Market Report

Issue 1: June 2012

Contents

Summary

This report presents the results of inspections of more than 14,000 services, between the start of the new regulatory system and 31 March 2012, across all the sectors that CQC currently regulates: healthcare, adult social care and dental care.

It provides a snapshot of the performance of health and social care providers across England against the essential standards of quality and safety required by law.

We have used this information to identify themes in strong and poor performance – both what the inspection data tells us, and what our inspectors believe are the areas of emerging risk.

The report is the first in a series of quarterly publications that will track performance across all sectors and flag issues of concern. We will use them to inform and target our regulatory activity.

On 31 March 2012, the majority of locations inspected as at that date were meeting all the essential standards checked: 72% in adult social care, 77% in NHS services and 82% in independent healthcare. The total number of locations meeting all standards was 10,313, which equates to 73% of all locations inspected.

We took action in the other 27% of locations checked. In most cases, we required an action plan from the provider to tell us how they intended to address the problem. The vast majority of providers worked positively with CQC to make sure they were taking all the necessary steps to improve.

In a small number of cases (130 locations, or 1% of all locations inspected), we had to use our powers on a more urgent basis to protect people from harm or hold the provider to account.

Our inspection data has highlighted some common issues of poorer performance across a number of the different health and social care sectors:

- **Management of medicines** (17% of all locations inspected were not meeting the relevant standard). Our inspectors are seeing a worrying number of examples where safe management of medicines is being

number of examples where safe management of medicines is being compromised, often by a lack of information given either to those taking the medicines, or those caring for them. We are also starting to see more complex drug treatments and significant growth in co-morbidity, putting an increasing demand on social care environments in particular.

- **Record keeping** (15% of all locations inspected were not meeting the standard). Issues range from records – which include crucial information about people's care – being incomplete or not up-to-date; not kept securely or confidentially; or not showing that risks to people had been identified and were being managed appropriately.
- **Staffing** (11% of all locations inspected were not meeting one or both of the two main staffing standards). Issues to do with staffing emerge as a key driving factor in many instances of non-compliance, both in terms of the numbers of staff available and in the support they are given to do their job. The non-availability of temporary staff and organisations leaving vacancies open for a number of months – particularly for qualified staff – can lead to compromises in the quality of care given to people, and staff training and supervision.

These are all issues that have an impact on the other essential standard that tended to have poorer performance across sectors – care and welfare of people and patients (13% of all locations inspected were not meeting the relevant standard).

The safety and suitability of premises was also an issue of concern to our inspectors in social care settings.

The report includes a special focus on maternity services, an area where a number of providers have struggled to meet essential standards. The report looks at the themes emerging from this, notably around staffing, and also reviews third party data that we use to inform our view of risk.

We will continue to review areas of strong and poor performance, and use subsequent quarterly reports to monitor these. We will explore the reasons behind non-compliance with those that have responsibility for ensuring that people are protected from poor care.

We will also seek to highlight where sectors and organisations have taken significant steps to improve their services.

Registered providers and locations

The shape of the health and social care sector in England and the nature of provision are constantly evolving. This Market Report provides an update on the number of providers and services that we have registered across the country.

Care providers are registered with CQC to carry out 'regulated activities'. Conditions of registration can apply to each regulated activity separately. Table 1 shows the number of registered providers as at 31 March 2012. A provider may operate in more than one care sector – in these cases it is categorised according to its main area of operation. There is significant variation in the types of services and activities that CQC regulates within the broad categories outlined.

Table 1: Number of providers registered with CQC

Care sector	Providers as at 31 March 2012
NHS healthcare	291
Adult social care	12,429
Independent healthcare	1,227
Primary dental care	8,112
Independent ambulance	243
Total	**22,302**

A single provider may provide services from a range of locations (for example, one registered provider may run several care homes, or one NHS trust may operate several hospitals and clinics). Table 2 shows the number of registered locations as at 31 March 2012. Registered locations reflect the scale of what CQC has to monitor and inspect, as generally each registered location requires its own inspection. These locations vary significantly in terms of their complexity, as a large NHS trust will require a different level of resource to a small care home.

