



The state of health care and adult social care in England

An overview of key themes
in care in 2009/10



Care Quality Commission

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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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FOREWORD

by the Chair and the Chief Executive

This is our second annual report on the state of health care and adult social care in England. It covers the period April 2009 to March 2010 and is based on CQC's responsibilities under the previous legislation, the Care Standards Act 2000 and the Health and Social Care Act 2003.



People who use services tell us that they want care that is safe and of decent quality. They also want choice and control over their care, and for it to be tailored to their needs as individuals. We have therefore mapped all of the relevant data and information that we hold against these headings, when setting out the results of our assessments in this report.

We looked at outcomes for people using health care and social care services in 2009/10, to provide a picture of their experiences within the previous legislative framework. We have taken a broad view across the public, private and voluntary sectors, drawing on the evidence we have gathered from our regulation of providers and assessment of local authority commissioners. Wherever possible, the information that we have used is based directly on the experiences of people who use services.

Improving services for the people who use them demands a concerted approach by commissioners and providers, working closely with the public. Our report shows that there have been real improvements in health care and adult social care over time, but no significant upward shift in 2009/10. However, many people had greater control over their care, through more choice about appointment times, the location and their care provider. We also found that independent health care providers were treating more serious health conditions, which again increases people's choice.

Our analysis of the data found that care was safer in 2009/10 than in previous years. There were fewer healthcare-associated infections and services had made improvements in protecting adults from abuse and neglect, showing greater awareness of the issues and investigating concerns more effectively.

However, our report also highlights unacceptable levels of variation across England in provision of adult social care and in progress to improve outcomes. While more of those who were receiving funded care had access to personalised services through direct payments and personal budgets, there were wide variations in progress. And because the number of people who were eligible for funding fell, fewer had the option of being in control of their care in this way.

Our special review of services for people who have had a stroke and for their carers revealed that in many parts of the country community care and support for people after leaving hospital needs to improve significantly.

Mental health services varied in the extent to which they involved patients in planning their care and reviewing their treatment. A finding of particular concern to us was that many detained patients who were certified as consenting to treatment, appeared to be refusing to give consent or lacked the capacity to do so.

To protect people from poor-quality care, we took action where necessary using our regulatory powers under the previous legislation. We also worked with other parts of the sector responsible for performance management of the care system, such as strategic health authorities, primary care trusts, local authorities and government offices for the regions.

The next few years will be a crucial time for health care and social care in England. Important system changes are being introduced, along with new structures in health and local government including HealthWatch; GP-led commissioning consortia; the NHS Commissioning Board; Health and Well Being boards; and Monitor, the new economic regulator.

CQC will, of course, continue to carry out its strengthened regulatory role, with responsibility for assessing quality across the care sectors. Using our powers under the Health and Social Care Act 2008, we developed a new system for regulating providers of health care and adult social care in 2009/10. We introduced this new, registration-based system in the NHS in April 2010, and in social care and independent health care in October 2010. Based on ongoing monitoring of compliance, it is more closely linked to 'real time' events, which allows us to identify and respond more quickly if a service is not meeting essential standards of quality and safety.

Over time, there have been significant improvements in outcomes for people who use health care and adult social care. We believe that it is now vital that all parts of the newly emerging care system build on that positive position. Together, we must consolidate the best of what has worked well for people who use services, and ensure that everything we do in the future is informed by their views and experiences.



Chair
Jo Williams



Chief Executive
Cynthia Bower

SUMMARY

This report to Parliament describes the state of health care and adult social care services in England in 2009/10. Our findings refer mainly to evidence from regulation, assessment and review activities. We also highlight the views of people who use services, and draw on facts and figures from published national statistics.

2009/10 was the last year in which services were regulated under the Care Standards Act 2000 and the Health and Social Care Act 2003. When carrying out our regulatory responsibilities during the year, we used criteria and methods inherited from predecessor organisations and previous legislation, apart from our work registering and monitoring NHS trusts' compliance with new regulations on healthcare-associated infection from April 2009.

New laws governing the regulation of health care and adult social care in England came into force in 2010. The legislation introduced a common set of essential standards of quality and safety that all care providers must now meet.

We intend that the evidence we have used and the conclusions we have drawn in this report should inform and encourage action to improve the quality of care for

people using services in 2011 and beyond. We highlight progress with improvements in quality, and also make clear where progress is needed to meet the standards that people who use services have the right to expect.

The report covers all of the services that CQC regulated and assessed under the previous legislation:

- Adult social care services (care homes, nursing homes and home care agencies).
- The NHS and independent health care services.
- Councils and primary care trusts (PCTs), which provide and purchase (commission) adult social care and health care services for their communities.

The report has four main sections: safe care, choice and control, person-centred services, and standards of care. The following is a summary of our main findings.

Safe care

Safety is not simply about the obvious risks to health from infection, incompetent practice or lack of cleanliness. It also includes protection from neglect and subtle forms of abuse that may be more difficult to detect. We found that:

- There was a reduction in some healthcare-associated infections such as MRSA, and patients thought that hospitals were cleaner. We tackled poor performance swiftly and effectively through our monitoring and inspection work.
- There were significant improvements in protecting adults at risk from abuse or neglect, with care services showing greater awareness and investigating concerns more effectively than in previous years.
- More care homes and home care services made improvements to meet safe care standards, including safe working practices, hygiene and infection control. But still too few met the standard for managing medicines.
- In a significant minority of mental health inpatient wards, over-occupancy and inadequate staffing, which can compromise safety, continued to be an issue.
- Some Black and minority ethnic groups were over-represented in the total number of patients detained in hospital, or subject to community treatment orders, under the Mental Health Act.

Choice and control

Priorities for improving choice and control have been to promote a wider range of good quality services that maintain health and support independent living. People are increasingly knowledgeable about health and care and this raises their expectations and confidence when they use services. We found that:

- Improved practices in many acute hospitals and among GPs have increased convenience for patients, giving greater choice over appointment times.
- There was a continuing rise in the numbers of private sector health services and in the proportion of private care services, and a continued reduction in the number of NHS beds and in-house care services provided by

local councils. This has presented more options for people who fund their own care or treatment or where treatment is purchased by the NHS.

- Independent health care options expanded further to treatment of more serious conditions, for example those requiring dialysis.
- When visiting mental health inpatient wards, our Mental Health Act Commissioners sometimes had concerns about the level and indiscriminate nature of restrictions placed on patients, which reduced their liberty and therefore their control.
- Some important changes to widen choice in social care had gathered pace. A higher number of 'personal budgets' offered more people the flexibility to arrange the personal support they need to live at home, and to pay for it directly. However, these choices could only benefit the reducing number of people who had access to council-funded services in the first place.
- The number of adults receiving a community care service fell by nearly 5% against the previous year, according to (provisional) national statistics, despite rapid growth in the number of older people in the population likely to need support. The number of financially supported care home admissions continued to fall, but the number of community care services was also substantially reduced. This meant that proportionally fewer people benefited from the wider choices becoming available to people who still qualify for a service.

“We intend that the evidence we have used and the conclusions we have drawn in this report should inform and encourage action to improve quality of care for people using services in 2011 and beyond.”



Person-centred services

For many years now, it has been national policy that care services should focus on meeting each individual's needs. Person-centred care puts people at the centre of the design and delivery of the services they use, and matches their differing needs with an equally diverse range of services. It also means organising health care around patients and providing timely and convenient services that not only manage and cure ill health, but also help to prevent it. We found that:

- More people had access to personalised services through direct payments and personal budgets, but there were wide variations in progress across the country.
- Councils found it challenging to extend further the options for independent living. Fewer people received publicly funded community care services in 2009/10 compared with previous years.
- People were generally treated with respect when first seeking advice and support. However, councils need to give more attention to carers' needs at first contact, and when they redirect people to other (usually voluntary) organisations for support, they should look at a sample of these people afterwards to find out if the outcomes needed were met.
- There was mixed progress in avoiding unnecessary hospital admissions and ensuring effective hospital discharge, with much variation between councils. There was significant growth of intermediate care services, but the numbers of people over 75 who had repeated emergency admissions suggested a lack of effective community support.
- The support available for people when leaving hospital after a stroke varied significantly across England. While the treatment that people received in the hours and days immediately after stroke had improved, many areas needed to improve the community-based care and support that people receive in the weeks following discharge and in the longer term.

“There was significant growth of intermediate care services, but the numbers of people over 75 who had repeated emergency admissions suggested a lack of effective community support.”

Standards of care and support

Since our last report, we have seen further improvements in many aspects of the quality of health care and social care services, and still fewer services that give serious cause for concern. We believe that this has been due partly to the actions of service providers and commissioners, and partly to effective regulation. Some aspects of quality deteriorated, however, and there is still a way to go in reducing variations between and within regional areas. We found that:

- Overall, performance in social care improved again, and so continued the trend of recent years. For the seventh successive year, no councils were rated “poor”.
- The proportion of councils judged to be “excellent” in improving the quality of life for people who use services increased from 25% in 2008/09 to 34% in 2009/10.
- The overall quality of regulated care services continued to show further improvement overall. The proportion of services rated “poor” fell from 3% in May 2008 to 1% in April 2010.
- The variable quality of inpatient mental health services, as suggested by our visits to wards with detained patients, continued to cause us concern. For example, some wards were over-occupied, or showed a lack of one-to-one work with patients or unnecessary restriction of people’s liberty.
- The proportion of care services arranged by councils that achieved higher quality ratings improved considerably: the percentage of people supported in “good” or “excellent” care homes rose from 75% to 86% in 2009 and the percentage of people supported by home care agencies rated good or excellent rose from 87% to 93%.

86%

of people living in council-funded care homes were in homes we rated either “good” or “excellent”, compared with 75% the year before.



SAFE CARE



**Member of cleaning staff
at nursing home involved in
MRSA screening project**

Introduction

Safety is fundamental to high-quality care.¹ Everyone who uses health care and social care services should be able to feel confident that they will be protected from avoidable harm and treated with compassion, dignity and respect.

Wherever the setting, the care environment must be safe and clean, and people should be protected from healthcare-associated infections. They should feel assured that healthcare staff pay proper attention to safety in diagnosis and treatment, and that their discharge from hospital is planned in a way that minimises the risk of them needing to be re-admitted.

People in vulnerable circumstances can be at risk of abuse and neglect, and should be safeguarded when they are unable to protect themselves. All the agencies involved in a person's care should work together to reduce the risk of abuse, and respond quickly if abuse of any kind occurs.

In our last State of Care report, which looked at care in 2008/09, we had noted unacceptable variations in services' performance against safety standards. We called for good practice in safety, safeguarding arrangements and workforce training to be implemented more widely.

When assessing services' progress in delivering safe care in 2009/10, we have drawn mainly on surveys of patients using NHS services, routine monitoring of special health care issues, our performance assessments of all councils with adult social services responsibilities and our assessment of adult social care services. Direct comparisons with previous years have not always been possible because of changes to reporting. We have nevertheless been able to identify some areas of progress and areas where improvement is still needed.

"We were one of two care homes in the area that nominated ourselves to be involved in the year-long screening and training project with Bournemouth PCT. We were keen to see what the results would show about our practices and levels of infection, and to give our staff the opportunity of more training in infection control and prevention."

Seema, Director of Nursing at a nursing home in Poole

Key messages about safe care in 2009/10:

- Progress continued in reducing healthcare-associated infections such as MRSA. Our inspection programme was effective and swift in dealing with poor performance, and feedback from patients also indicated good progress with cleanliness in hospitals.
- Patients' perceptions of other aspects of safe care remained broadly similar to previous years, showing either very slight improvement or very slight deterioration.
- Survey responses showed no improvement in information for patients when leaving hospital. Too many of them – around 40% – said they were not told what danger signals to watch out for after they went home. Around 45% of respondents said that they were not told enough about the side-effects of medication.
- There was a substantial increase in the number of care homes and home care services meeting safe care standards, including safe working practices and hygiene and infection control. Further improvement in management of medicines is still needed.
- Councils made significant improvements in adult safeguarding and in maintaining the dignity and respect of people in vulnerable circumstances.
- Over-occupancy and inadequate staffing, which can compromise safety, continued to be an issue on a significant minority of the inpatient wards that our Mental Health Act Commissioners visited. Further progress is needed in monitoring mental health patients' physical health needs, and in ensuring that those who live in the community have access to crisis support.
- Some Black and minority ethnic groups were over-represented in the total number of patients detained in hospital, or subject to community treatment orders, under the Mental Health Act.

Safe patient care

In 2009/10, we assessed the safety and quality of services provided by more than 400 NHS provider trusts, 1,500 registered independent health providers, and more than 12,500 registered adult social care providers, mainly against criteria in the previous legislation of the Care Standards Act 2000 and the Health and Social Care Act 2003.

In this section we give an overview of developments in safe care and report on some of the monitoring systems in place to minimise risks to patients. Our report focuses on the national picture in the NHS, while benchmarking data on the performance of individual trusts is available on the CQC website.²

The sheer number of services that exist, and the associated range of possible risks to health and wellbeing, make safety regulation a huge and complicated undertaking. What constitutes risk, how different types of risk are assessed and monitored, and what levels of risk are acceptable or unacceptable are all complex and widely debated issues. This is reflected in the wide variety of ways in which safety in NHS hospitals is assessed and understood.

Our monitoring and analysis work in 2009/10 continued to identify “mortality outliers” – a term used to refer to an unexpectedly high ratio of observed to expected deaths in a hospital. We work closely with any hospitals in which such issues arise, to ensure that they understand the underlying causes and take action to resolve them.

The publications of the Dr Foster organisation, which is partly funded by the Department of Health, pointed to overall safety improvements in hospitals in 2009/10.³ Deaths in hospitals were reported to have fallen by 7% between 2008/09 and 2009/10, but variations in mortality ratios persisted.



Patient safety incidents and alerts

It is crucial that organisations report their mistakes and near misses, so that they can learn and put things right, and create a culture of improvement in safety. Such reporting also helps other services to reduce safety risks. The National Patient Safety Agency (NPSA) collects patient safety incident reports from all NHS organisations and it was a positive sign that the reporting of incidents continued to rise during the year. In 2009/10, 1.19 million incidents were reported to the NPSA, an increase of 18% over 2008/09. As well as this rise in the overall reporting rate, there was an increase in the number of organisations that reported incidents.⁴

The NPSA routinely analyses the information it receives to identify areas of urgent risk and then sends safety alerts to NHS trusts and independent providers. These alerts are a critical tool for ensuring safer care – by implementing them services can help to reduce risks for people in the future.

There was a clear improvement in NHS trusts' response to safety alerts in 2009/10. No trust said that it would take longer than six months to become compliant with them.⁵

Patients' perceptions of the safety of NHS care

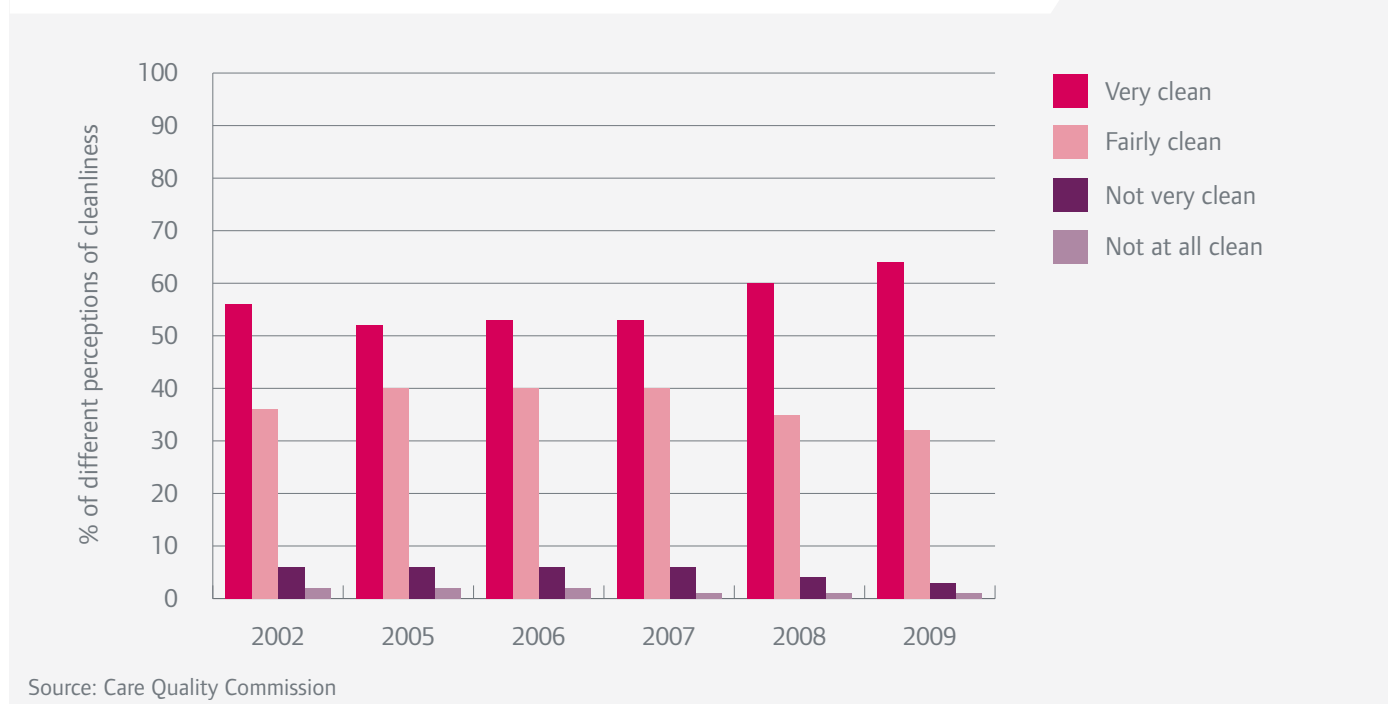
We asked patients about their experience of NHS care in four major surveys in 2009 and 2010. We received responses from 69,348 adult inpatients, 72,447 adult outpatients at acute and specialist trusts, 25,000 women who gave birth in NHS maternity facilities or at home and 17,199 people aged 16 or over who were using community services provided by mental health trusts.

In this section we report on these patients' perceptions of aspects of safe care, highlighting any changes from previous years. All the changes reported were statistically significant, in that they were unlikely to have occurred by chance. However, most of the changes over time were small – often around one percentage point or less.^{6, 7}

Cleanliness

Patients' feedback suggested good progress in hospital cleanliness, with year-on-year improvements since 2005. By 2009, 64% of inpatients thought the hospital room or ward was "very clean" – a rise of four percentage points since 2008 – and a further 32%

Figure 1: Inpatients' perceptions of cleanliness of hospital wards, 2002–2009



found it “fairly clean”. Those who thought it was “not very clean”, or “not at all clean” dropped from 5% to 4%. Responses about cleanliness of bathrooms and toilets showed similar levels of improvement.

People’s responses in the outpatient survey reflected similar improvements.

Washing and cleaning hands before contact with patients is essential to control the spread of infection within hospitals. There was an increase in the proportion of inpatients who reported that, as far as they knew, doctors and nurses “always” washed or cleaned their hands between touching patients.

Ninety-six per cent of respondents remembered seeing posters or leaflets asking patients to wash their hands or to use hand-wash gels and 97% of patients said these were available for patients and visitors to use. One per cent of respondents said that the hand-wash gel containers were empty and 2% said that they did not see any hand-wash gels while in hospital.

