe and appropriate care that meets their needs and supports their rights
5	Meeting nutritional needs	Food and drink should meet people's individual dietary needs
6	Cooperating with other providers	People should get safe and coordinated care when they move between different services
7	Safeguarding people who use services from abuse	People should be protected from abuse and staff should respect their human rights
8	Cleanliness and infection control	People should be cared for in a clean environment and protected from the risk of infection
9	Management of medicines	People should be given the medicines they need when they need them, and in a safe way
10	Safety and suitability of premises	People should be cared for in safe and accessible surroundings that support their health and welfare
11	Safety, availability and suitability of equipment	People should be safe from harm from unsafe or unsuitable equipment
12	Requirements relating to workers	People should be cared for by staff who are properly qualified and able to do their job
13	Staffing	There should be enough members of staff to keep people safe and meet their health and welfare needs
14	Supporting workers	Staff should be properly trained and supervised, and have the chance to develop and improve their skills
16	Assessing and monitoring the quality of service provision	The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care
17	Complaints	People should have their complaints listened to and acted on properly
21	Records	People's personal records, including medical records, should be accurate and kept safe and confidential

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