Table 2: Number of CQC registered locations

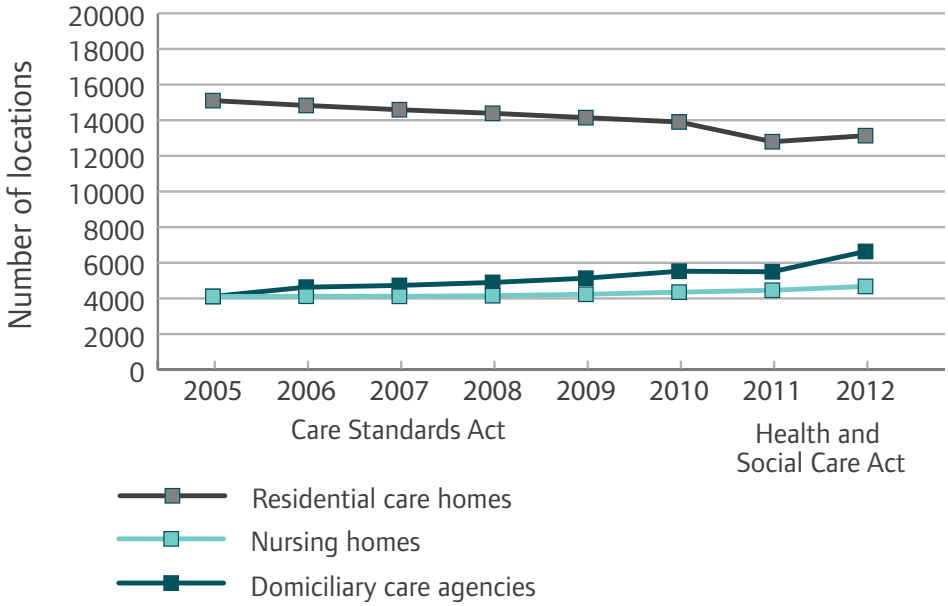
Care sector	Locations as at 31 March 2012
NHS healthcare	2,396
Adult social care	25,008
Independent healthcare	2,764
Primary dental care	10,130
Independent ambulance	323
Total	**40,621**

Overall, at the end of March 2012 there were 22,302 registered providers providing health, social care and dental services in 40,621 locations in England.

Changes in the provision of registered adult social care

Figure 1 illustrates the changing nature of the registered adult social care sector, with a policy direction leading a long-term trend towards more provision that enables people to continue living in their own homes and communities. There is also consolidation within the sector that may be leading to bigger care homes that accommodate more people, as larger corporate groups buy smaller independent organisations. We will continue to monitor both the consolidation of care home provision and the growth of micro providers, particularly in domiciliary care, and look at how these changes impact on total capacity.

Figure 1: Change in the provision of adult social care 2005—2012[1]



1 Note that different registration criteria were in place under the Care Standards Act, than currently apply under the Health and Social Care Act.

Compliance with the essential standards

We present here the first complete findings from our regulatory activity under the Health and Social Care Act 2008. Although many sectors have been regulated under previous acts, this new regulatory system introduced a common set of essential standards of quality and safety that apply across all health care and adult social care services in England (with the exception of GP practices and primary medical care services, which come into the new system from April 2013).

We registered NHS trusts and hospitals from April 2010, independent healthcare and social care providers from October 2010, and primary dental care and independent ambulance providers from April 2011.

Once providers are registered, we check that the essential standards of quality and safety, required by law, are being met. There are 28 standards in total, but, of these, we focus on 16 standards that most directly relate to the quality and safety of care.

We produce guidance for providers that helps them understand what meeting the essential standards looks like. This sets out outcomes that would be experienced by a person using the service if the provider was complying with the standards.