Security

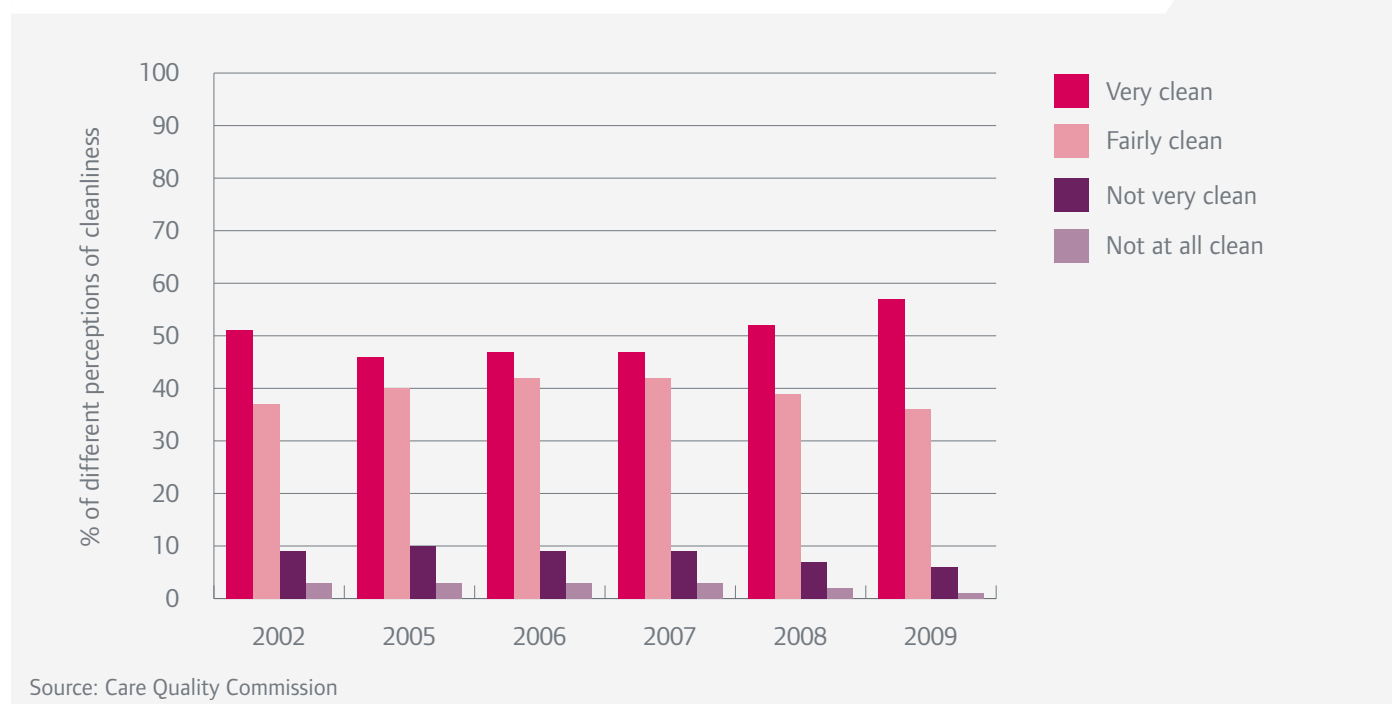
A small proportion of respondents (4%) in acute and specialist trusts, excluding people using mental health

services, said they felt threatened by other patients or visitors during their stay in hospital. This percentage had not changed since the previous year. Just under a third of inpatients (32%) stated that they had somewhere on the ward to keep their personal belongings, which they could lock if they wanted to – an increase of just one percentage point since 2008. Four per cent of respondents reported that they had nowhere to keep their personal belongings, showing no change since 2008/09. The remaining 63% of respondents said that they did have somewhere to store belongings but no way to lock it, compared with 65% in 2008.

Responses to calls for help

Overall there has been very little change since 2008 in how quickly call buttons were usually answered. The proportion of inpatients who stated that call buttons were answered “right away” went down from 17% in 2008 to 16% in 2009. Otherwise there has been no change since 2005: 38% of respondents said their call was answered in one to two minutes, 29% said between two and five minutes, 15% said more than five minutes, and 2% said they never got help when they used the call button.

Figure 2: Inpatients’ perceptions of cleanliness of toilets and bathrooms, 2002–2009



Patients' feedback on hospital discharge

Information to patients on discharge

When people are discharged from hospital, they need good information about any risks and danger signals to help them to manage their ongoing care safely, to manage their medication and to know whom to contact if they have a concern. Feedback from the inpatient survey showed that many patients did not receive this crucial information and that there had been very little improvement since previous years:

- More than a third of patients (37%) said they were not given written or printed information about what they should or should not do after leaving hospital.
- A quarter of patients (25%) said they were not told whom to contact if they were worried about their condition.
- A third of patients (33%) said that doctors and nurses did not give their family or someone close to them all the information they needed to care for them.
- Fewer than one in five patients (18%) said they were not given clear written or printed information about their medicines, and 45% said they were not told about possible side-effects.

Feedback from the outpatient survey raised similar issues. A third of outpatients were not told about danger signals to watch out for after leaving hospital or whom they could contact about them, although this represented some improvement over previous years. Thirty-five per cent of outpatients were not told about possible side-effects of their medication.

Effective communication between professionals is also crucial for safe care. The Department of Health's guidance states that patients should receive copies of letters sent between clinicians. Although the majority of inpatients (53%) did not receive copies of letters sent between hospital doctors and their GPs, the proportion of those who did improved from 35% in 2005 to 47% in 2009. There had also been some improvement for outpatients – the percentage who said they had received some or all of these letters rose from 22% to 44%.

1/3
of patients who responded to our survey were not told about danger signals to watch out for after leaving hospital or who to contact about them.

Lack of effective communication and information at the point of discharge was also highlighted by CQC's special review of services for people who had had a stroke and their carers.⁸ The review found that although people were given a range of information when leaving hospital after a stroke, it was often poorly organised. Only 40% of patients said that they found it easy to find information in these materials, and most of the packs did not contain good information on local services.

Continuing support after hospital discharge

When people need continuing support after leaving hospital to help them maintain and maximise their independence, good partnership working between health care and social care is vital. In section 3, "Person-centred services", we report on services' overall progress in providing rehabilitation, intermediate care and reablement, with more detailed findings from our special review of stroke services.

SEEMA'S STORY

In 2009/10, Bournemouth and Poole PCT launched an innovative pilot project with two local care homes to explore the prevalence, prevention and control of MRSA in the homes. Seema is Director of Nursing at one of the homes and a member of the project group.

“The project firstly involved screening our existing residents for MRSA and liaising with their GPs about treatment if they tested positive. Then over the next 12 months, we screened new admissions to the home, working closely with GPs and infection control leads in the local hospital and PCT. And during the year, staff from more than 100 care homes in Bournemouth and Poole took part in a series of training events on infection control issues organised by the PCT.”

A source of infection can be when residents are admitted to, or return to, a care home after spending time in hospital. So one of the aims of the project has been to make hospital staff aware of the types of information, and medical supplies for the resident, that care homes need in this situation. This is particularly important for non-nursing care homes, as they can't access potential residents' hospital notes.

“Better information from hospitals, along with more training for care staff, leads to homes being more confident and capable about treating and containing HCAs. This in turn means fewer residents being sent back to hospital because the home can't address their infection.”

Seema, Director of Nursing at one of the homes involved in the MRSA pilot project

Seema said “Many hospitals had little idea of the information they need to give care home staff, so a working group is now developing a fact sheet for them that sets out exactly what's needed simply and clearly.

“Bacteria lurks in unexpected places – so at our nursing home we use ultraviolet torches and special UV powders in staff training sessions to highlight high contact areas such as wall handrails, door handles, light switches and chairs.

“During the course of the study, we were fortunate enough to be designing a purpose-built laundry including the latest OTEX ozone disinfection system. The ozone is a natural disinfectant which acts 3,200 times faster than chlorine bleach and destroys even spore-forming bacteria such as *Clostridium difficile* and other dangerous bacteria and viruses on wash cycles as low as 40 degrees. It can eradicate MRSA and norovirus, so we use it to decontaminate soft furnishings, mops, sponges and cleaning cloths as well as sheets and residents' clothes.”



35%

the percentage drop in reported cases of MRSA between 2008/09 and 2009/10; reported cases of *C. difficile* fell by 29% in the same period.

Monitoring special issues

Reducing healthcare-associated infections

Healthcare-associated infections (HCAIs) are infections that people can sometimes acquire when receiving health care in hospital or in other settings. Tackling such infections continues to be a key safety issue and is a priority for the NHS. On 1 April 2009, the government introduced regulations to ensure that patients, staff and others are protected from the known risks of acquiring an HCAI. From that date, all NHS trusts that provided health care directly to patients had to be registered by CQC to show that they met the registration requirement on cleanliness and infection control. For 21 trusts, we made their registration conditional on them making specific improvements, including improving their cleaning, arrangements for decontamination, staff training, plans and policies for infection prevention and control, and rates of infections. We later removed these conditions, as all 21 trusts had made the changes needed.

During the year we monitored trusts' ongoing compliance with the regulations on HCAIs. Our assessors made 256 inspections, including 63 follow-up visits. This work covered all acute trusts, where concern about HCAIs is usually highest; all ambulance trusts; and a small sample of primary care trusts and mental health trusts. We found that 49 of the trusts were not meeting the regulations, and in these cases we followed up until we were assured that they had made the improvements needed.

The outcome of our inspection programme showed that its methodology allowed poor performance to be quickly and effectively addressed, and that trusts rose to the challenge and made swift improvements.

The best known HCAs are Meticillin-resistant *Staphylococcus aureus* (MRSA) and *Clostridium difficile* (*C. difficile*). The numbers of cases of them had risen dramatically since the 1990s, although the trend has been reversed in recent years. In 2009/10, the NHS continued to make good progress overall in tackling both types of infection. There were 1,898 reported cases of MRSA, compared with 2,935 in 2008/09, representing a 35% reduction. Reported cases of *C. difficile* also fell by 29% in the same period, with 25,604 cases compared with 36,095 in 2008/09. Almost half of these cases were not attributable to the hospital the patient had been admitted to - for example, they may have gone to their GP or directly to the hospital with the infection, or were resident in a care home when infected, or had transferred from another healthcare facility when the infection was first diagnosed.⁹

Management of controlled drugs

Controlled drugs are a group of drugs that have the potential to be misused. They include opioids such as morphine and diamorphine, which are used to relieve severe pain and treating drug dependence; benzodiazepines (tranquillisers and sleeping tablets); anabolic steroids and growth hormones. The Controlled Drugs (Supervision of Management and Use) Regulations 2006 were introduced in 2007 in response to the Shipman inquiry.¹⁰

CQC is responsible for making sure that providers of health care and social care create a safe environment for the management of controlled drugs. In 2009, we found that they were embedding their arrangements for safer management of controlled drugs, and further developing mechanisms for sharing information, concerns and best practice locally and nationally.¹¹ All NHS trusts and independent hospitals had

“This year we have again observed an impressive reduction in the total number of both MRSA and *C. difficile* infections and this is a credit to the hard work of our colleagues in the NHS which continues to strengthen good practice in infection control measures.”

Executive lead for the Health Protection Agency Healthcare Associated and Antimicrobial Resistance programme

appointed an accountable officer with organisational responsibility for monitoring controlled drugs, in accordance with the regulations. Through local intelligence networks, these officers meet with other accountable officers, regulators and agencies to share concerns and good practice.

We found evidence of increasing good practice in 2009, including improvements in the systems that providers used to report concerns about controlled drugs. For example, NHS Tees' local intelligence network had developed a secure online reporting tool to enable accountable officers to report concerns in real time rather than retrospectively.

20%

of homes for older people needed to improve the safety of their working practices.

Enforcing the Ionising Radiation (Medical Exposure) Regulations 2000

Medical ionising radiation, such as from x-rays or radiopharmaceuticals, is used widely to aid diagnosis of disease, to guide cardiac interventions and surgery, and in the treatment of cancer.

CQC is responsible for enforcing the regulations in place to protect patients during use of ionising radiation. We do so by inspecting healthcare organisations, and by investigating their notifications to us of exposures “much greater than intended”, including carrying out reactive inspections to gather evidence. We estimated that each year around 40 million radiological examinations are carried out in the NHS and independent healthcare in England.

Between 2007 and 2009, we carried out 31 inspections of radiotherapy services. During 2008/09, we began to also inspect cardiology services and piloted inspections in dental and chiropractic radiography.¹²

In 2009, we received 483 notifications of exposures “much greater than intended”, compared with 403 in 2008 and 327 in 2007. We believe that this continued increase has been largely due to providers’ improved understanding and awareness of the regulations. Most of the incidents were in diagnostic radiology departments, and overall we considered that they did not present an additional risk to the patient. We visited four NHS services that had notified us about incidents that we thought would present an additional risk.

Half of the errors in diagnostic radiology that we were notified of in 2009 were due to operator error. Incidents where the wrong patient had been x-rayed because they had been incorrectly referred or mis-identified, remained the major cause of error (30%). The other causes were “repeat x-rays” and “wrong anatomy”.

Following up outliers

CQC follows up with NHS trusts where the number of patients with poor outcomes is significantly higher than we would expect (“outliers”). The outcomes we analyse include deaths and emergency re-admissions after being admitted to hospital for a particular condition or procedure, and some maternity indicators.¹³ We use alerts generated by our statistical data to identify any outliers, and then inform the trust involved. An alert warns the trust of potentially dangerous practice, but does not necessarily mean that a problem exists. Trusts need to be able to respond quickly to any alert that emerges, to understand why it has happened and to act appropriately.

Unless the trust provides convincing evidence that the alert was not related to the quality of care, we pursue the case with the trust until we receive a satisfactory response. Our action could include making recommendations for improvement and

closely monitoring the trust's progress against an agreed action plan. We close the case when the trust has provided sufficient evidence that there is not a problem with poor quality of care, or has identified areas where the quality of care could be improved and assured us that it has adequate plans in place to address these.

We dealt with 111 mortality alerts in 2009/10, 35 of which resulted in trusts submitting a plan for improvement. In the remaining cases, they provided sufficient evidence that the alert was not related to quality of care.

Safe care standards in social care services

In 2009/10, social care providers were assessed against the National Minimum Standards for care, a number of which relate to safe care.

The proportion of care homes for older people that met or exceeded the standards for safe working practices had doubled since 2003 to 80%, but still remained low compared with the proportion of other minimum standards that they met. Home care and nursing agencies performed particularly well in this area, with 93% and 91% of them respectively meeting or exceeding the standard.

There has been considerable improvement in the number of services meeting hygiene and infection control standards since 2003. In 2010, this standard was met or exceeded by 87% of care homes for older people and 92% of care homes for younger adults.

In contrast, the proportion of care homes for older people that met the medication standard remained too low at 72%, though improvements had been achieved. Among care homes for younger adults, 79% met the medication standard.

Dignity and safety of people in vulnerable circumstances

Overall progress by councils

In 2009/10, we used a performance assessment framework built around the seven outcomes for people who use services described in the 2007 white paper on health care and social care, *Our health, our care, our say*.¹⁴ One of these outcomes was to maintain personal dignity and respect, with the aim that people who use social care and their carers should be able to expect:

- Prompt and effective help from any member of the local safeguarding partnership to reduce risks, prevent or respond to abuse of any kind.
- Personal care in all settings to respect their dignity, privacy and personal preferences and to uphold human rights.
- Social care workers to work with family members and carers as experts and partners.

Councils improved outcomes in this area – the number performing “well” increased from 60% in 2008/09 to 74% in 2009/10, and just three were judged to be “poor”.^{15, 16}

Table 1: Councils' performance in meeting the outcome “Maintaining dignity and respect”, 2008/09–2009/10

	Excellent	Well	Adequate	Poor
2009/10	12 (8%)	113 (74%)	24 (16%)	3 (2%)
2008/09	12 (8%)	89 (60%)	45 (30%)	2 (1%)

Source: Care Quality Commission

Safeguarding

Safeguarding referrals increased by nearly a third in 2009/10, to a total of 103,030 across all client groups: older people; people with learning disabilities; people with physical and sensory disabilities; those with mental health problems; people who use HIV/AIDS services, people who use drug misuse services, and carers. This increase is seen to be a reflection of raised awareness.

In 2009/10, older people continued to be the largest source of referrals of adults vulnerable to abuse. Referrals for them and for people with mental health problems both showed the largest percentage increase (34%) among the four main client groups (older people, and those with learning disabilities, physical and sensory disabilities, or mental health problems) since 2008/09.

Safeguarding practice improved and was identified as a strength in two-thirds of councils. However, it was clear that many of the other councils still needed to make further improvement – for example, with their performance management, and with quality assurance to monitor, evaluate and improve service delivery and outcomes in this area.

In 2008/09 eight councils in England were rated as only performing “adequately” overall. By 2009/10, five of these councils had demonstrated improvement. We had carried out a service inspection, which included a focus on safeguarding, at four of these five improved councils. All five of them had developed and successfully implemented an improvement plan to address the issues that we identified.

Councils that we rated “excellent” demonstrated:

- Increased rates of referrals from a variety of agencies, improvements to procedures as a result of effective monitoring and appropriate implementation of deprivation of liberty safeguards.
- Strengths in risk management for those who buy their own care and procedures for ensuring that safeguarding is embedded in commissioned services.

- Well-monitored, cross-sector safeguarding training, which was up to date and inclusive of minority groups.
- Strong links with partners, resulting in better awareness of safeguarding and increased referral rates.

Dignity in social care

Personal care that respects the dignity, privacy and personal preferences of people who use services was a strength in over a third of councils, and an area for improvement in almost a quarter of them. Excellent councils demonstrated a strong commitment to promoting dignity in care; they could demonstrate improvements to their services as a result of active contact with the people who use them and those in minority groups to capture their views.

We advised councils that needed to improve in this area to raise the profile and monitor the impact of ‘dignity champions’, to improve the proportion of commissioned services that meet dignity standards, and to increase their involvement of people who use services to improve monitoring of levels of satisfaction.

Social care service providers performed well against the national minimum standards relating to privacy and dignity. Ninety-seven per cent of home care agencies and 93% of care homes for older people met or exceeded these standards – an improvement in both since previous years.

Dignity in health care settings

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

Eighty-seven per cent of outpatients (excluding people who use mental health services) reported feeling that they were treated with respect and dignity “all the time”. A slightly smaller majority of inpatients (79%) felt they were “always” treated with respect and dignity when they were in hospital. This represented a very slight improvement for both types of patient since 2004.

Safe care of people using mental health services

Patients' perceptions of community mental health services

Our survey of people using community mental health services drew responses from just over 17,000 patients, of whom 42% were male and 58% female.¹⁷ Because of changes in the sampling methods and survey questions, the results of the 2010 community survey cannot be compared directly with those for previous years' surveys between 2004 and 2008.

Physical health care

Physical health care is particularly important for people using mental health services, as many of them are at greater risk from conditions such as heart disease, respiratory disease, diabetes, stroke and even some forms of cancer. The survey found that for those with physical health needs, just over a third (39%) felt that mental health services had "definitely" given them enough support in getting help for these needs and 27% said "to some extent". Thirty-three per cent said that they had not received enough support. More than a third of all of the respondents said that in the last year they had not been asked about any physical health care needs they might have.

Medication

Involving patients in decisions about their treatment is important in all aspects of health care, including mental health. As regards deciding which medications to prescribe, 57% of respondents said that their views were "definitely" taken into account, and 31% said that their views were taken into account "to some extent".

Regular review of medication is an indicator of good care. Many respondents who took prescribed medications had been doing so for 12 months or longer (87%). Of these, 81% said that they had been asked in the last 12 months about how they were



getting on with their medicines, which indicated a review had taken place. This suggested that up to a fifth (19%) of respondents had not been asked about their medicines or couldn't remember being asked.

Crisis support

With more people receiving specialist support in the community for their mental health than ever before, it is vital that they have access to crisis support. Only 56% of those responding to the community mental health services survey had the telephone number of someone from their local NHS mental health service whom they could phone out of hours. This suggests that there is considerable way to go in ensuring everyone using these services can get help at times of crisis.

Of those that did have a telephone number for their local service, more than a third (36%) had called it in the last 12 months. On the last occasion that these service users had called the number, half had "definitely" received the help they wanted and a third had "to some extent". Eighteen per cent of respondents said that they had not received the help they wanted.

“The skill is to get an accurate snapshot, in the space of a day, of what that ward is like for the people detained there. You need to look at it from a number of different angles, including whether it’s meeting the requirements of the Mental Health Act, the Code of Practice and the outcomes that CQC expects for patients.”

CQC Mental Health Act Commissioner

Care under the Mental Health Act

Each year, there are more than 45,000 detentions of people in hospital under the Mental Health Act for assessment and treatment in the interests of their own health and safety, or the safety of others. In November 2008, community treatment orders (CTOs) were introduced in England as a means of legally supervising patients who are treated in the community rather than under detention in hospital.

CQC’s Mental Health Act Commissioners visit all psychiatric wards in England where patients are detained, to monitor how the services are using their legal powers under the Act and ensure that patients’ rights are being upheld. We aim to visit each ward at least once every 18 months. In this report on the state of care in England, our comments about people’s care under the Mental Health Act are based on our Commissioners’ findings when visiting detained patients. Their visits focus on identifying concerns that need to be addressed to protect patients, as do their subsequent reports to each service visited and CQC’s annual report to Parliament on the use of the Mental Health Act.¹⁸ Because of this need to focus on identifying concerns rather than on what is working well, our observations will not necessarily reflect the day-to-day care that most detained patients would have been receiving in 2009/10.

Safety and appropriateness of care

In our 2009/10 report on the use of the Mental Health Act, we noted a marked improvement since 2008/09 in the number of young people inappropriately admitted to adult psychiatric wards under the Act. This particularly applied to young people aged under 16. However, our long-running concern over inadequate staffing and over-occupied wards remained. Only 21% of the acute wards that we visited could meet the Royal College of Psychiatrists’ recommendation of 85% bed occupancy. Twenty-nine per cent of the wards were over-occupied, and 7% of these were over-occupied by more than 25% of their capacity.

Table 2: Bed occupancy levels at CQC visits to 486 acute psychiatric wards, 2009/10

Occupancy band	Number of wards	Percentage band	
<= 90%	141	< 100%	42%
90%+ to <100%	64		
Exactly 100%	142	= 100%	29%
100%+ to 105%	16	> 100%	29%
105%+ to 110%	28		
110%+ to 115%	26		
115%+ to 120%	17		
120%+ to 125%	17		
> 125%	35		
Total	486	100%	

Source: Care Quality Commission

Our Commissioners observed that staff often did not recognise that commonly used forms of ‘mechanical’ restraint – such as supportive chairs – were forms of restraint. We have suggested that a system of notification of their use be introduced.

In addition, we questioned whether more could be done to de-escalate situations before staff used seclusion or restraint. Our Commissioners noted examples of where seclusion had compromised patients’ dignity or privacy, including where they were held unclothed, or without access to normal toilet facilities. Commissioners also encountered situations where the ward’s general security measures showed a disregard for patients’ privacy and dignity, or where voluntary patients were being treated within locked wards, and so possibly being unlawfully deprived of their liberty.

Since their introduction in 2008, the rate of new CTOs has averaged almost 370 a month, which greatly exceeds the Department of Health’s estimate of 400 to 600 in the first year.¹⁹ We had concerns about the

potentially very broad use of the coercive powers of CTOs, and we plan a further study of their use. An additional concern, which we had also raised in the 2007–09 report on the use of the Mental Health Act²⁰, was the apparent over-representation of some Black and minority ethnic groups among the total number of people on CTOs. Over-representation of the same groups is also seen among detained patients – as has been shown by the annual ‘Count me in’ census each year since 2005. The findings of the sixth and last census continued to show differences between Black and minority ethnic groups and White groups, and also differences within these groups.²¹ Although the overall number of inpatients recorded on the day of the annual census has fallen since 2005, ethnic differences in rates of admission, detention under the Act, and use of seclusion have not altered materially since 2005.

CHOICE AND CONTROL



Advocacy and support service for carers from Black and minority ethnic groups, at Carers Corner, Rotherham

Introduction

To help improve people's choice and control over the care they receive, it has been a national priority in recent years to promote a wider range of services that maintain health and support independent living. We reflect this aim in our regulatory work, by encouraging practices and processes that put people who use services more firmly in control.

People are increasingly knowledgeable about health care and social care. They can find and share information about it more easily than ever before, and the growth of such information is one of the factors raising people's expectations about services. It also helps to build their confidence when dealing with complex service organisations such as the NHS or local councils.

Our last State of Care report had noted that more people were getting better information about care options, but that it was not always communicated in a way that they could understand. And while in 2008/09 more outpatients were being offered a choice of hospital, we had concerns about the adequacy of patient information on health conditions or treatment. The number of social care services that were meeting choice and control outcomes had continued to increase, but in health care, patients needed to be much more involved in decisions about their treatment – particularly in mental health services. Commissioners of health care were finding it difficult to balance spending on prevention while funding services for people with high levels of need.

“Carers need hope, and one of the things the centre does is give people hope. A lot of our loved ones will never recover, which means we are always going to be carers. Carers Corner – our dedicated centre – is a lifeline for us. I care for two people with schizophrenia, but I sometimes have mental health problems too. If it wasn't for the centre, there would be three ill people in my life.”

Glynn, a member of Rotherham carers forum, who acts as carer for his mother and partner

Key messages in 2009/10 about choice and control:

- Improved practices in many acute hospitals and among GPs have increased convenience for patients, giving greater choice over appointment times.
- There was a continuing growth of private health care and social care services, and a further reduction in NHS bed capacity and in-house council care services. Long-term social care in particular is now largely 'out-sourced' to private service providers, some large, but most still small, and with many local variations.
- In health, there was continuing growth in private options for treating serious health conditions: for example, those requiring dialysis. This is an example of widening choice for people who have either health insurance or other financial means, or where the NHS purchases the service on their behalf.
- Some important changes to widen choice in personal care gathered pace during the year, but this could only benefit the reducing number of people who had access to services in the first place. According to (provisional) national statistics, the total number of people receiving publicly-funded community care services fell by nearly 5% against the previous year, despite the rapidly growing proportion of older people with support needs.
- The growing use of self-directed support and personal budgets for more flexible support to live at home is perhaps the best example of widening care choice. Personal care provided in this way remains a strong development priority for most councils, but few have yet built and established all of the processes and systems needed to achieve it.
- Better support for independent living had already brought more choice and control for many, when compared with receiving care in a residential home or long-stay hospital. However, commissioners continued to face difficult decisions when re-organising support while their resources came under increasing pressure. To further restrict the number of care home admissions without providing adequate alternatives creates the risk of people's health and wellbeing deteriorating if they do not qualify for support.
- In mental health services, there was variability in patients' involvement in treatment planning and access to independent mental health advocates. Our visiting Mental Health Act Commissioners found that some services applied security measures in ways that unnecessarily restricted people's autonomy or compromised their privacy.

Changes and choices in health care

Changes in the provision and capacity of health care

Health services continued to respond to people's changing expectations of quality and convenience. Some evidence of this, both for the NHS and independent health care providers, is given below.

NHS bed numbers

Capacity in the independent health care sector expanded significantly, as it had in 2008/09, but hospital bed capacity in the NHS contracted further, continuing the reductions of recent years.²² However, changes in the number of beds cannot be used alone as a measure of NHS capacity or effectiveness. Activity level and outcomes also need to be considered – including for example, further improvements made in waiting times for treatment.

In other cases, NHS functions were transferred to other services, and this may account for the reduced number of beds.

Some points to note:

- The increase in day treatment in the NHS, which had reduced the length of time people spend in hospital and increased overall treatment capacity.
- As a matter of policy, NHS bed capacity for people with learning disabilities has been largely replaced over several decades by more 'mainstream' alternatives in private or voluntary sector care homes, in group homes or in individual accommodation supported by social carers. During 2009/10, the NHS continued to accelerate the delayed transfer of people from NHS campus accommodation, and expected that everyone still living in such accommodation would have new, alternative support in place for them and a full transition plan by the end of 2010.



- The number of NHS 'geriatric' beds fell still further, despite the rapidly rising proportion of very elderly people with health care and social care needs in the population. For this group, a higher proportion of longer term care was provided in care homes – either through NHS paid-for continuing health care in nursing homes or through support for independent living, following successful rehabilitation such as intermediate care or reablement.
- In effect, less long-term care for older people was provided directly by the NHS and a higher proportion was provided through means tested social care, continuing the trend of many years.

Table 3: NHS bed numbers, 2005/06–2009/10

Year	All specialties (excluding day only)	General & acute	Acute	Geriatric	Mental illness	Learning disability	Maternity	Day only
2005/06	175,436	132,826	108,134	24,692	29,802	3,927	8,881	9,726
2006/07	167,019	126,976	104,079	22,897	27,914	3,486	8,643	10,342
2007/08	160,891	122,374	101,644	20,730	26,929	3,147	8,441	10,479
2008/09	160,286	122,569	101,520	21,050	26,448	2,882	8,386	10,959
2009/10	158,319	121,558	100,621	20,937	25,563	2,805	8,392	11,221

Source: Department of Health

Choices and rights in the NHS

Established in 2009, the NHS Constitution reinforced patients' rights to choose, including the right to choose a GP surgery and express a preference for a particular doctor; make choices about NHS care, and receive information; be involved in discussions and decisions; accept or refuse treatment, and not be given physical examination without consent.

No monitoring data were available to assess the implementation of the constitution, but some information about choices of hospital and appointment times were included in patient surveys. The existence of the constitution has made it clear that choices are of fundamental importance to the NHS. There are few similar rights within social care that are expressed in this way, although people due to enter a care home are legally able to exercise a choice of home.

Independent health care

There was a further rise in the number of independent health care establishments and services, continuing the trend since 2004. The data shows an almost three-fold increase in the number of establishments registered since 2004 and more than double the number of services offered; also that most of them are becoming more specialised.²³ Regulated independent health care includes a wide range of private hospitals, clinics and agencies, all of which have been regulated by CQC since April 2009.

Growth of different types of services

There was further growth in all service types, but to differing degrees. The number of hospices, for example, only increased from 178 in 2004 to 194 in 2009, while prescribed techniques and technologies, such as lasers used for surgery, more than tripled in the same time period, from 685 to 2,082.

Regional variations

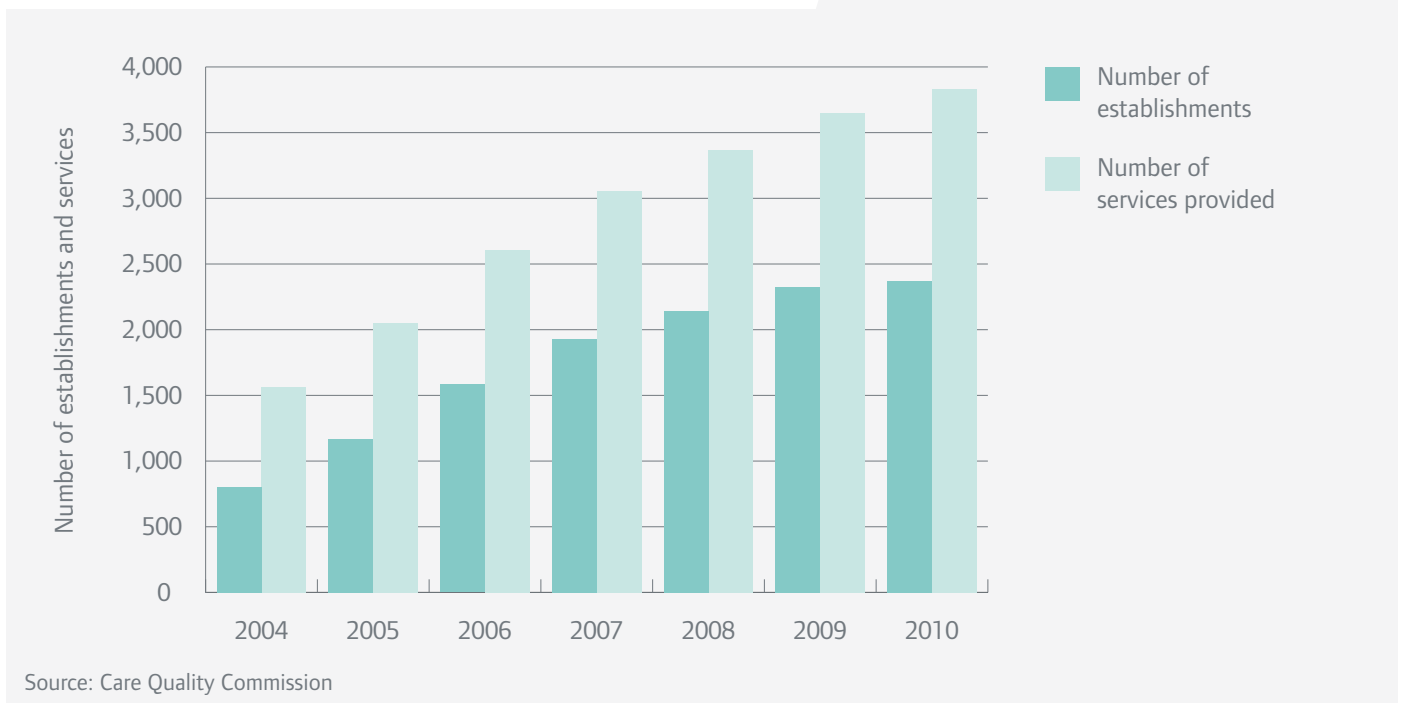
The rate of growth of independent health care services continued to vary across regions, with London and the South East showing the highest rates. Yorkshire and Humberside and the East Midlands followed closely behind, and although the numbers of registered services in these regions were much smaller, they too increased three-fold. The North East and South West had the smallest growth in the independent healthcare sector.

Table 4: Growth in different types of registered independent health care services, 2004–2010

	Number of registered services 2004	Number of registered services 2010	Increased number/ percentage of new services 2004-2010
Acute hospitals (including acute, cosmetic surgery, and local anaesthetic hospitals)	374	637	263 (70%)
Hospices (adults and children)	178	194	16 (9%)
Mental health (including establishments where people may be detained)	203	309	106 (52%)
In vitro fertilisation (IVF)	33	44	11 (33%)
Termination of pregnancy clinics	54	80	26 (48%)
Prescribed techniques and technologies	685	2,082	1,397 (203%)

Source: Care Quality Commission

Figure 3: Numbers of registered independent health care establishments and services, 2004–2010



Changes and choices in social care

As CQC regulates most types of adult social care services, our information from our registration and inspection processes tells us a great deal about the social care market. In a report published in November 2010²⁴, we drew attention to a number of important findings about the state of the social care market.

Market capacity continued to grow, and the overall number of services increased. The market remained fairly stable in 2009/10, but further growth will be needed to meet the still-growing level of needs and changing expectations.

Some important questions for policy makers and regulators are:

- Whether the market will adapt quickly enough to meet the growing expectations of quality and personalisation that people who use services are seeking.
- Whether an increasing number of people will choose support at home instead of choosing to enter a care home.
- Whether the actions of local commissioners can and will influence the types and relative volume of services to meet local needs.
- The private sector continued to expand, and the public sector contracted further: For example, local authorities now own only 11% of all care homes in England, continuing the trend towards greater outsourcing, generally at a lower cost.
- The number of residential care homes continued to fall, but the number of nursing homes increased, and homes were a little larger on average. This reflected a number of factors, including the business strategies of service providers, the preferences of people who use the services, longer periods of independent living supported by help at home, and the shorter time that people now spend in hospital.

- More people were supported to live independently in their own homes, as was reflected by the growing number of home care services. But for those receiving publicly-funded care, services were provided more intensively than ever before. The challenge now is for providers and commissioners to work together to further develop the market in anticipation of people's future long-term care needs and preferences.
- The number of home care services increased. In some parts of the country, such as London, significantly more services were geared towards providing care to people in their own homes rather than in care homes.

Growth of service type by user group

The growth of care home places varied according to the type of need. One of the most pressing demands in recent years has been for growth in support for older people with mental health needs, such as those arising from dementia. Between 2008/09 and 2009/10, 17,733 new places were registered, representing rapid growth of 8%. The variation in increase of number of care home places for people predicted to have dementia remains striking, and is an example of the wide regional variations in community care that continue to exist. In some regions, there was a much more frequent use of care homes than in those with more widely developed alternatives. The number of places in other non-specified care home places for older people increased by 7,573 (growth of 2%), and by 2,000 for people with a physical disability (growth of 1.8%). There was a very small growth of services registered for people with a learning disability or sensory impairment, or people with alcohol or drug misuse problems.

Table 5: Numbers of places* in care homes registered to provide care for older people with dementia, per 100 of population aged 65 and over predicted to have dementia in 2010

Region	Number of places
North East	54.8
Eastern	42.4
Yorkshire and Humberside	41.6
East Midlands	39.2
North West	38.0
West Midlands	37.9
South East	37.5
London	33.7
South West	29.7

Source: Department of Health

*As at 31 March 2010

Access to services

Hospital waiting times

Waiting times for treatment in NHS acute hospitals

Waiting times for NHS hospital treatment are carefully monitored. During 2009/10, it was an NHS requirement that nobody should wait more than 18 weeks from the time they were referred to the start of their consultant-led treatment, unless it was clinically appropriate to do so or they chose to wait longer. These waiting times were set out in the NHS Constitution.

Under the performance standard that trusts were expected to achieve in 2009/10, at least 90% of their admitted patients and 95% of non-admitted patients should have started consultant-led treatment within a maximum of 18 weeks. These standards are lower than 100% to allow for any waits of longer than 18 weeks that may result from clinical necessity or patient choice.

The Department of Health's statistics show positive progress: "The percentage of admitted patients treated within 18 weeks increased from 48% to 86% between March 2007 and March 2008. Non-admitted performance increased from 76% to 93% between August 2007 and March 2008. Both series showed a further, steady increase between March 2008 and January 2009, since when performance has been relatively stable at around 93% for admitted patients and 98% for non admitted patients."

"The average waiting time for admitted patients fell from just under 19 weeks in March 2007 to around eight weeks in March 2008, and has levelled off since. The average for non-admitted patients fell from just under eight weeks in August 2007 to around four weeks in March 2008, and has also been broadly level since."²⁵

Choosing and waiting for hospital services

What patients tell us about their experiences gives important insight into the impact of having to wait for hospital treatment or for decisions about it. Our inpatient surveys have highlighted some improvements over time in this area. The main points from our 2009 survey were:

- The proportion of respondents that said they were admitted "as soon as they thought was necessary" (76%) had not changed since 2008, but was an improvement on the first inpatient survey in 2002, when 68% said this. Sixteen per cent of respondents felt they "should have been admitted a bit sooner", while 8% said that they "should have been admitted a lot sooner".
- There was no improvement in choice of admission dates: 29% of patients said that they were given a choice of dates compared with 30% in 2008. Three per cent said their appointment had been changed two or three times. However, less than 1% said it had been changed four times or more – an improvement since 2002.
- There was some improvement in the proportion of people waiting no more than a month for their planned admissions.

6%

The reduction in the proportion of patients who had to wait more than 4 hours in A&E before being admitted to a ward in 2009/10.

- Thirty-one per cent of respondents who were elective admissions recalled being offered a choice of hospital, and 59% said they did not mind not being offered a choice.
- Twenty-eight per cent of respondents waited for more than four hours after arriving in accident and emergency (A&E) before being admitted to a ward – an improvement of six percentage points since 2008.
- The proportion of respondents who reported a delay in their discharge from hospital (40%) had remained unchanged since 2008. The most common explanations for delay were a wait for prescriptions or to see a doctor.

For hospital outpatients, there were improvements since the last survey in 2004. A higher proportion of respondents said that they:

- Waited less than six weeks for an outpatient appointment from the time they were first told they needed one. At 73%, the proportion had risen very substantially since the 54% reported in 2004.

- Were offered a choice of appointment times (34% in 2009, compared with 30% in 2004).

But there were also some disappointments, in that less than a fifth of outpatients said that they were seen on time, or early. This indicated no change since the 2004 survey, although on average people did not have to wait for as long as in 2004.

Council performance on choice and control

Choice and control featured strongly in our assessment of councils' social care performance, and we found that some progress had been made. Where councils are judged "excellent" in the area of choice and control, people who use their services and carers can expect:

- Help to take control of their support, with clear information and advice about support options, risks, costs and funding.
- Help to assess their own needs, and to plan and manage their support, or to have access to skilled advocates if they are unable to make their own decisions.
- To benefit from a broad range of support services designed to meet people's needs and preferences for independent living, including those of people from diverse communities and backgrounds.
- To be able to contact service providers when they need to, and for any complaints they have to be well managed.

The proportion of councils performing "excellently" at increasing choice and control for people remained at 18% in 2009/10, while the proportion performing "well" increased to 67%, from 59% in 2008/09. One council was performing "poorly" in this area in 2009/10.^{26, 27}

THE STORY OF CARERS CORNER

One in eight of the 250,000 people living in Rotherham, South Yorkshire, are carers. May 2010 saw the opening of a dedicated facility for them – the result of a campaign by members of the local carers' forum.