Each inspection looks at a different range of outcomes, so not every outcome is assessed at every inspection. We carry out a mixture of planned inspections (conducted as part of our ongoing programme), responsive inspections (conducted in response to a problem or concern being raised with us) and themed inspections (looking at a particular issue or type of care). Almost all of these inspections are unannounced.

In the sections that follow, we show two different types of information for each care sector:

(i) The pie charts show whether providers were meeting the essential standards we had checked, at all locations that had had a published inspection report as at 31 March 2012. Therefore they give a snapshot of compliance for that sector at that date. Where a location had been inspected more than once (and the inspection report published by 31 March 2012), the compliance status is that of the most recent inspection.

The charts show the split between locations that were meeting and not meeting all the standards we had checked. They also show the level of action we took where they were not meeting the standards.

If a provider is not meeting one or more standards, the action we take is proportionate to the impact that this has on the people who use the service and how serious it is.

Usually, if the breach of the regulations has a minor impact on people, or the impact is moderate but it has happened for the first time, we require the provider to tell us how they intend to address the problem. Once we are

satisfied that they are taking all the necessary steps, they need to tell us when they have made the improvements so we can follow it up and check.

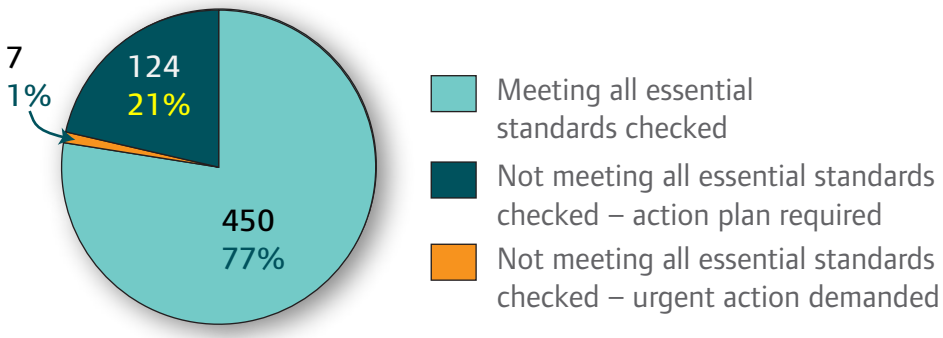
For more serious cases, we use our powers on a more urgent basis to protect people from harm or to hold the provider to account. Generally we either issue a warning notice (urgent public notification that they must take immediate action), restrict the service that the provider can offer, suspend the provider's registration, or cancel it altogether (which means the provider can no longer offer services at that location).

(ii) The tables show the standards which had the highest non-compliance. Full tables that show the compliance status for all 16 standards in each sector, for locations that had had that standard checked between the start of the new regulatory system and 31 March 2012, are shown in the appendix.

NHS services

At 31 March 2012, of the NHS locations we had inspected since the start of the new regulatory system, 77% were meeting all the essential standards we had checked. In 21% of cases (124 locations) on that date, the service was not meeting at least one standard and we required an action plan telling us how they were going to improve. On 31 March 2012, there were seven locations (1% of cases) where serious concerns had led us to use our powers on a more urgent basis to protect people from harm or hold the trust to account (see figure 2).

Figure 2: Compliance in NHS locations inspected as at 31 March 2012



NHS healthcare organisations (581 locations inspected)

The standards where we found the poorest performance in NHS hospitals (below 90% compliance) were those dealing with care and welfare of patients; management of medicines; staffing and supporting staff; and record keeping (see table 3).

Table 3: NHS hospitals – highest non-compliance per outcome, as at 31 March 2012

Outcome		% non-compliant
13	Staffing	15%
21	Records	15%
9	Management of medicines	14%
4	Care and welfare of people who use services	12%
14	Supporting staff	11%

The standards where we found the best performance were those dealing with the safety of equipment and having staff that are qualified and fit for the job.

The full compliance table for NHS hospitals is shown in the appendix.