Every aspect of the new centre has been shaped by their vision. Claire project-managed the in-depth consultation that led to 'Carers Corner' – a light, welcoming space on a busy corner of the town's shopping precinct. Anyone who is a carer can drop in for advice, information, peer support and access to more than 30 different services.

"At Rotherham Council we felt that our role was to facilitate the carers' development of the centre, rather than leading it for them. So it was a case of us feeding back on their suggestions – of which there were around 450 – and including as many as possible in the final design. The forum decided on the centre's name, location, and interior layout – open plan with relaxing

sofas, but also with private rooms for confidential discussions and just a small office area. We invited the Rotherham customer access audit group to inspect the centre, to ensure it was fully accessible – including lots of disabled parking outside. Young carers were also asked for their views, through a joint event with Barnado's – as shown by the Nintendo Wii and computer games in their 'chill out' zone."

The centre's manager, Bev Pepperdine, is a carer herself, so she has very good understanding of people's needs. "When carers first come to us they have often reached a point of crisis, so the first thing we offer is a welcoming face, a hot drink, and a sympathetic chat and advice. We tell them about the different support groups that meet at the centre, including for carers from Black and minority ethnic groups, those caring for people with mental health problems, and parents of children with disabilities."

"Nearly 4,000 carers have come through the door in the ten months since Carers Corner opened, and around half of them use the services we provide with partners, including access to training, legal support, benefits advice and employment information."

Claire, project manager of the consultation with carers



Table 6: Councils' performance in meeting the outcome "Choice and control", 2008/09–2009/10

	Excellent	Well	Adequate	Poor
2009/10	28 (18%)	102 (67%)	21 (14%)	1 (1%)
2008/09	26 (18%)	88 (59%)	34 (23%)	0 (0%)

Source: Care Quality Commission

We saw growing use of self-directed support and personal budgets, which widened people's options for support and services. It was a strength in 40% of the 65 councils assessed in this area, while more than half needed to improve further. Excellent councils had introduced self-directed support champions, offered personal budgets to all and showed increases in the number of people taking up personal budgets. We encouraged councils that needed to improve to establish self-directed support across all sectors, increase the number of people holding personal budgets and to improve their monitoring.

Councils' capacity to provide personal care on a 24/7 basis is an important factor in extending the possibility of independent living, reducing hospital admissions, and further reducing admissions to care homes when people are frail or ill. In 2009/10, out-of-hours services were highlighted as strong in just three councils, which were providing people with an increased and more varied range of support options to people.

Equality of access

Our annual assessment of councils' social care performance included how well they ensure freedom from discrimination and harassment. Where councils achieve an excellent judgement for this outcome, people who use social care services and their carers can expect:

- Fair access to services, including advice about entitlements and options for support.
- Entitlements to social care and continuing health care to be upheld.
- To be free from discrimination or harassment when they use services.

Overall, councils' performance in achieving this outcome was good. The proportion of councils performing excellently or well increased from 19% to 26%. Councils continued to work towards the staged achievements described in the national Equality Framework for Local Government.²⁸

Table 7: Councils' performance in meeting the outcome "Freedom from discrimination and harassment", 2008/09–2009/10

	Excellent	Well	Adequate	Poor
2009/10	40 (26%)	98 (64%)	14 (9%)	0
2008/09	28 (19%)	106 (72%)	14 (9%)	0

Source: Care Quality Commission

Fair access

Fair access to services was judged to be strong in 26% of the 43 councils assessed in this area and as an area for improvement in 12% of them. Typically, the latter needed to improve access to services for minority groups, use monitoring more effectively to improve access, and to improve how they monitored people from diverse communities who had personal budgets.

Ethnicity recording

Recording people's ethnic background is an essential part of monitoring fairness of access, yet we noted deterioration in this area in 2009/10. Of those who were assessed for eligibility for funded care, 3.3% did not have their ethnicity stated in the council's records. Recording of ethnicity also deteriorated for those who were receiving services, with 2.2% not having their ethnicity recorded. However, although ethnicity recording is a useful indicator of commitment to fair access, we allowed for the fact some people choose not to disclose their ethnicity to their council.

Equality impact assessments

Over half of the 43 councils assessed in this area demonstrated a strong approach to equality, and were carrying out equality and diversity training for staff, equality impact assessments and monitoring action plans. These councils also achieved higher standards on the Equality Framework for Local Government. We advised 19% of the councils assessed to improve an aspect of their approach to equality, such as staff training, further use of equality impact assessments or better monitoring in this area.

Eligibility criteria

Councils are required to set eligibility criteria that determine who can receive their community care services, and to use a national framework to grade the level of need. This is one of the processes used to manage demand for services and control council expenditure on care. In 2009/10, three councils set their eligibility threshold for care-managed services at "critical" (indicating the most restricted level of

19%

The proportion of councils that needed to improve an aspect of their approach to equality, such as staff training, use of equality impact assessments or better monitoring in this area.

access to services), while 107 set their threshold at "substantial". Only three councils were planning to raise their eligibility threshold in 2010/11, while one was expecting to lower its threshold from "substantial" to "moderate".

However, the number of people receiving publicly funded services in 2009/10 fell by nearly 5% against the previous year, according to (provisional) national statistics, (see page 47).²⁹

The publication of clear information about eligibility criteria was noted as a strength in a quarter of the 43 councils assessed in this area. Excellent councils provided support and information in a range of formats and in a number of locations. In addition, about a fifth of councils assessed were highlighted as strong in supporting people who are not eligible for funded care, re-directing them to other services, such as those provided by voluntary organisations. We recommended that more councils should sample the quality and outcomes of grant-funded services provided to people who fall outside their eligibility criteria.



Experience of people who use services

Putting people in control

The NHS Constitution makes very clear commitments to greater choice and convenience for people who use NHS services: this remains one of the key areas in which outcomes need to improve in health care and social care.

Involving and informing NHS patients

We found several areas of improvement since the 2008 patient surveys, including more inpatients “definitely” feeling involved in decisions about their discharge from hospital.

However, there was a decline or continued low achievement in some other aspects of choice and control. Having knowledge and being informed are key to people being able to take more control, yet we saw a decline in the number of patients who agreed that:

- The purposes and side-effects of their medicines and how to take them had been “completely” explained to them in a way they could understand.
- Nurses always answered their questions in a way they could understand.
- Their family or someone else close to them had the opportunity to talk to a doctor if they wanted to.
- They were given enough information about their condition or treatment on the ward.
- They were given enough information about their condition or treatment while in the A&E department. More than a quarter said they were either not given enough information (16%) or were not given any at all (10%) – a slight worsening in performance since 2008.

There was no significant improvement in the extent to which people felt involved in decisions about their care and treatment, or in the time they waited to be admitted to a bed on a ward after arriving at the hospital.

NHS community mental health care – involving service users

Most people who used community mental health services were positive about their contact with staff.

- Eighty per cent reported that their health or social care worker “definitely” listened carefully to them. Just under a fifth (17%) said that this person listened carefully “to some extent” and 3% said they were not listened to carefully.
- Seventy-five per cent felt that the health or social care worker “definitely” took their views into account. Just over a fifth (21%) said that he/she took their views into account “to some extent”, with 4% saying their views were not taken into account.

Our survey findings suggested that many people should be more involved in some aspects of planning their care. Of all those who said that they had a care plan:

- Just under half (48%) said that they “definitely” understood what was in it and 29% said that they understood their care plan “to some extent”.
- Nine per cent said that they did not understand what was in their care plan, and 15% were “not sure”.
- Just over half (53%) “definitely” thought their views were taken into account when deciding what was in their care plan; 34% thought this was true “to some extent” and 13% said that their views were not taken into account.

The Care Programme Approach (CPA) has been the policy framework for supporting and coordinating care for people in contact with specialist mental health services since 1991.³⁰ Seventy-one per cent of respondents who received care under this approach said that they had been given or offered a written or printed copy of their care plan; 55% said that they had “in the last year” and 16% said “more than a year ago”. Over a quarter (30%) said that they had not been given or offered a written or printed copy of their care plan.

13%

The percentage of people using community mental health services who said that their views about their care plan were not taken into account.

Information about mental health medication

Understanding medication and its potential risks is as important in mental health care as it is in physical health care. Just over two-fifths of respondents (42%) had had new medications prescribed for them by a mental health worker in the previous 12 months. Of these respondents:

- Just over two-thirds (69%) said that the purpose of the new medication had “definitely” been explained; almost a quarter (24%) said that the purpose had been explained “to some extent” and 7% said that the purpose was not explained to them.
- Less than half (43%) of the respondents said they were “definitely” told about possible side-effects of their new medication, with 28% saying they were told “to some extent” and 29% that they were not told about possible side-effects.
- Just over half (52%) said that they were “definitely” given information about the new medication in a way they could understand; 32% said that this was done “to some extent”, and 15% did not receive information about their new medication in a way they could understand.

"In Westminster we have always recognised the contribution people who use services can make if they are given the opportunity. They have led our personalisation programme through our Choice and Control Board, which is made up of service users representing each care group, ensuring that we keep their needs at the centre of the design of our new services."

Strategic Director for Adult and Community Services, Westminster Council

Due to changes in the sampling method and questions used in the community mental health services surveys over time, it has not been possible to report comparisons between patients' views in 2010 and those in previous years' surveys.

Online information about social care

Information to aid people's choice and decision-making continued to be a focus for improvement in social care in 2009/10. We commended some of the councils we judged "excellent" in this area on the quality of the information on their websites. For example, one council was supporting people's independent living through a comprehensive catalogue of information and resources to help them plan their care and support.

Getting people involved and making a positive contribution

Where councils achieve an excellent judgment for this outcome, people who use social care and carers can expect:

- Support to take part in community life.
- Active voluntary organisations that contribute to the improvement of services for people in all communities, and that are accessible to people who use services and carers.
- That their experiences and views contribute to shaping improvements in services.

Councils continued to perform strongly on this outcome. The proportion that performed excellently increased from 51% to 64%, and no councils were judged poor or adequate.

Table 8: Councils' performance in meeting the outcome "Making a positive contribution", 2008/09–2009/10

	Excellent	Well	Adequate	Poor
2009/10	96 (63%)	56 (37%)	0	0
2008/09	75 (51%)	72 (49%)	1 (1%)	0

Source: Care Quality Commission

Listening to service users and carers

Just a quarter of the 42 councils assessed in this area were judged to be strong in getting service users and carers involved, which was a significantly deterioration since 2008/09. We expect good performance to include involvement training for people who use services and their carers, along with a range of ways in which they can give feedback on services and their quality.

Around 10% of the councils assessed needed to do more to support user-led organisations and to get more representatives onto partnership boards.

Excellent councils engaged with minority and hard-to-reach groups. They monitored the take-up of services to ensure fair access and designed services to meet the particular needs of the community. Almost two-thirds of the councils assessed were judged to be effective in communicating with minority groups. However, we advised 10% to improve their contact with minority and marginalised groups to improve equality of opportunity – for example, in take-up of services.

Three-quarters of all councils demonstrated that their commissioning processes included actively engaging people who use services, and carers and partners. Excellent councils used methods that went beyond simply consulting with people. They showed that they used ‘co-production’, in which the council would work systematically with its service users and carers as partners, so that they were genuinely involved in decisions.

Advocacy services

For people who have difficulty in communicating, the availability and support of advocates is particularly important in protecting their interests and safety. Advocacy services were identified as being strong in just a fifth of the 65 councils assessed in this area, while 14% were encouraged to improve. Those performing well had an advocacy strategy, good partnerships with advocacy organisations, and provided good-quality, highly accessible advocacy services, which meant they could demonstrate positive outcomes. The total public spend on advocacy in England increased from £20.7 million in 2008/09 to £23.2 million in 2009/10 – an increase of 12%.

Autonomy and choice in care homes

Good practice in promoting autonomy and choice was one of the national minimum standards applied in our inspection of care home services for older people. In our final annual account of performance under the former inspection system, care homes for older people showed significant improvement over time in meeting the autonomy and choice standard (93%). Performance against the information standard also improved dramatically over time, to the point where 84% of homes met it in 2010 – an improvement of 58 percentage points since 2003.

Similar standards applied in care homes for younger people under the headings of “decision making” and “participation”. Here again, the percentage of homes meeting the standards improved steadily over time to levels of 92% and 93% respectively in 2010 from a low base in 2003.

Home care agencies showed significant improvement in meeting the autonomy and independence standard since 2005, with 93% of them achieving it in 2010.

Commissioning for independent living

Councils are expected to achieve more choice and control for people who use home care and care homes, by commissioning services that support more of them to live independently. To do this, councils must first understand the changes taking place in local people’s health and wellbeing, as well as their changing preferences. They must then plan and arrange or purchase services that meet these requirements.

Only a third of councils were able to demonstrate strengths in using their knowledge of the local population’s needs to commission effectively, while a third needed to improve.

In their commissioning work, councils continued to face difficult decisions in re-organising care while their resources were under increasing pressure. To further restrict the number of care home admissions without providing adequate alternatives creates the risk of people’s health and wellbeing deteriorating if they do not qualify for support.

Joint commissioning with health partners was highlighted as a strength in only a third of councils and an area for further improvement in 16%. Excellent councils demonstrated effective joint commissioning, management and contract monitoring with health partners. These councils demonstrated a number of positive results in joint working and commissioning, including improved commissioning decisions, efficiency savings, progress with the personalisation of services, and more integrated support to promote independence.

56

wards in a sample of 311 did not have access to independent mental health advocacy services for patients detained under the Mental Health Act.

Choice and control: the Mental Health Act

People whose freedom is restricted under the Mental Health Act are in a vulnerable position. They can be legally prevented from choosing whether or not to receive treatment and care, or how it is provided to them, even if they have the mental capacity to consent to treatment.

Changes in patient status in mental health hospitals

In 2009/10, the Mental Health Act was used more than ever before, with 45,755 detentions made under the Act. Although in 2009/10 more people were treated in hospital as inpatients – the first rise since 2004/05, up 5% to 107,765 – the proportion of them who were detained patients was larger than in 2008/09.

However, more than 90% of people who used mental health services in 2009/10 did not spend any time as an inpatient during the year. Overall, the care they received outside hospital involved around 12.5 million contacts with health care and social care professionals.

Patients' experience

Patients' feedback to our Mental Health Act Commissioners in 2009/10 suggested that hospital life has become more focused on rules and security. An increasing number of acute inpatient mental health wards were locked wards, even though they were usually providing care to voluntary patients as well as to detained patients. In 2009/10 – as in previous years – CQC voiced concern that voluntary patients in locked wards were at risk of being unlawfully deprived of their liberty. They were being prevented from leaving the ward and denied control over their circumstances, but in law were subject neither to formal powers under the Mental Health Act nor to Deprivation of Liberty Safeguards under the Mental Capacity Act.

Patients' participation in their treatment

Mental health services should provide treatment in the least restrictive manner possible, respecting patients' wishes and focusing on recovery and autonomy. The patient should have the opportunity to be involved in planning and reviewing their care and treatment, as should their carers, providing the patient agrees.

Services varied in the extent to which they involved patients in planning care. Some excellent examples demonstrated how this is possible even when a patient's rights are restricted. However, we found that many services needed to substantially improve their practices.

There was some improvement in the degree to which patient complaints were received and acted on, although this was variable.

In our 2009/10 report on the use of the Mental Health Act, one of the areas that we identified as a "key area for special focus" was detained patients' consent to treatment. We found that many patients who were certified as consenting actually appeared to be refusing to give consent or to lack the capacity to do so.

Patients' experience of being subject to a community treatment order (CTO) was strongly influenced by the extent to which they had been involved in planning their care before discharge from hospital. Those who felt that they had been closely involved were likely to view their CTOs much more positively.

Advocacy for detained patients

In April 2009, PCTs became legally responsible for commissioning independent mental health advocacy (IMHA) services for people whose rights are restricted under the Mental Health Act. Out of a sample of 311 wards, we found that 18% did not have access to IMHA services and 40% did not display information about any type of advocacy service.

Use of control and restraint, and seclusion

A positive therapeutic environment helps reduce incidents that call for control and restraint. However, there are times when hospital staff need to use methods of control and restraint in response to disturbed behaviour.

During their visits to detained patients in 2009/10, our Commissioners noted examples of wards where the lack of a stimulating environment and activities for patients, and of one-to-one time with staff, was increasing the likelihood of incidents that called for control and restraint. In a few exceptional cases, patients had been subject to control and restraint that did not minimise risks to their health and safety and/or that compromised their privacy and dignity.

Mechanical restraint

According to the Mental Health Act Code of Practice, mechanical restraint should not be used in acute mental health settings as a standard means of managing disturbed behaviour. However, the code of practice does not extend to other types of mental health or learning disability services. On non-acute wards for older people, we noted fairly wide use of forms of 'mechanical' restraint, such as use of supportive chairs, and that staff often did not recognise supportive chairs as a form of restraint. We believe that there is a strong argument for introducing a system of notifications about their use, as government has suggested in the past.

Use of seclusion

Seclusion is the supervised confinement of a patient in a room, to contain severely disturbed behaviour and should only be used as a last resort for the shortest possible time.

On the basis of some of our Commissioners' findings when visiting wards in 2009/10, we questioned whether some hospitals could have done more to de-escalate situations before using restraint or seclusion. If patients are kept in seclusion longer than necessary, or for reasons other than containing severely disturbed behaviour, the hospital's actions may be challengeable in law. If the ward manager decides to use seclusion or long-term segregation, the Code of Practice requires that reviews are carried out to ensure that the patient is returned to the ward as soon as possible. This was not always being done routinely, and our Commissioners noted major shortcomings in the rooms that some hospitals use for seclusion, including a lack of facilities to meet basic needs.

PERSON-CENTRED SERVICES




Ward manager and patient of psychiatric intensive care unit

Introduction

For many years now, national policy has emphasised the importance of care services focusing on meeting people's individual needs. Person-centred care puts people at the centre of the design and delivery of the services they use. In addition, it acknowledges and responds to the wide variety of needs that different people have, through a diverse range of services that support independent living. A person-centred approach to healthcare means organising it around patients' lives, with timely and convenient services that prevent – as well as manage and cure – ill health.

In last year's State of Care report, we had noted some areas of progress in person-centred care, including an increase since 2005 in the number of people aged 65 and over who were being supported to live independently at home. And in 2008/09 more people had access to services that helped them to avoid hospital admissions or to return quickly from hospital. However, we had found a marked variation in the extent to which different councils were using long-term residential care for older people, and huge variation in the proportion of people whose discharge from hospital was delayed.



“Our patients usually have complex individual needs in addition to – and often as a result of – their illness. Things like family issues, housing, financial problems, educational and employment issues . . . We focus on thinking positively and creatively about solutions with each individual, both in terms of their treatment and care and lives outside hospital.”

Claire, ward manager of a psychiatric intensive care unit for male patients in north London

Key messages from 2009/10:

- More people had access to personalised services because of the expansion of direct payments and personal budgets. Personal care provided in this way remains a strong development priority for many councils, but there were wide variations in progress between one local area and another.
- Councils found it challenging to extend further the options for independent living. Although the number of financially supported care home admissions continued to fall, the number of community-based services also fell. The rapid growth of demand for support, especially due to the rising number of older people, was not matched by growth in the availability of more person-centred support during the year. This meant that proportionally fewer people benefited from these options, unless they were able to pay for them privately.
- People were generally treated with respect when first seeking advice and support from councils. There was a need for councils to give more attention to carers' needs at this first contact and to follow up what happens to people whom they redirect to other organisations.
- Progress was mixed as regards avoiding unnecessary hospital admissions and promoting effective hospital discharge, with considerable variation between NHS and council areas. While there was significant growth in intermediate care services, the numbers of people over 75 who had repeated emergency admissions increased, suggesting a lack of effective community support.
- The support available for people when leaving hospital after a stroke varied significantly across England. While there have been improvements in the treatment people receive in the initial hours and days after stroke, action is needed to improve the care and support they receive in the longer term through community services.

Support for independent living

Access to support for independent living

A key priority for councils is to make sure that care is centred on people's individual needs. For the last time in 2009/10, our annual assessment of their performance was built around the seven outcomes which the 2006 white paper, *Our health, our care, our say*, seeks for people who use services³¹.

In this section we report on the extent to which councils have established person-centred services to support independent living. We draw on assessments of their performance against outcomes for improved health and emotional wellbeing, improved quality of life and economic wellbeing, and some aspects of improved choice and control. We also reflect findings from special reviews and routine data collections.

Trends in council-funded access to care

Greater choice was extended to 131,605 people in 2009 through the expanded use of direct payments or personal budgets.³² The largest increase was in direct payments to carers, with 33,883 people receiving them for the first time during the year.³³

The main message, however, was that many councils found it challenging to extend further the options for independent living. Although the number of financially supported care home admissions continued to fall, the number of community care services was also reduced. The balance between these two different approaches is a key indicator of wider choice, and councils' performance did not suggest strong progress during the year.

The number of older people and of those with a disability or long-term condition is growing fast in England. Yet the number of adults of all ages who were receiving a community care service fell by 4.7% during 2009/10, with 83,930 fewer people receiving a service than in 2008/09.³⁴ The reasons for this are not yet clear, but may be linked to improved reablement services or to councils applying more stringently their criteria for access.



There were significant reductions in the volume of all major community care services provided, including the numbers of people attending day services, or receiving a home care service, respite care, meals at home, or equipment and adaptations.

This reduced provision was not offset by help from grant-funded organisations. Although councils often use these as a way of supporting people who do not meet council criteria for funded care, the estimated number of people who benefited from such services also fell during the year. Based on the latest data available (for 2008/09), 336,900 people had a "person-centred" service operated by an organisation grant-funded by a social services budget.³⁵ We were concerned from an earlier study that councils do not monitor what happens to a sample of people who are "signposted" to other support, so unmet need is not being recorded, nor are those people's outcomes known.³⁶

“Only a minority of councils routinely checked up on the experiences of people they signposted to other services or sources of help or advice.”

People’s experience of first contact with social services

When people first contact a council seeking support, the council's response is crucial to the outcomes that those people will experience.

In 2009/10, we reviewed how well councils responded when people contacted them for the first time for help, advice or support with their social care needs or those of someone else.³⁷ Our review was based on a ‘mystery shopping’ exercise based on an average of 50 initial calls to all local councils (approximately 7,500 calls overall), supported by two surveys to councils. We found that although there had been progress in some areas of concern raised by a previous study³⁸, there was still need for improvement in the areas of carers’ rights and needs, and councils’ sampling of service quality and outcomes for people they re-directed to other organisations.

People were generally treated with respect when first seeking advice and support. Councils were most likely during their first telephone conversation to offer people a further discussion or formal assessment, often without exploring their care needs in detail. However, people were generally only signposted to other sources of help and support once their needs had been fully discussed.

Councils rarely asked people about their financial circumstances during their first contact, and when they did, it was usually after the caller’s needs had been explored. This is good news, since the previous study had found that some councils appeared to use financial screening routinely when people first contacted them, which goes against national guidance.

The results of our mystery shopping exercise showed that our callers were rarely asked about other family members, or advised about the rights of carers or how their needs might be addressed.

Only a minority of councils routinely checked up on the experiences of people they signposted to other services or sources of help or advice, or shared high-level information with other organisations on the numbers of people they had re-directed to them.

Promptness of assessments

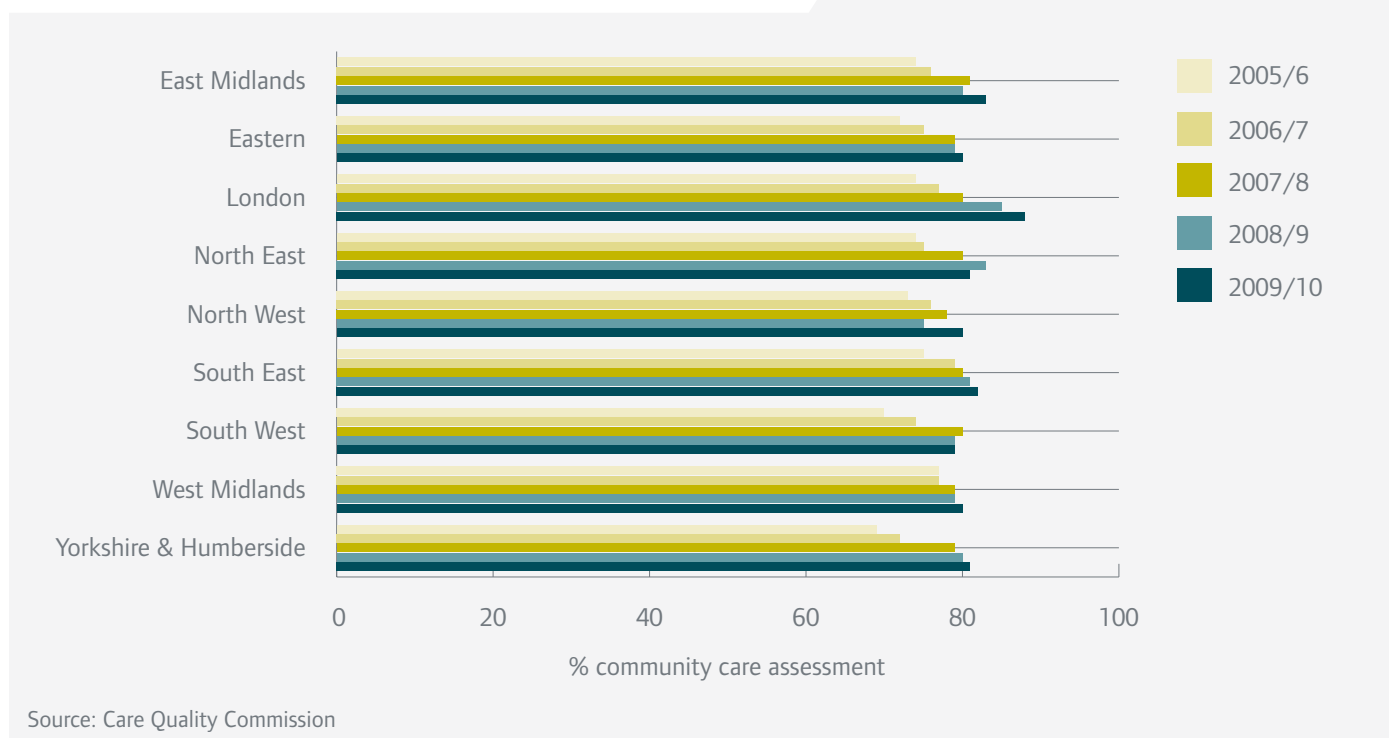
People who use services should expect practical help and other support to arrive promptly after they have made contact with their council. For people who needed a full community care assessment, the length of time that the social services department took to complete the assessment improved in the last four years. In 2009/10, 81% of people had their assessments completed within the acceptable waiting time of four weeks.

Community mental health services - meeting personal goals to promote recovery

A person-centred approach implies that the person using services is actively involved in setting objectives to promote their recovery and maintain independent living wherever possible. Our 2010 survey of people using NHS community mental health services found that of those who had a care plan:

- Four-fifths of respondents (80%) said that it set out their goals, either “definitely” (42%) or “to some extent” (38%). The remaining 20% said that their care plan did not set out their goals.

Figure 4: Percentage of people who had a community care assessment completed in four weeks, 2005/06–2009/10



- Of those whose care plan set out their goals, just under half (47%) said that the mental health services they received “definitely” helped them to achieve these goals, 46% thought their care plan did so “to some extent” with 7% saying that the mental health services they received did not help them to achieve these goals.

Effective support for independent living may involve meeting a wide range of needs, including help looking after children or other family members, housing, finding or maintaining employment, and managing money. Feedback from respondents who had used services under the Care Programme Approach showed that in the previous 12 months:

- Just under two-thirds (61%) of those respondents who wanted help said that someone in mental health services had helped them with finding or keeping work. Over a third (39%) said that they would have liked help but did not receive any.

- Just over two-thirds (68%) of those respondents who wanted help said that someone in mental health services had helped them with finding or keeping accommodation. Almost a third (33%) said that they would have liked help but did not receive any.
- Almost three quarters (71%) of respondents who wanted help said that someone in mental health services had helped them with getting financial advice or benefits (such as housing benefit, income support or disability living allowance). Over a quarter (29%) said that they had not received any help but would have liked some.

Preventing hospital admission and ensuring effective hospital discharge

Overall progress

There was an overall improvement in councils' performance on improving health and wellbeing in 2009/10. The proportion of them that performed excellently increased from 29% to 34% and the proportion that performed adequately decreased from 8% to 3%. Where councils are judged "excellent", people can expect effective rehabilitation, reablement or intermediate care services that reduce the need for care in hospital or care homes.

Table 9: Councils' performance in meeting the outcome "Improved health and emotional wellbeing", 2008/09–2009/10

	Excellent	Well	Adequate	Poor
2009/10	52 (34%)	96 (63%)	4 (3%)	0
2008/09	43 (29%)	93 (63%)	12 (8%)	0

Source: Care Quality Commission

These services, which include joint working arrangements with health and other partners, were recognised as strong in more than half of all councils. Those councils rated "excellent" demonstrated effective partnerships and timely services, to prevent hospital admissions and support people to live independently. They worked with partners to integrate services, so that people did not remain in hospital for longer than necessary and received services promptly to enable them to retain or regain their independence.

Over half of councils still needed to improve in this area by improving their partnerships, extending the scope of their community-based services, and monitoring services to ensure that they meet the needs of the community and improve outcomes for people.

Increase in intermediate care

Continuing the trend from previous years, there was significant growth in the number of people receiving intermediate care, either to prevent hospital admission or to facilitate discharge from hospital.

Table 10: Number of people receiving intermediate care, 2008/09–2009/10

Main purpose	2008/09	2009/10	% change
Prevent hospital admission	148,046	159,561	7.8%
Facilitate discharge	156,536	170,531	8.9%

Source: Care Quality Commission

Delayed discharge

A quarter of the 41 councils assessed on this outcome demonstrated a strength in reducing delayed discharges or delayed transfers of care. Just over a quarter of councils needed to improve joint working arrangements, and to improve intermediate care and reablement services. The number of delayed discharges from hospital was highlighted as an area for improvement for 14 NHS/council partners.

CLAIRE'S STORY

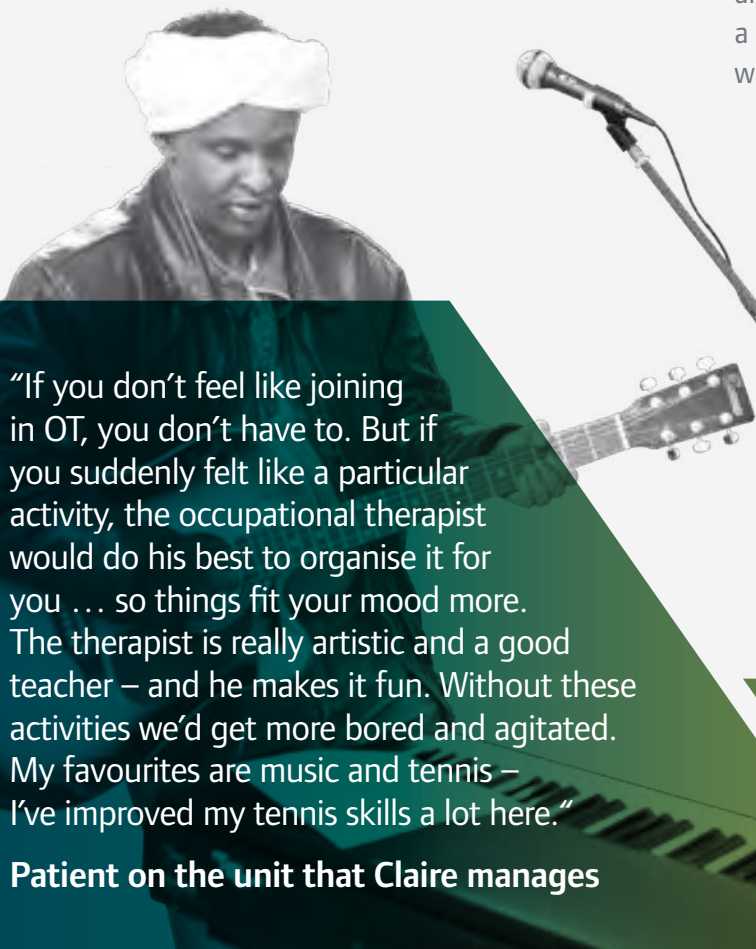
Claire is the ward manager of a psychiatric intensive care unit for male patients in north London. It cares for those who have become so distressed as a result of their acute illness that being on other types of wards might increase their distress or cause danger to themselves or others. All of the unit's patients are detained there under a section of the Mental Health Act.

Despite their often challenging work, the ward staff are committed to seeing each patient as a unique individual and tailoring their care accordingly. This person-centred approach extends to the therapeutic activities for patients. "We have a dedicated occupational therapist who takes a flexible approach that increases patients' enjoyment and motivation to take part", said Claire. "When a patient arrives on the unit, we make sure that we find out very quickly what kind of activities

they like or dislike. And our therapist tends to work with small groups or on a one-to-one basis, tailoring the programme according to what patients are interested in on the day. For example, we had lots of art last month as the patients in the unit then were really keen on it, but this month we have a different set of patients who prefer music, so we're now focusing on that. But all of the patients like the outdoor sport activities, such as football or tennis.

"Our patients nearly always have complex individual needs in addition to – and often as a result of – their illness. Things like family issues, housing, financial problems, educational and employment issues ... We focus on thinking positively and creatively about solutions with each individual, both in terms of their treatment and care and lives outside hospital.

"The culture on the ward is one of respect for others, and treating others as you would wish to be treated yourself. This also applies among the staff – we're all different grades, but everyone's suggestions and ideas are respected, including by the most senior staff. As a result, our staff get real satisfaction from their work with patients, and remain here a long time."



"If you don't feel like joining in OT, you don't have to. But if you suddenly felt like a particular activity, the occupational therapist would do his best to organise it for you ... so things fit your mood more. The therapist is really artistic and a good teacher – and he makes it fun. Without these activities we'd get more bored and agitated. My favourites are music and tennis – I've improved my tennis skills a lot here."

Patient on the unit that Claire manages

Repeated hospital emergency admissions

The level of repeated emergency admissions, in which a patient is admitted to hospital as an emergency on multiple occasions, is one of the indicators of poor care in the community. For example, if an older person is admitted to hospital repeatedly, this may show that they need better ongoing support or crisis support.

We were concerned that, after levelling off in 2006/07 and 2007/08, the number of people over 75 who had had two or more emergency admissions increased in 2008/09 and 2009/10. In 2009/10, 292,522 of them had two or more emergency admissions – 15,089 more than in 2008/09. This represented a rise of 4%, following on from a steep rise of 9% in 2008/09.

Support after hospital discharge for people who have had a stroke

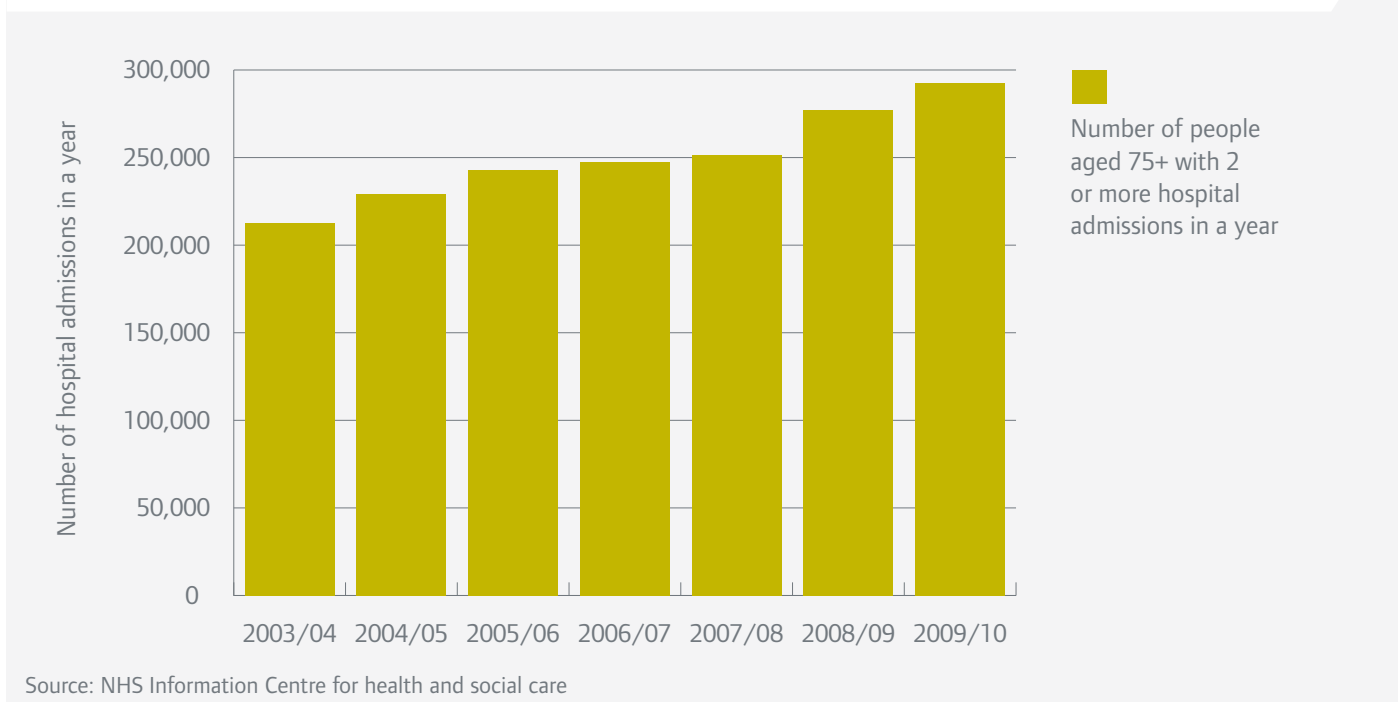
The preventative value of good community services can be seen among people who have had a stroke. Stroke can be a devastating and life changing event, but our special review of stroke services showed that the extent to which stroke survivors and their carers are supported to cope with life after leaving hospital varied significantly across England.³⁹

In particular, there was a threefold variation in the proportion of people returning to hospital in an emergency within a month of going home. While there have been improvements in the way stroke is treated in the initial hours and days immediately after the event, action is needed to improve the care and support that people receive in the longer term in the community.

A quarter of PCT areas performed very well across most of the aspects of care that we looked at. People living in these areas were more likely to experience a smooth return home from hospital and to have had access to a broad range of services to help them recover from, and cope with, the effects of stroke.

Less positively, 24% of areas were rated as “least well performing” and had significant room for improvement. Services in these areas did not work well together, and support services were either not available at all or were more difficult or slower to access. People were given less information about the support available locally and less help with identifying and accessing it. The remaining areas were rated as “fair performing” (23%) or “better performing” (26%).

Figure 5: Number of people aged 75+ with two or more hospital admissions in a year, 2003/04–2009/10



We found that rehabilitation services after transfer home from hospital were inconsistent across the country and that people in some areas had little or no access to specialist community-based stroke rehabilitation. Only two-thirds of PCTs commissioned specialist stroke physiotherapy and less than 40% of areas provided good access to psychological therapy or stroke counsellors.

Other types of support that people could not always get access to when they needed it included:

- Early supported discharge, which provides much of a patient's rehabilitation at home rather than in hospital and could benefit up to 40% of stroke survivors. Although known to achieve better results for people and to cut pressure on hospital beds, it was only available in 37% of PCT areas.
- In 48% of areas, people had to wait an average of two weeks or more before receiving community-based speech and language therapy.
- Only 37% of areas provided community-based rehabilitation services focused on helping people return to work.

Services were not always adapting well to meet people's needs, such as the communications needs of people with aphasia (damage to the parts of the brain that control language) or of those who did not speak English. Other communications issues included:

- While 87% of areas provided a helpline, only 26% ran them outside office hours and 38% did not train helpline staff to deal with people who had aphasia.
- Around three-quarters of social services could direct people to community-based services to help them with their physical disabilities, but less than half could signpost similar services for people with aphasia.
- Only a third of areas provided information on stroke in community languages other than English.

People were not always engaged in decisions about their care. For example, sometimes services did not agree the goals in a care plan with the stroke survivor, and less than half of patients were given a copy of their care plan when going home from hospital.