Behind the numbers: what our inspectors found

Staffing in the NHS

Staffing emerges as a key driving factor in many instances of non-compliance. The non-availability of temporary staff and vacancies in qualified staff often led to compromises around the care and welfare of people using services and support for staff, including training and supervision.

Sometimes, formal staffing assessments had not been undertaken or, where they had, they had not been implemented.

Continuity of care was also affected, leading to a poorer patient experience. Typical of this was a mental health setting, where escorted leave could not always be accommodated – so a lack of staff was directly affecting the ability to provide a range of services that can support patients and improve their care and welfare.

Case study

In April 2010, Cambridgeshire Community Services NHS Trust became the first specialist NHS community trust created in England. At the time, the trust acknowledged it was not meeting required staffing levels, affecting the special care baby unit, its health visiting service and the district nursing service. By November 2011, the trust had confirmed that they had secured staffing in the special care baby unit and health visiting service. However, it remained non-compliant with staffing in the district nursing service across Cambridgeshire.

The key reasons for this were due to staff shortages: they were only just able to meet the demand for staff to respond to urgent requests for patient visits, staff were being frequently moved around to cover leave and sickness absence, and some patients said they were receiving poor continuity of care due to staff changes.

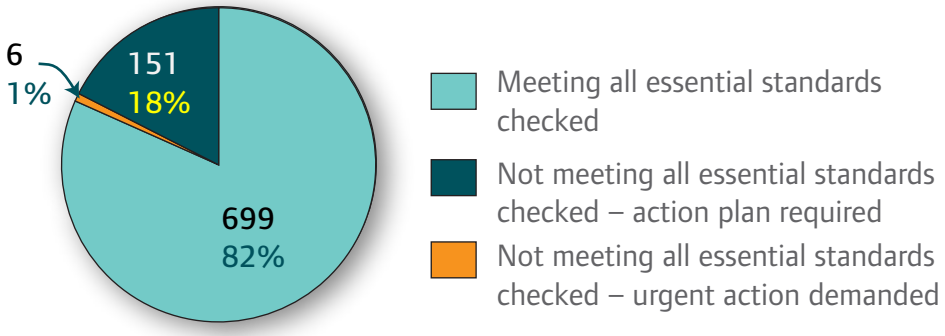
Action we took

We asked for an action plan from the trust to tell us how they were going to tackle this. They sent us a detailed plan which outlines how they will achieve a stable district nursing service within Cambridgeshire. They have also demonstrated to us in meetings that they have taken clear and robust action to understand and manage the risks to the service on a daily and ongoing basis. The action plan will involve a large amount of work to change the service and the trust is aiming to meet the standard by the end of June 2012. We will follow up to ensure the necessary action has been taken.

Independent healthcare services

At 31 March 2012, of all the independent healthcare services that we had inspected since they transferred into the new regulatory system, 82% were meeting all the essential standards we had checked. In 18% of cases (151 locations) on that date, the service was not meeting at least one standard and we required an action plan telling us how they were going to improve. On 31 March 2012, there were six locations (1% of cases) where serious concerns had led us to use our powers on a more urgent basis to protect people from harm or hold the provider to account (see figure 3).

Figure 3: Compliance in independent healthcare locations inspected as at 31 March 2012



Note: percentages do not sum to 100% due to rounding

Independent healthcare organisations (856 locations inspected)

The standards where we found the poorest performance in independent hospitals and clinics (below 90% compliance) were those dealing with the management of medicines and record keeping (see table 4).

Table 4: Independent hospitals and clinics – highest non-compliance per outcome, as at 31 March 2012

Outcome		% non-compliant
21	Records	13%
9	Management of medicines	12%

The standards where we found the best performance were those dealing with meeting patients' nutritional needs and how the hospitals cooperate with other providers.

There are emerging indications that there may be a disparity between the performance of acute hospital services and mental health services in the independent sector, and this is something we will explore in a future report.

The full compliance table for independent hospitals and clinics is shown in the appendix.

Behind the numbers: what our inspectors found

Records management in independent hospitals

The management of records appears as an area of greater non-compliance in a number of sectors; for independent hospitals it was the area with the most overall major and moderate concerns.

In our inspections where it was an issue, we found a range of problems: records sometimes incomplete or not up-to-date, putting people at risk of receiving unsafe or inappropriate care; records being accurate but not kept securely or confidentially; records not clearly showing that people were involved in their treatment or that risks to their safety had been identified and managed.

There were sometimes problems of inaccessibility of records – for example, the operation records for a consultant being stored in a folder in the treatment room, which did not comply with national guidance and created a greater risk of the records getting lost or accessed inappropriately.

Case study

The Retreat, an independent hospital providing care and treatment for people detained under the Mental Health Act, had moved to storing and recording care documentation in computerised records, which were supplemented by paper records. There were inconsistencies in which records were stored on computer and on paper for each unit. Some of the paper records were chaotic and had very old records with recent entries. The nurses and support workers showed us how they use the computerised records; we found all had different levels of competency in navigating the records and some struggled to identify the care needs from the records. However, one of the managers was able to use the computer system very well and was able to instruct inspectors in how to navigate the records.

The computerised records did not have a method for patients to record their consent and their views. The senior managers explained that these should be printed off and stored in the paper records. However, this was not happening consistently on the wards and some of the printed records we saw had not been signed by anyone.

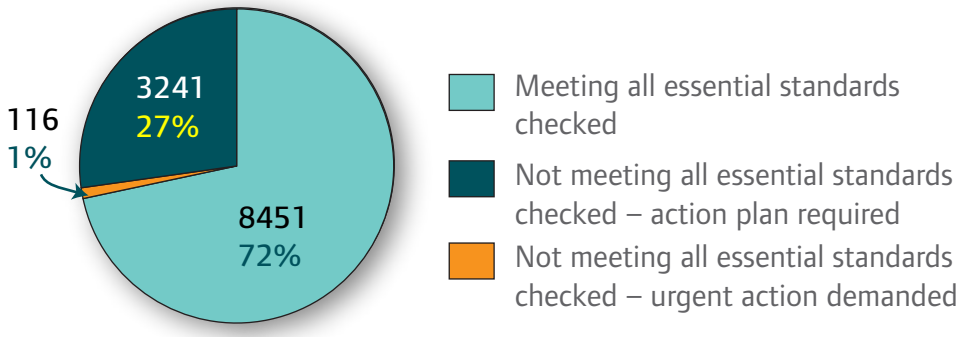
Action we took

We asked the hospital for an action plan to tell us how it would improve its maintenance of patients' records and how it would make sure that all staff are able to access the appropriate records to carry out their work safely. We will re-inspect the hospital shortly.

Adult social care services

At 31 March 2012, of all the adult social care services that we had inspected since they transferred into the new regulatory system, 72% were meeting all the essential standards we had checked. In 27% of cases (3,241 locations) on that date, the service was not meeting at least one standard and we required an action plan telling us how they were going to improve. On 31 March 2012, there were 116 locations (1% of cases) where serious concerns had led us to use our powers on a more urgent basis to protect people from harm or hold the provider to account (see figure 4).

Figure 4: Compliance in adult social care locations inspected as at 31 March 2012



Social care organisations (11,808 locations inspected)

In looking at adult social care services in detail, we split services into nursing homes, residential homes (those without care from registered nurses) and domiciliary care agencies (providing care to people in their own homes).

Nursing homes

The standards where we found the poorest performance in nursing homes (below 90% compliance) were those dealing with care and welfare of people; cleanliness; management of medicines; premises; staffing and supporting staff; monitoring the quality of service provision; and record keeping (see table 5).

Table 5: Nursing homes – highest non-compliance per outcome, as at 31 March 2012

Outcome		% non-compliant
9	Management of medicines	20%
4	Care and welfare of people who use services	18%
21	Records	17%
10	Safety and suitability of premises	15%
14	Supporting staff	15%
8	Cleanliness and infection control	14%
13	Staffing	14%
16	Assessing and monitoring the quality of service provision	12%

The standards where we found the best performance in nursing homes were those dealing with how they cooperate with other providers and how they handle complaints.