“We were both frightened about Keith coming home from hospital, as it had been like a cocoon with doctors and physiotherapists there all of the time. While we both wanted him to be back at home, we didn't want him to be unsafe. But having this support has been brilliant, with the physio and communication therapy paramount in helping Keith regain his independence.”

Wife and carer of stroke survivor who benefited from early supported discharge

After people were discharged, six-monthly and annual reviews of their progress and care – a key part of the National Stroke Strategy – were only happening across less than a quarter of PCT areas.

A more positive story emerged about support for carers. In most areas, a range of support was provided for carers and families, and people were generally happy with the information carers received when the stroke survivor came home from hospital. However, peer support – such as carer support groups or befriending schemes – were lacking in a third of areas.



Community-based support for improved quality of life

Overall progress

The outcomes we look at when assessing councils' performance include the crucial area of "improved quality of life". Where councils are judged excellent for this outcome, people who use social care and their carers can expect:

- At an early stage, advice and support that considers their needs and those of their family, aimed at preventing loss of independence and isolation, and maintaining people's quality of life.
- Support with having a social life, including access to transport, health care, leisure, colleges and other local services.
- Choice in how and where they receive support, including people with complex, intensive, or specialised support needs, and their carers.

Most councils performed well or excellently at improving the quality of life for people who use services. The proportion that performed excellently increased from 25% to 34% but there was only a small reduction in the proportion of councils that performed adequately.

Table 11: Councils' performance in meeting the outcome "Improved quality of life", 2008/09–2009/10

	Excellent	Well	Adequate	Poor
2009/10	52 (34%)	87 (57%)	13 (9%)	0
2008/09	37 (25%)	96 (65%)	15 (10%)	0

Source: Care Quality Commission

Helping people to remain independent

More than three-quarters of the 54 councils assessed in this area demonstrated strengths in helping people to remain independent, including having effective telecare services and high-quality preventative, intermediate, and rehabilitation and reablement services. As a result, some councils were able to show clearly that they had reduced the number of people who had had falls and the number of admissions to residential care.

But despite these strengths, over two-thirds of the councils assessed needed to make further improvements in supporting people to live independently and maintain their quality of life. Typically, councils were encouraged to use telecare services more effectively, reduce waiting times for adaptations, and ensure that admissions to care homes were appropriate for the person.

In some areas, telecare provision was working very well. This technology consists of a range of sensors positioned throughout a person's home, which alert their carer, or a monitoring centre, if they have a fall or if there is a problem such as a gas leak or fire. In addition, emergency night support services for people with long-term conditions, or for those in care homes, were helping to prevent the need for hospital admissions. The number of older people who were supported by telecare equipment in 2009/10 increased by 167,685 and joint services with partner organisations continued to rise.

The growth of "extra care" housing is an important part of the range of services that can help people to live independently for longer. This is a form of "very sheltered" housing for older people who are extremely frail, and/or less mobile. Such schemes normally have staff on site and provide meals to the people using them. Extra care was judged to be strong in only nine councils, and was an area for further improvement in 14 councils where the number of extra care places was failing to meet demand.

Just under half of the councils assessed needed to either reduce the length of time people waited for assessment and review, or to improve early intervention and preventative services to help people to maintain independence.



3/4

of councils assessed showed strengths in helping people to remain independent, and some could show clearly how this had reduced the number of people who had had falls or been admitted to residential care.

Person-centred services

Support for those with complex needs

As the overall number of people cared for in the long term in NHS facilities or in care homes continues to fall, it is important that people with complex or multiple needs continue to have choices and support for independent living. Just under a quarter of councils demonstrated a strength in supporting people with more complex needs, and specialist services were recognised as a strength in only seven of them.

Support for carers

Support for carers was identified as a strength in only 43% of the 54 councils assessed. Just over a third needed to improve; for example, by involving carers more in the design of services and providing them with more support, advice and respite care. Typically good practice would include carers having assessments and support plans, flexible support and breaks, along with a clear focus on supporting young carers.

The number of carers who had direct payments to enable them to work rose substantially in 2009/10 from 21,116 to 33,883. Almost half of the 35 councils assessed in this area demonstrated strength in supporting carers to stay in employment or to return to it.

The range and quality of services for young carers was an area that needed to improve in 9% of the 54 councils assessed. We encouraged these councils to improve their support for young carers, including working with providers of secondary education. Councils also needed

to improve the range of services they offer to all carers, increase the number who take breaks, and improve monitoring to ensure that their services are meeting carers' needs and leading to positive outcomes.

The Carers' Strategy, published in 2008, committed £150 million to provide breaks for carers through PCTs. £50 million was to be given in 2009/10 and £100 million in 2010/11. However, this money was not ring-fenced and it has not always been apparent how PCTs have used the funding. A report by the Princess Royal Trust for Carers found that in 2009/10 PCTs planned to use only 23% of the £50 million to increase support for carers.⁴⁰ This issue continues to cause concern, and the 2011–2012 NHS operating framework sets out explicitly the expectation that PCTs should agree policies, plans and budgets to support carers with local authorities and local carers' organisations, and make this information available to local people.⁴¹

Promoting economic wellbeing

A third of the 35 councils assessed in this area delivered excellent outcomes in economic wellbeing, by improving people's access to skilled information and advice, and giving assistance in preparing for and providing work. Nearly all of the remaining councils performed well, with just three councils performing only adequately in this area.

Table 12: Councils' performance in meeting the outcome "Economic wellbeing", 2008/09–2009/10

	Excellent	Well	Adequate	Poor
2009/10	52 (34%)	97 (64%)	3 (2%)	0
2008/09	44 (30%)	98 (66%)	6 (4%)	0

Source: Care Quality Commission

Nearly all of the 35 councils assessed in this area gave good support and advice on welfare benefits and to help vulnerable people to maximise their income. Councils demonstrated strength in helping people overcome barriers to employment, increasing the range and choice of employment opportunities, and supporting people to access training and employment.

Some councils needed to improve access to advice and support for all groups, advocacy services, partnership working to increase employment opportunities (particularly for those with a disability) and monitoring processes to demonstrate outcomes.

1 in 3

The proportion of councils that needed to improve their support for carers, including involving them more in the design of services and giving more advice, support and respite care.

STANDARDS OF CARE AND SUPPORT



**Meeting of the residents'
forum at a nursing home in
Weston-super-Mare**

Introduction

In 2009/10, we noted further improvements in the standards of health care and social care services in England, with still fewer services giving serious cause for concern. Some aspects of care had deteriorated, however, and there is still a way to go in reducing variations in quality from place to place.

As ever, when making our judgements about quality we gave weight to people's experiences and their views about the services they have used. We do this as a matter of course in our inspections and special reviews.

Because of changes in national arrangements for the assessment of public services, it was not possible to compare our 2009/10 ratings of NHS trusts with past years' ratings, nor to update our judgements about the quality of independent health care. When making our assessments, we used the following as our main sources of information:

- Assessment of the overall quality standards achieved by adult social care services (mainly care and nursing homes, home care agencies and shared lives schemes) as at 31 March 2010. This is our last report on their performance against the National Minimum Standards introduced in 2003.
- Surveys of patients using NHS services.
- The performance assessments of all councils with adult social services responsibilities, including the quality of the few care services that councils operate directly, and that of the many services that they purchase from independent care providers.
- Our report to Parliament on the operation of the Mental Health Act in 2009/10.



“When the home is recruiting staff, two of us sit on the interview panel to make sure we have a say about who is appointed. If we don't think a candidate is right for the residents, the management would not take them on – our views are respected. This is important, because the attitude and ability of the staff have a big influence on our daily lives.”

Anne, a resident at a nursing home in Weston-super-Mare

Key findings about quality in 2009/10:

- Since our last report, we have noted further improvements in many aspects of the quality of health care and social care services, with still fewer services giving serious cause for concern. We believe that this has been due partly to the actions of service providers and commissioners and partly to effective regulation.
- The overall performance of councils in delivering social care improved again, continuing the trend of recent years. In 2009/10, councils sustained existing year-on-year improvements. For the seventh successive year, there were no “poor” performing councils and 95% of councils performed either “excellently” or “well” (24% and 71%) in delivering outcomes for local people. The remaining 5% of councils were performing “adequately”.
- The number of councils that performed “excellently” in improving the quality of life for people using their services increased from 37 (25%) to 52 (34%). Thirteen councils (9%) were delivering outcomes that were only “adequate”.
- The quality of services continued to improve overall, and again, this continued the trend of recent years. In May 2008, the percentage of services rated as “good” or “excellent” stood at 69% and this rose to 83% by April 2010. The proportion of services rated as “poor” fell from 3% in May 2008 to 1% in April 2010.
- The quality of some mental health inpatient services continued to cause concern; for example, where we observed over-occupied wards, lack of one-to-one work with patients, or unnecessary restriction of their liberty.
- The quality of privately run care services is generally lower than those run by councils or voluntary organisations, although the costs were often lower as well.
- The quality of care arranged by councils between September 2008 and September 2009 improved – the percentage of people supported in care homes that were rated “good” or “excellent” increased by 11% from 2008 to 2009, and the equivalent figure for home care agencies was 6%.
- Workforce development was gathering pace in the NHS, but in social care it appeared to be less well resourced and led.

Quality standards in social care for adults and older people

Quality ratings

Because CQC has now implemented changes to the methods and criteria we use to assess health care and adult social care, 2010 was the last year in which we awarded quality ratings to care services. Our State of Care report therefore presents a valuable opportunity to look at the progress made since quality standards were introduced in 2008. It is very pleasing to be able to report a significant overall improvement in the ratings that services have achieved, with continuous improvement in the proportion of services rated good or excellent, and a reduction in the proportion rated adequate or poor.⁴²

Evidence used for quality ratings

CQC based its judgements about services' quality ratings on the following evidence:

- Our interviews with staff and the people using the care service.
- Information that the service gave to CQC.
- Surveys filled in by people using the service, their relatives and other professionals involved in their care.
- A key inspection by CQC inspectors (the service did not usually know when they were coming to visit).
- Information CQC held about the history of the service.

Highlighted findings

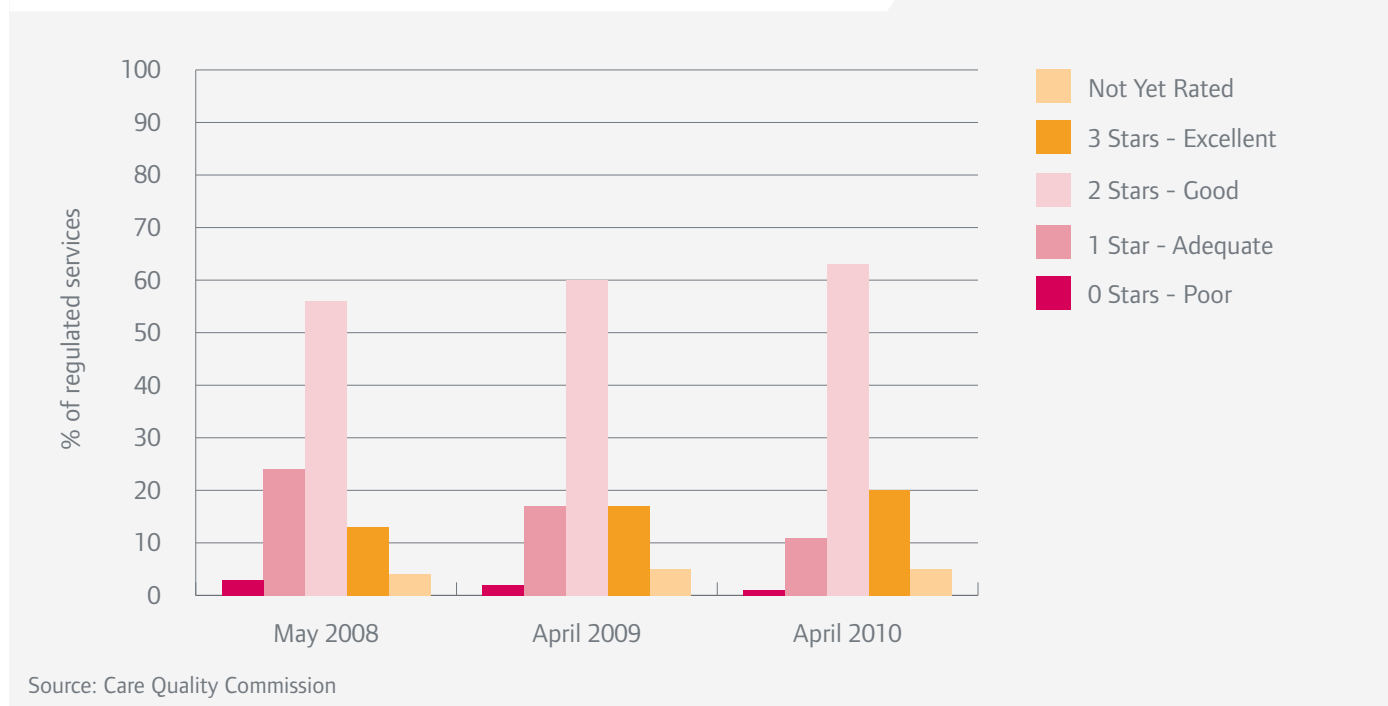
Findings from our analysis that we have chosen to highlight here include:

Quality and type of service

- Shared lives schemes (family placements for adults), had the highest proportion (95%) of services rated good or excellent of all regulated social care service types. Over a third (38%) of these schemes was rated excellent. By April 2009, none had a poor rating and by April 2010 the proportion of shared lives schemes rated adequate had fallen by two-thirds since 2008. However, shared lives schemes represent a very small proportion of adult social care services.



Figure 6: Quality ratings for regulated care services, 2008–2010



Quality and sector of provider

- In May 2008, voluntary-run services had the highest proportion of services rated good and excellent (80%). However, by April 2010, services run directly by councils and those run by voluntary organisations had the same proportion of good and excellent services (91%). It should be remembered that the voluntary sector now runs only a very small proportion of regulated services.
- Privately run services had a significantly smaller proportion of good and excellent ratings (81%) than other sectors in April 2010, though this was a significant improvement on May 2008, when the figure was 66%. Twenty-nine per cent of voluntary run services had an excellent rating compared with just 18% of those that were privately owned. By the same measure, council-run services were just behind the voluntary sector, with 26% of their services rated excellent.

- By April 2010, the proportion of services rated good or excellent in all three sectors significantly increased (between 10% and 15%) compared with May 2008. During the same period, the proportion of poor services in the private sector also fell significantly, from 3.3% to 1.6% (283 services).

Quality by size and type of home

- Smaller care homes were a little more likely to be judged good or excellent than medium-sized or large homes.
- Large homes had the same proportion of excellent ratings as small homes, but proportionally fewer had a good rating than had small or medium-sized homes. Large homes also had the largest proportion of adequate and poor ratings (15%).

ANNE'S STORY

Anne has been living in a nursing home in Weston-super-Mare for two years now. She thinks the home has a "lovely homely atmosphere" compared with others she's known, and that the staff are "very understanding, patient, and polite." Another thing Anne appreciates is the way residents are genuinely involved in decisions that affect their life in the home.

"When the home is recruiting staff, two of us sit on the interview panel to make sure we have a say about who is appointed. If we don't think a candidate is right for the residents, the management would not take them on – our views are respected. This is important, because the attitude and ability of the staff has a big influence on our daily lives." Catherine, the home's manager, also asks residents for feedback before staff have their performance appraisals.

A couple of years ago the home set up a residents' forum, which usually meets every three months. One of the residents or Catherine chairs the meeting, and everyone gets a copy of the minutes afterwards.

"We discuss all sort of things, from new menus and activities for residents, to politics and issues in the newspapers and on TV that affect older people," says Anne, "And if by any chance we wanted a residents-only discussion, staff would leave the meeting."

The residents have their own newsletter and are also kept as involved as possible in external events. "At the time of the general election last year, Catherine arranged for us all to vote by post. Afterwards we wanted to meet our new MP, but he was so busy it was difficult to get a slot in his schedule, so Catherine arranged for the mayor to come and visit us instead!"

As manager, Catherine is a key link between the residents and the care and nursing staff, and sometimes between residents and their families. She talks to each resident every day to get their feedback on day-to-day life at the home, and if she needs to negotiate with families on behalf of a resident, Catherine ensures that the resident's wishes are given top priority.

"We believe in the human touch ... wherever possible we try to put people before 'policy and procedures', and to consider things from a resident's perspective, while making sure we follow good practice. The most important qualification we look for in staff is true dedication to caring for older people and to making our residents feel that living here is their 'home away from home'."

Catherine, manager of the nursing home where Anne lives



Standards of care and support

- Care homes for younger adults were more likely to be rated good or excellent (89%) than care homes for older people (84%). Both showed significant improvement since May 2008, but the rate of improvement was greater for care homes for older people. The proportion of home care agencies rated good or excellent rose from 72% in May 2008 to 80% in 2010. The proportion of good services rose by just under 2% (1.9%), while the proportion of excellent services rose by 6%. The most significant change was in the proportion rated adequate, which had decreased by 12% by April 2010.
- Smaller, less formal settings were most strongly associated with the quality criteria used in our former rating scheme. However, the trend among service providers is towards larger care homes.

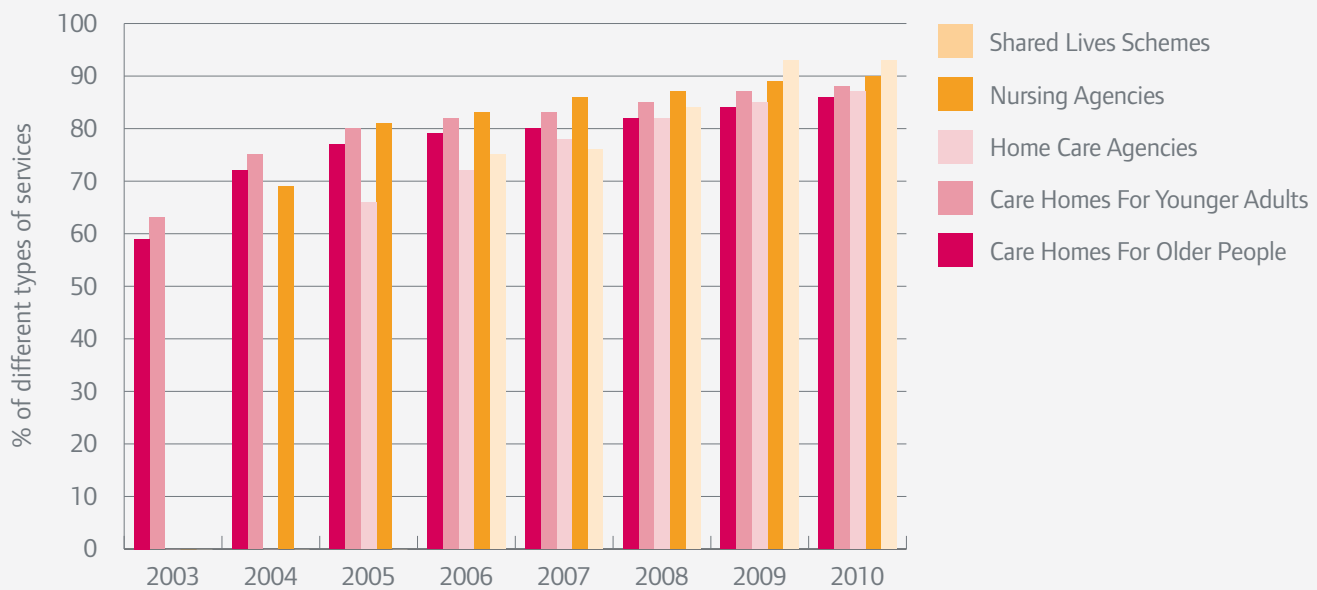
Performance against National Minimum Standards

Figure 8 summarises the consistent and positive picture seen in quality improvements in services since 2003. Each year there has been an increase in the average percentage of standards that services met or exceeded, although this was less marked in 2009/10 than in some earlier years.

Care homes for older people have made the greatest improvement since the National Minimum Standards were introduced in 2003, meeting 27% more of the standards in 2010 than in 2003. Care homes for younger adults made a similar improvement, meeting 25% more of them on average.

Shared lives performed best in relation to national minimum standards, meeting 93% of them on average. They also improved the fastest, meeting almost a fifth (18%) more standards in 2010 than in 2006.

Figure 7: Percentage of care services meeting national minimum standards, 2003–2010



Source: Care Quality Commission

Table 13: Change in percentage of care homes for older people meeting national minimum standards, 2003–2010

National minimum standard	Percentage of homes meeting the standard in 2010	Percentage points change 2003-10
Meals and mealtimes	90%	+12%
Space (space available in residents' rooms)	93%	+28%
Furniture and fittings	84%	+40%
Shared facilities	88%	+12%
Premises (general physical condition of the home)	81%	+26%
Social contact	82%	+10%
Heating and lighting	78%	+35%

Source: Care Quality Commission

Care homes for older people

Among care homes for older people, progress with quality improvement was fairly consistent between 2003 and 2010. However, some important quality standards, such as for medication, were still only being achieved by a relatively low proportion of homes in 2010 (72%).

Care homes for younger adults

In care homes for younger adults, similar or higher levels of attainment were achieved, with some considerable improvement against specific quality standards, as shown by the examples in table 14. Some of these findings suggest that the physical condition of many care homes improved significantly between 2003 and 2010.

28%

of care homes for older people were not meeting the minimum standard relating to medication, which includes keeping proper records of residents' medication and making sure staff are properly trained.

Table 14: Change in percentage of care homes for younger adults meeting national minimum standards, 2003–2010

National standard	Percentage of homes meeting the standard in 2010	Percentage points change 2003–10
Decision making	93%	+23%
Personal development	92%	+4%
Education and occupation	94%	+5%
Community links and social inclusion	95%	+8%
Leisure	89%	+12%
Meals and mealtimes	94%	+13%
Personal support	96%	+11%
Premises	80%	+28%
Space requirements	93%	+18%
Furniture and fittings	87%	+34%

Source: Care Quality Commission

Quality of adult social care commissioned by councils

The council's role as purchaser

Councils in England are responsible for arranging and financially supporting care services for three-quarters of a million adults. Collectively they spend nearly £8 billion each year on care homes and home care. It is estimated that around half of all places in the country's care homes are occupied by people whose care is council-funded.

As the leading purchasers of care services, councils have great actual or potential influence over the quality of these services. And even though people using services have a right to choose the care home they enter, very often their choice is limited by the level of funding available when the council is paying.

Improvement in quality of care purchased

When we compared the overall quality of care arranged by councils between September 2008 and September 2009, we found that the proportion of people receiving care from services rated good or excellent had increased both for care homes and home care. It had risen by 11 percentage points from 2008 to 2009, with care purchased from homes providing nursing care for older people showing the greatest improvement. There was a corresponding increase of six percentage points for domiciliary care.

Volume and quality of care home places purchased

At September 2009, England's councils were funding care home places for 230,000 adults. More than eight out of 10 (86%) of these people were living in care homes rated good or excellent.⁴³

Ninety per cent of care home places that councils purchased for younger adults were rated good or excellent. And in the six months to September 2009, 85% of the 31,500 older people who moved permanently into a council-arranged care home place went into a home rated good or excellent.

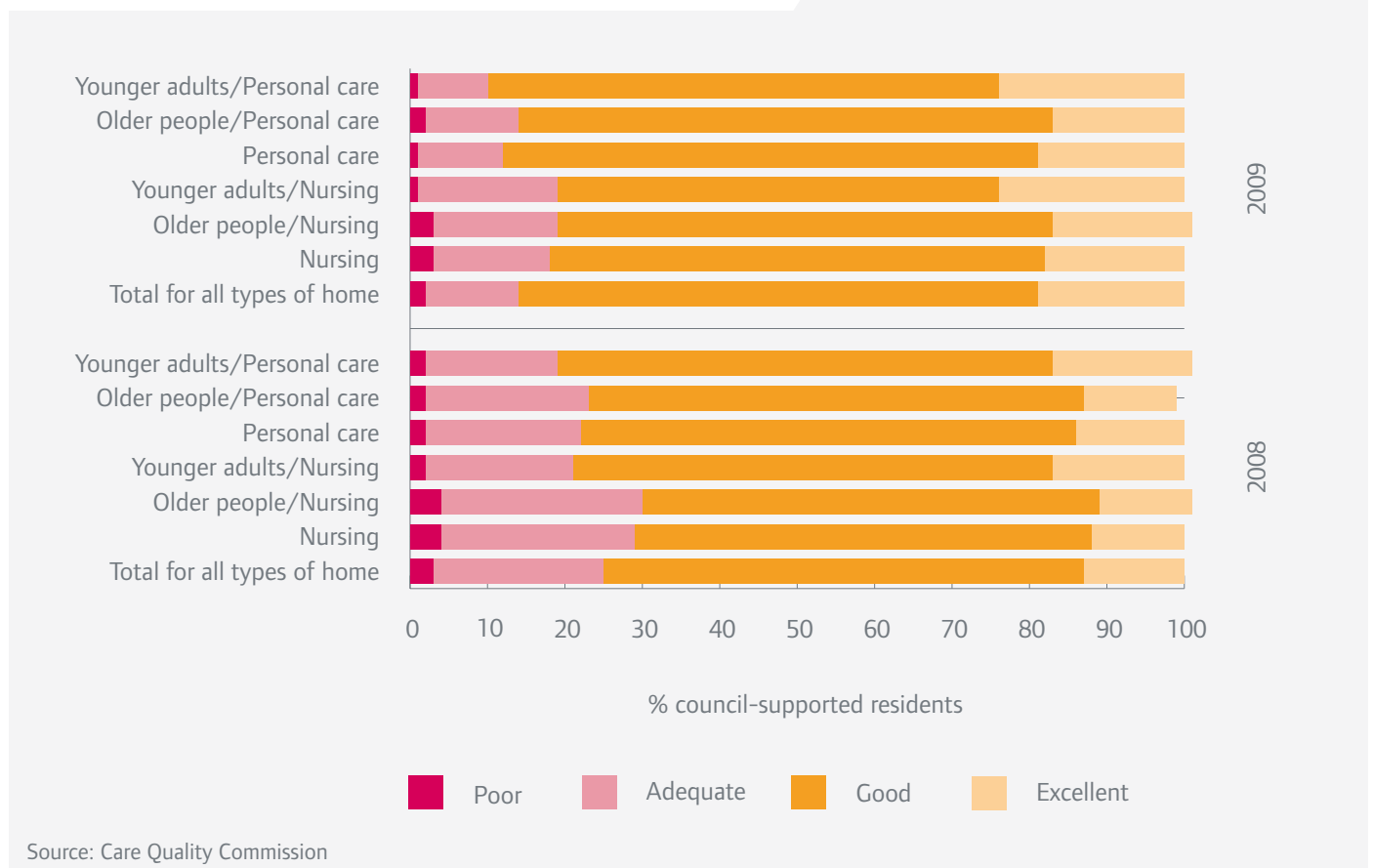
Improvement in councils' purchasing of care home places

In each of the four main types of care homes – for adults, for older people, personal care, nursing care – the proportion of council-supported residents in homes rated good or excellent had increased between September 2008 and September 2009.

Regional variations

Figure 9 shows how the percentage of council-supported care home residents who were receiving good or excellent services varied between different regions of England. There was a particularly marked, unacceptable gap between the proportion of people in the London region who received higher quality services and the proportion who did so in the West Midlands.

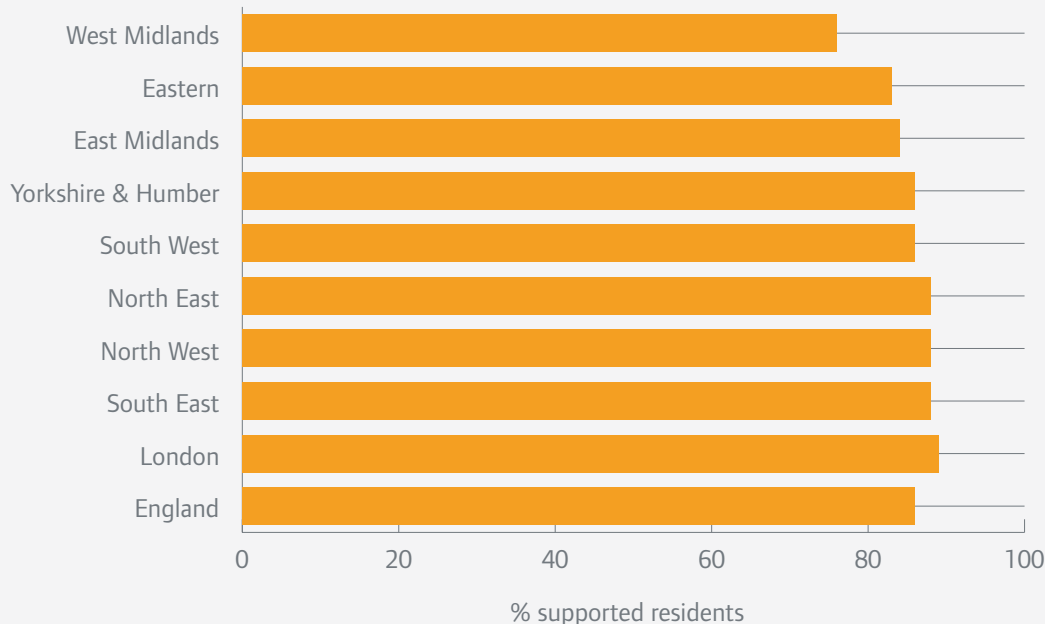
Figure 8: Percentage of council-supported residents by type of home* and quality rating, 2008 and 2009**



* As at September 2008 and September 2009

** As at December 2008 and May 2010

Figure 9: Percentage of council-supported residents living in homes rated “good” or “excellent”* by region, September 2009



Source: Care Quality Commission

* Quality ratings as at May 2010

9%

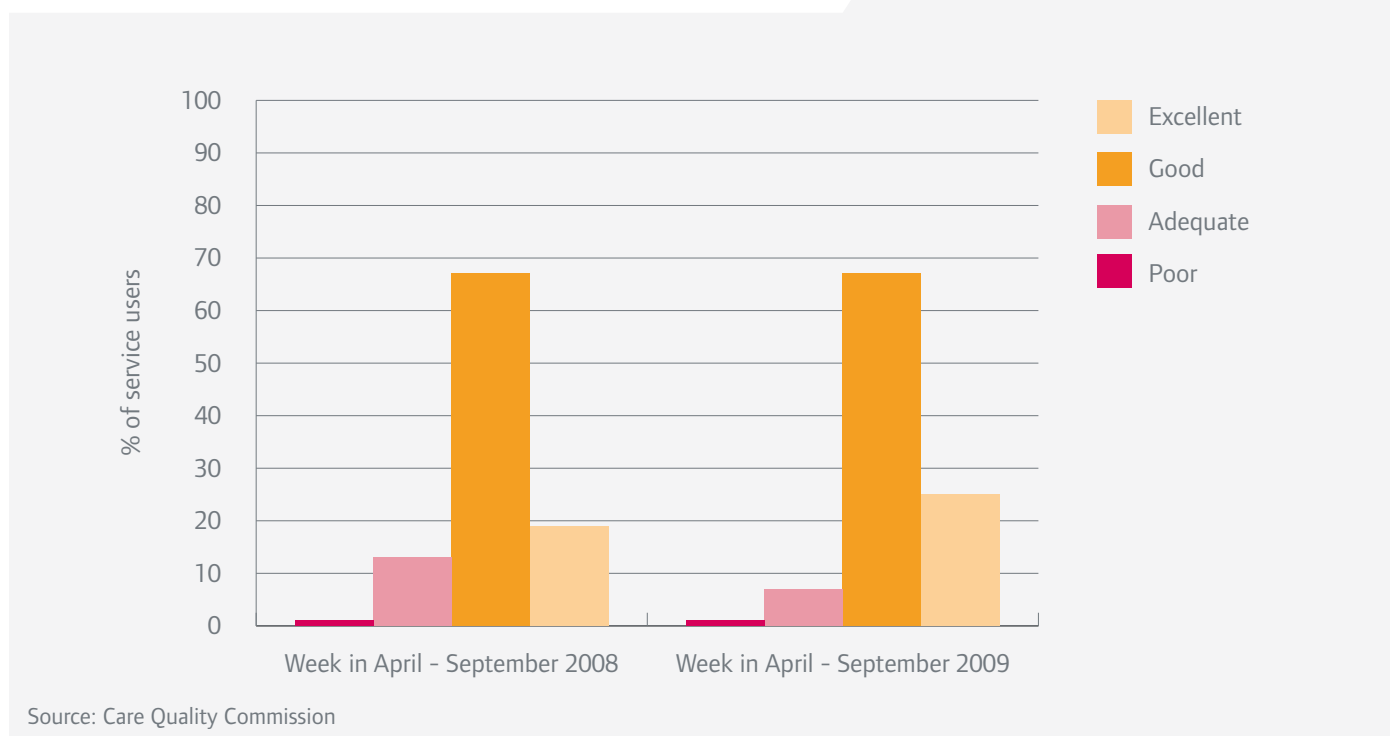
of councils had improved their performance in delivering outcomes for people through social care, but in 5% of councils performance deteriorated.

Quality of home care services purchased

The quality of home care services is a matter of growing importance, as all councils arranged or purchased home care to help 582,000 adults live independently in 2008/09. It is the largest single service provision by councils, and a vital support to independent living. In 2008/09, approximately £1 in £4 of councils' net spending on care services for adults was on home care, which constitutes nearly half of all net spending on community-based care services.

From April to September 2009, 93% of people whose home care was arranged by their council received a service from a home care agency that was rated good or excellent. However, 1,900 adults received home care from services rated as poor, and a further 21,800 received their care from services rated as adequate.⁴⁴

Figure 10 : Percentage of people using council-arranged homecare services by services' quality ratings*, 2008 and 2009



*Quality ratings as at December 2008 and May 2009

Councils' performance in delivering outcomes in social care

A council's role as the main commissioner of local care services is crucial to the overall standards and outcomes of care in its area. In 2009/10, councils' overall performance in delivering social care outcomes improved once again, continuing the trend of recent years. For the seventh successive year, there were no poor performing councils.

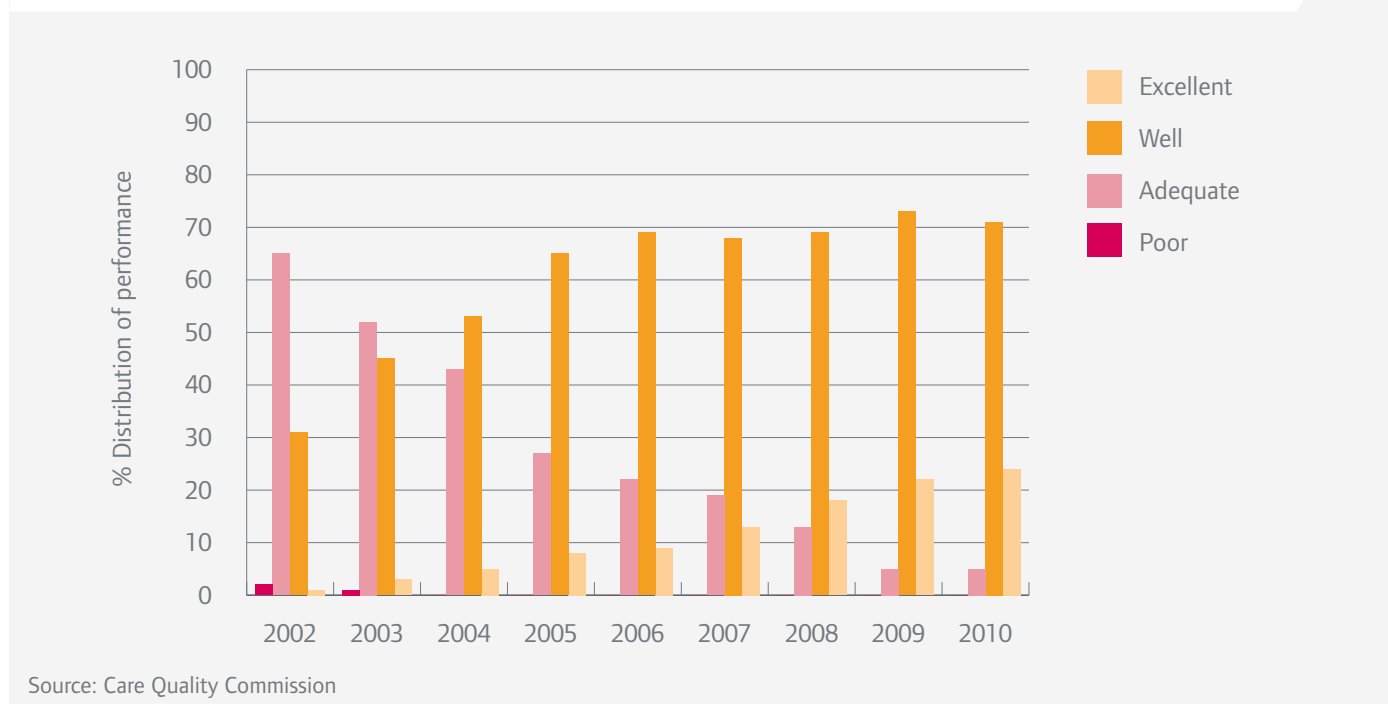
Ninety-five per cent of councils performed either "excellently" or "well" (24% and 71%) in delivering outcomes for their population. The remaining 5% of councils performed "adequately".

In both 2008 and 2009 there had been a significant increase in the momentum of improvement over previous years, and this continued in 2010:

- In their performance in "delivering outcomes", 9% of councils improved and 5% deteriorated.
- Five out of eight councils that were performing adequately in 2009 were judged to be performing well by 2010.

The number of councils within each category for delivering outcomes in 2010 was: seven (5%) adequate, 108 (71%) performing well and 37 (24%) excellent.

Figure 11: Council performance in delivering outcomes in adult social care, 2006–2010



Quality of health care

Patient-centred care

To help improve the quality of NHS services for the people who use them, it is important to understand how patients rate their care and treatment. We ask those who have recently used their local health services to tell us about their experiences. Our 2009 survey of adult inpatients was the seventh such survey, and involved 162 acute and specialist NHS trusts.⁴⁵ We received responses from more than 69,000 patients.

The results show sustained improvement in patients' view of the overall quality of their care and treatment, and of some specific areas such as cleanliness. But feedback on other standards, such as the quality of hospital food or the number of people who felt they wanted to complain, was not particularly encouraging. It suggested fairly modest improvement and limited impact over time on patients' quality of experience in NHS hospitals.

Patients' perceptions of specific aspects of care

Confidence and trust in doctors and nurses

Being able to feel confidence and trust in healthcare staff is one of the most important aspects of quality from a patient's perspective. Our respondents reported generally high levels of this in 2009, which was broadly similar to previous years. Among inpatients, 80% "always" had confidence and trust in their doctors and 17% "sometimes" did.

The proportion of inpatients who said that they "always" had confidence in the nurses treating them fell by one percentage point to 74% in 2009, while those who said that they "sometimes" did increased one percentage point to 23%. Three per cent said they did not have confidence and trust in the nurses treating them, showing no change since 2008.

Outpatients also reported high levels of confidence and trust, with 82% of respondents reporting that they "definitely" had confidence and trust in their doctors, an increase of one percentage point since 2004.⁴⁶ A further 15% said that they did "to some extent" (down from 16% in 2004), while 2% reported that they did not have confidence or trust in their doctor, down one percentage point from 2004.

Making complaints

When asked if they had wanted to complain about the care they received in hospital, 92% of respondents replied “no”, and 8% replied “yes”. The number of people (5,371) who wanted to complain was a concern, and had not appeared to vary since 2008. However, the NHS has made it easier for patients to complain and figures are only available for the last three years.

Noise at night from other patients or hospital staff

Many people continued to be concerned about noise at night. Although there was no significant change since 2008 in the proportion of respondents who said that they were bothered by noise at night, either from other patients and/or staff, this proportion has increased steadily since this question was first asked in 2005 – from 37% to 40%.

Hospital food

The quality of hospital food remains a long-standing concern. Inpatients’ perceptions of it changed very little, with 55% rating it as “good” or “very good” – a small improvement from 2002 (53%). As regards choice, 94% said they were always or sometimes offered a choice of food. Of those who needed help with eating, 18% said that they didn’t get enough help – the same figure as in 2002.

Pain management

Sixty-seven per cent of patients said they were in pain at some point during their hospital stay, unchanged from 2008. There has been a decrease in the proportion of respondents who said that staff “definitely” did enough to help control their pain (71%), compared with 72% in 2008 and 2002. Twenty-three per cent of respondents said that this was the case “to some extent”, but 6% did not think that the staff did everything they could have done to control their pain – a figure that has not changed since 2002.

Mixed sex accommodation

The virtual elimination of mixed-sex accommodation is a priority within the NHS Operating Framework for England for 2010/11. We found that there had been some significant improvements in this area in 2009/10. The majority (92%) of respondents whose hospital admission was planned said that they did not share a sleeping area with patients of the opposite sex when first admitted, or when they were moved to another ward – an increase of two percentage points and no change respectively.

Seventy-nine per cent of respondents who had an emergency or urgent admission said that they did not have to share a sleeping area, such as a room or bay, with patients of the opposite sex when they were first admitted to bed on a ward. This was an improvement of eight percentage points since 2008.

Patients should not have to share toilet and washing facilities with the opposite sex, unless they need specialised equipment such as hoists or specialist baths. Twenty-three per cent of respondents said that they had to use the same bathroom or shower area as patients of the opposite sex – an improvement since 2008, when 30% reported having this experience.

Privacy

More generally, people should be able to expect privacy when discussing their conditions or being examined or treated. Our 2009 surveys found a small improvement in this area, with 88% of inpatient respondents saying that they “always” had enough privacy when being examined or treated, while 10% saying that they “sometimes” did. Among outpatients, 91% said that they “always” had enough privacy when being examined or treated and 8% “sometimes” did.



Availability of staff

Fifty-nine per cent of respondents said they thought there were “always or nearly always” enough nurses on duty to care for them while they were in hospital, up from 58% in 2008. Another 30% said there were “sometimes” enough nurses, down from 31% in 2008. Ten per cent said there were “rarely or never enough” nurses.

Twenty-two per cent of respondents reported that they could not find someone on the hospital staff to talk to about their worries or fears – this was unchanged since the 2008 survey but higher than in 2002 (17%). Forty-one per cent said they were “definitely” able to find someone and 38% said they were able to “to some extent”.

Community mental health services

Care Programme Approach

The Care Programme Approach (CPA) is the framework for delivering specialist mental health care in the community for people with severe mental health problems. It involves an assessment and regular review of health care and social care needs, a written care plan and the appointment of a care coordinator.

Our 2009 survey of people using community mental health services suggested that the CPA process was working reasonably well overall.⁴⁷ However, many people were not involved as much as they would have liked in some aspects of their care: for example, they wanted more explanation of, or more say in, their treatment and support, including medication or care planning. There was still room for improvement in making sure people had: out-of-hours phone numbers to contact if they had a crisis, access to psychological therapies, help with day-to-day living and attention to their physical health needs.

Care coordinators

The majority of the respondents to the survey receiving care under CPA said that they knew who their care coordinator was (84%), but 16% said that they did not know or were not sure.

On the whole, respondents who knew who their care coordinator or lead professional was were positive about that person:

- Seventy-four per cent said that they could “always” contact their care coordinator or lead professional if they had a problem, with 22% “sometimes” able to contact them and 4% saying they were not able to contact their care coordinator or lead professional if they had a problem.
- Sixty-two per cent of people said that their care coordinator or lead professional organised the care and services they needed “very well”, with the remainder responding “quite well” (31%), “not very well” (5%) and “not at all well” (3%).

Care plans

Everyone who receives mental health care under the CPA should have a plan that explains what to do if they have a crisis. Just over half (52%) of survey respondents on CPA and who had a care plan said that it “definitely” covered what they should do, while 26% said it covered what they should do “to some extent”. However, over a fifth of respondents (23%) said that their care plan did not cover what to do if they had a crisis.

Confidence in community mental health staff

Seventy-two per cent of respondents using community mental health services said that they “definitely” had trust and confidence in the last health or social care worker they saw for their mental health condition. Twenty-one per cent said “to some extent”, but 7% said they did not have trust and confidence in this person.

73%

of mothers who responded to our survey said that they “definitely” had confidence and trust in the staff caring for them during labour and birth.

Women’s experience of maternity services

Our second national survey of women’s experience of NHS maternity care in England drew responses from over 25,000 women across the country who gave birth in a hospital, birth centre, maternity unit or at home in early 2010.⁴⁸ We found significant changes since the results of our first maternity survey in 2007.

Antenatal care

Women generally reported better communication and involvement in their antenatal care and were more positive about its quality. For example, 74% said that they were “always” involved enough in decisions about their care, compared with 67% in 2007. A greater proportion of women reported using some services sooner – for example, seeing a midwife for the first time at an early stage of pregnancy. There was also an increase in the proportion of women reported having a dating scan and test for Down’s syndrome, and a scan at around 20 weeks of pregnancy.

However, fewer women attended NHS antenatal classes – 58% compared with 61% in 2007. And more women said that they were not offered the opportunity to do so – 38% compared with 36% in 2007. There was also scope to increase the number of women who receive enough information from a midwife or doctor to help them decide where to have their baby.

Standards of care and support

Labour and birth

Support during labour and birth improved, but with room for still further improvement. More women reported that they were treated with kindness and understanding in hospital after the birth, and more felt they were “always” or “sometimes” involved enough in decisions about their care during labour and birth.

More women reported ‘definitely’ having confidence and trust in the staff caring for them during the labour and birth (73% compared with 68% in 2007), and “definitely” received the pain relief they wanted during labour and birth (65% compared with 64%). They were also more likely to have previously met the staff who cared for them. Fewer were left alone by staff during labour or shortly after birth when it worried them.

The majority of women (85%) had skin-to-skin contact with their babies shortly after birth. However, fewer women having normal deliveries were encouraged to take more active birthing positions. An increased proportion gave birth lying down, and there was a marked increase in those being supported with stirrups – a practice that is discouraged by the National Institute for Health and Clinical Excellence (NICE) unless clinically necessary.

Staying in hospital

More women reported being treated with kindness and understanding while in hospital, but the information and explanations that staff gave them still needed to improve.

Feeding

The proportion of women who were breastfeeding increased, as did the support they received to do so from midwives in the first few days after the birth. The picture was slightly different for women after going home with their baby, where there was a decrease in the number of people who received help and advice about feeding their baby in the first six weeks after the birth.

Care at home

Our survey findings suggested that information and support should be given more consistently to all women at home after a birth. More women reported they had “definitely” received help and advice about their baby’s health and progress in the first six weeks (60% compared with 58% in 2007), but more reported not receiving help and advice about feeding (13% compared with 11%).

There was no improvement in the proportion of women (95%) who were given the name and telephone number of a midwife or health visitor to contact if they were worried when at home after the birth. Nor was there any improvement in the proportion that received advice on contraception after the birth.

Almost all respondents were visited at home by a midwife after the birth, but there was a decrease in the total number of midwife visits reported. The proportion of women who saw a midwife five times or more decreased.

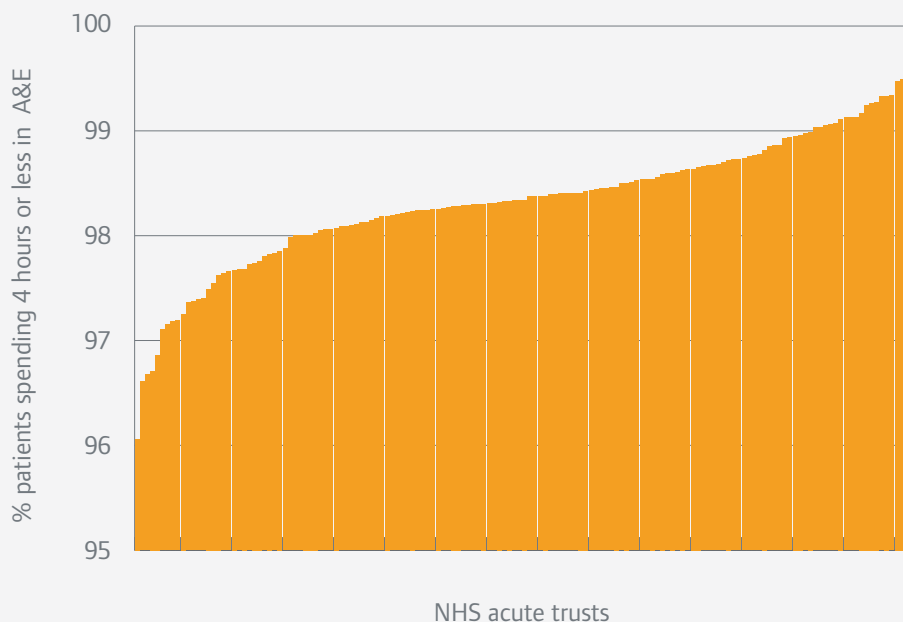
Meeting NHS commitments and priorities

Because of changes in the way that information about trusts’ performance against NHS commitments and priorities is collected and presented, it is no longer possible for us to report in detail on progress over time. We have therefore made a benchmarking tool available on our website, so that managers can look at their trust’s performance in the context of that of other trusts.⁴⁹

A&E waiting times

The NHS commitment on A&E waiting times has been that at least 98% of patients should spend no more than four hours in any type of A&E department, from arrival to admission, transfer or discharge. The NHS Operating Framework for 2009/10 confirmed that this standard should continue to be maintained during the year. Overall, NHS trusts met this commitment, with a national average of 98.12% and 20 trusts that achieved figures over 99%. The lowest figure achieved was 96%.

Figure 12: Patients spending four hours or less in A&E departments in 153 NHS trusts, 2009/10



Source: Care Quality Commission

Cancelled operations

Hospitals cancel operations for many reasons, both clinical and non clinical. If a hospital cancels an operation at the last minute for non-clinical reasons, and the patient has not been treated within 28 days of the cancellation, then this is recorded as a breach of the standard.

Data published by the Department of Health showed a positive reduction of 1,348 in the number of cancelled operations between 2009/09 and 2009/10.

Figure 13 shows the broad spread of performance in 2009/10 across 165 trusts, with 51 of them achieving better than expected performance. Seven trusts were below average, and of these, the performance of three was much worse than that of the other four trusts.

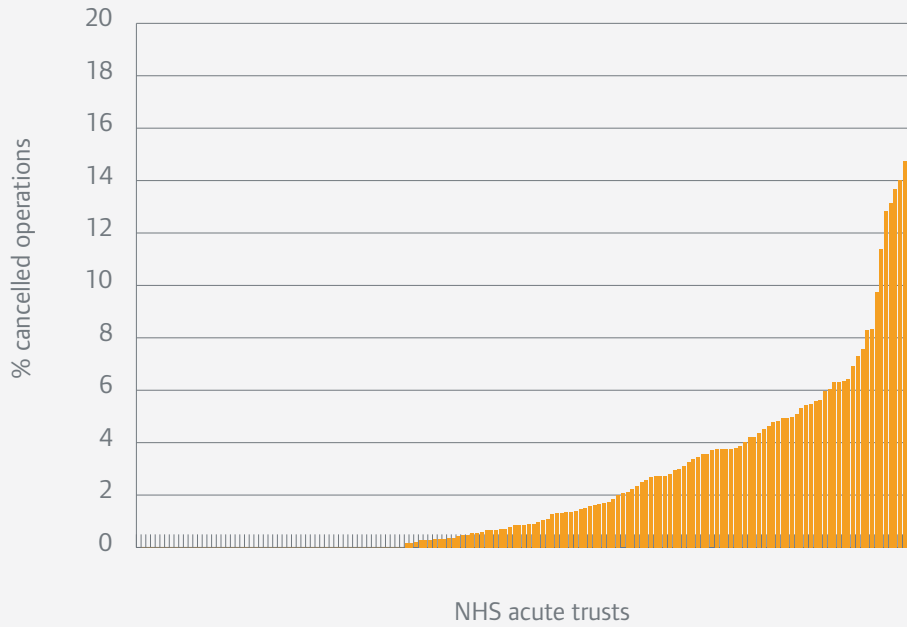
Quality of stroke care

The National Stroke Strategy defines excellent care at different stages, including the treatment within specialist stroke units and rapid access to services for people who have had a minor stroke or transient ischemic attack.

One measure of the quality of a patient's care after stroke is the proportion of time that they spend on a specialist stroke unit while in hospital.

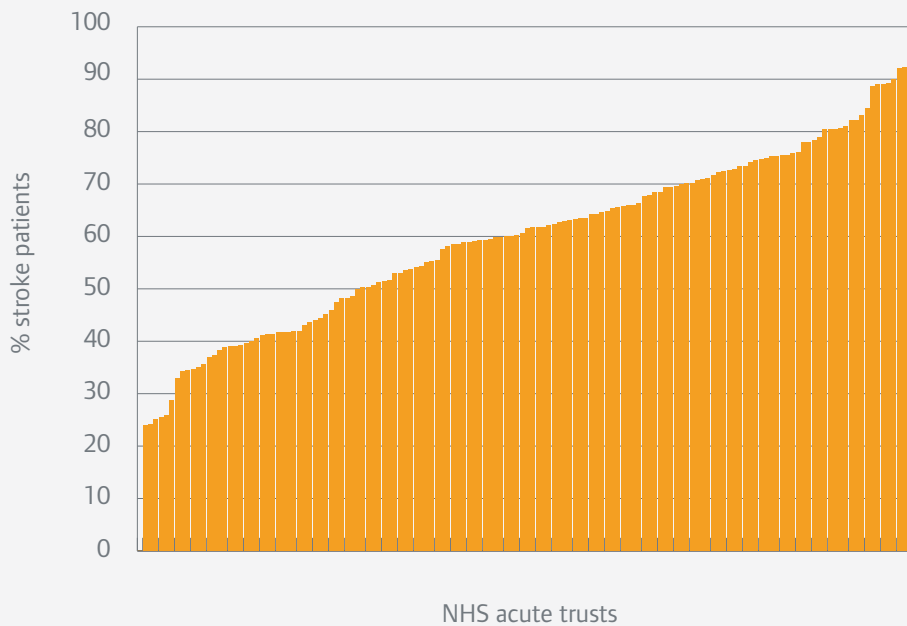
Of 147 trusts assessed for their stroke care, 13 exceeded expected performance, and the performance of nine of these trusts was much better than that of the other four. Twelve trusts showed performance lower than expected, and seven of these trusts performed much worse than the other five.

Figure 13: Cancelled operations – Percentage of patients whose operation was cancelled on the day of or after admission who were not treated within 28 days, 2009/10



Source: Care Quality Commission

Figure 14: Percentage of stroke patients who spent at least 90% of their time in hospital on a specialist stroke unit, 2010



Source: Care Quality Commission

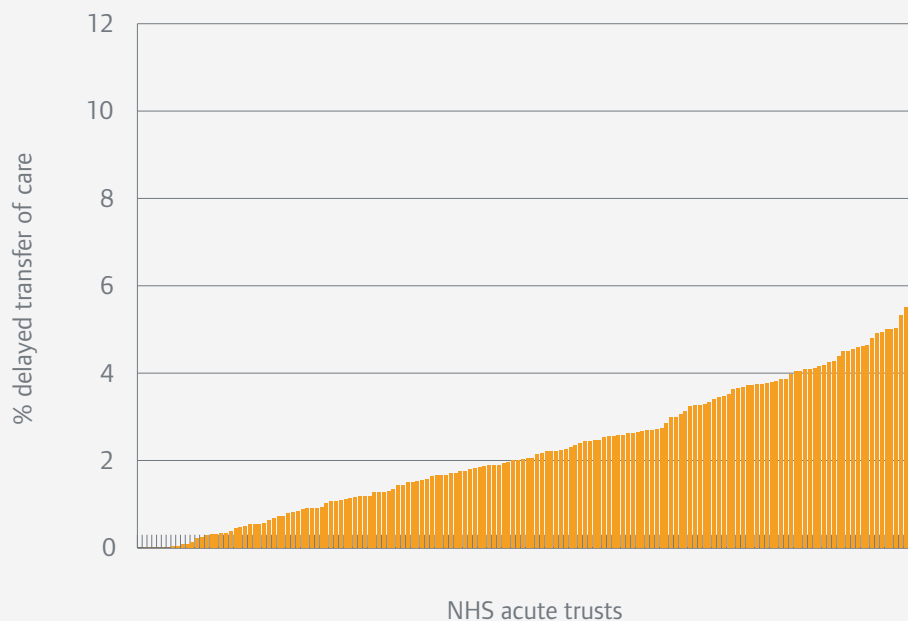
Delayed transfers of care

The frequency and length of any delays that patients experience when leaving hospital are used as measures of performance. Such delays matter, both in terms of the inconvenience to patients and the economic impact on the hospital. When asked if their discharge was delayed for any reason on the day they were due to leave hospital, 40% answered yes. The most commonly reported reasons were having to wait for medicines (61%) and having to wait to see the doctor (16%). A disappointingly high percentage of patients reported waiting for more than four hours (22%).

However, patients' perceptions of what constitutes a delay differ from the definition of delay used by NHS management. For trust managers, a delay starts and is timed from the moment that the patient is deemed ready to be discharged by a clinician. On this measure, 84 hospitals improved their performance in this area during 2009/10, 62 deteriorated, and two remained the same. Just 13 hospitals failed to meet the NHS commitment for delayed transfers, but this was 10 more than in 2008/09.

Figure 15 shows the spread of performance in 2009/10 across 162 trusts, in which 28 achieved better than expected performance and of these, 19 performed much better than the other nine trusts. Only four trusts were below average, and of these, the performance of three was much worse than that of the others.

Figure 15: Delayed transfers of care from NHS acute hospitals, 2009/10



Source: Care Quality Commission

Workforce development and staff training

Good quality care depends to a considerable extent on the skills and knowledge of the social care and health care workforce. We report briefly here on some of the training and development that informed services' performance in 2009/10. The data available does not allow for direct comparison between performance against training standards in the NHS and in adult social care.

Safeguarding training in adult social care

In safeguarding work with adults, the extent and quality of training is a major element in determining the effectiveness of the service: people who know how to identify the signs of abuse, and know how and when to react when this is suspected, can make a real difference in protecting people from serious harm.

We noted that in adult social care, safeguarding training was a strength in only 40% of councils and an area for improvement in 41%. Excellent councils demonstrated well-monitored, cross-sector safeguarding training, which was up to date and inclusive of minority groups. Where improvements were needed, this was most often about increasing levels of safeguarding training in independent services, in identifying staff training needs and in monitoring the effectiveness of training.

Meeting the standard for staff training

Turning to the wider areas of staff training in care services, there was a significant improvement in the performance of care homes for older people and for younger adults between 2003 and 2009, and also in the number of home care agencies meeting the standard for staff training and development.

NHS staff training

The NHS Constitution includes four pledges that set out what staff can expect from NHS employers. One of these is to "... provide all staff with personal development plans, access to appropriate training for their jobs and the support of line management to succeed.

Almost 290,000 NHS staff were asked for their views on working in the NHS in the seventh annual national NHS staff survey, held from September to December 2009.⁵⁰ Fifty-five per cent of all NHS staff responded. Of these, 60% had agreed a personal development plan as part of their performance review, up from 55% in 2008 and 52% in 2007. However, only half of these staff said that they had received the training, learning or development identified within the plan – a small increase on 49% in 2008. A further 29% said it was "too early to say".

Between 2008 and 2009, the number of clinically qualified staff in the NHS grew by 23,748 (3.4%).⁵¹

Workforce performance in adult social care

Our assessments of council performance in social care looked at evidence of effective leadership, including the extent to which leaders achieved "... a workforce with the capacity, skills and commitment to deliver improved outcomes with key partners." We found that levels of staff training, qualifications, knowledge and commitment were key strengths in just over a quarter of councils, and that 22% of councils needed to improve in this area.

Staff vacancy and absence rates can have a considerable impact on the quality of experience for people using a service, affecting as they do the continuity and reliability of people's care and support, and their relationships with care staff. Only 16% of councils demonstrated low absence and vacancy rates and high recruitment and retention rates, which confirmed that staffing issues continued to be a challenge in 2009/10.

"All NHS staff should have rewarding and worthwhile jobs, with the freedom and confidence to act in the interest of patients ... They must be treated with respect at work, have the tools, training and support to deliver care, and opportunities to develop and progress."

NHS Constitution 2010

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