The full compliance table for nursing homes is shown in the appendix.

Residential homes

For residential homes, the poorest performance (below 90% compliance) was in care and welfare of people; cleanliness; management of medicines; premises; monitoring the quality of care; and record keeping (see table 6).

Table 6: Residential homes – highest non-compliance per outcome, as at 31 March 2012

Outcome		% non-compliant
9	Management of medicines	16%
10	Safety and suitability of premises	15%
21	Records	14%
4	Care and welfare of people who use services	12%
8	Cleanliness and infection control	12%
16	Assessing and monitoring the quality of service provision	12%

The standards where we found the best performance in residential homes were those dealing with how they cooperate with other providers and how they handle complaints.

The full compliance table for residential homes is shown in the appendix.

Domiciliary care services

In domiciliary care services, there were only four areas of non-compliance below 90%: care and welfare of people; management of medicines; supporting staff; and record keeping (see table 7).

Table 7: Domiciliary care services – highest non-compliance per outcome, as at 31 March 2012

Outcome		% non-compliant
9	Management of medicines	16%
21	Records	14%
4	Care and welfare of people who use services	11%
14	Supporting staff	11%

The best performance was in meeting people's nutritional needs, cooperating with other providers, and the safety of premises and equipment.

The full compliance table for domiciliary care services is shown in the appendix.

Behind the numbers: what our inspectors found

Medicines management in adult social care

Medicines management was clearly the area of most concern across the different types of social care service. In this sector, we are starting to see that more complex drug treatments and significant growth in co-morbidity are putting an increasing demand on social care environments.

One of the most common problems we found concerned the administration of medicines not being correctly recorded, which reflects another of the standards with lower compliance.

Other problems included storage of medicines not being monitored in line with the provider's policy and staff not always correctly following the policies and procedures that are in place. Concerns about medicines training were raised by some staff: some nurses coming into the social care sector from healthcare find that they are more responsible for medication accuracy and carrying out audits than they were used to, which they may have underestimated.

Case study

At Hugh Myddelton House, a nursing home in North London, we found problems with a number of the medicines records we reviewed. People were missing doses of medicines, and poor records meant we could not tell whether some medicines had been given.

It was clear that the system for ordering medicines was not effective. During March, 12 prescribed medicines had run out, so people had missed medicines, including pain relief, for up to five days. One person should have taken an anti-coagulant medicine every day to reduce the risk of a stroke, but the medicines chart showed that this had not been administered for more than two weeks; however, staff had been waiting for advice from the GP or hospital.

Another person had been prescribed a controlled drug for pain relief, to be given at 8am. On the day of our visit, we saw that staff did not give this pain-relieving medicine until 11.45am. Staff told us that this was often given late because there was only one nurse on duty on the floor, so they had to wait for a second nurse to witness this medicine being given.

One resident should have had an anti-emetic patch, prescribed for use every 72 hours, but medicine charts showed it had been applied on four consecutive days. Some people had been prescribed sedatives to be used when they became agitated, but there was no guidance for staff on how these medicines should be used or records of why they were needed.

Staff did not always keep notes on people's records when medicines were stopped or changed, and medicines that were no longer needed were not being disposed off in a timely manner.

Action we took

We formally warned the provider, Barchester Healthcare Homes Limited, that it was failing to comply with Regulation 13 of the Health and Social Care Act. We issued a warning notice which made it clear that if the company failed to comply by 23 April, we would consider further action. The local council suspended further admissions to the home, working closely with CQC inspectors under safeguarding procedures to ensure that people were not at risk of further harm.

Barchester Healthcare provided us with an action plan telling us how the care home would make sure that people would always be given the correct dose of medicine at the correct time, and that this would be correctly recorded. Inspectors have been back to the home to check compliance with the regulations and will decide whether any further action is required. A full inspection report will be published.

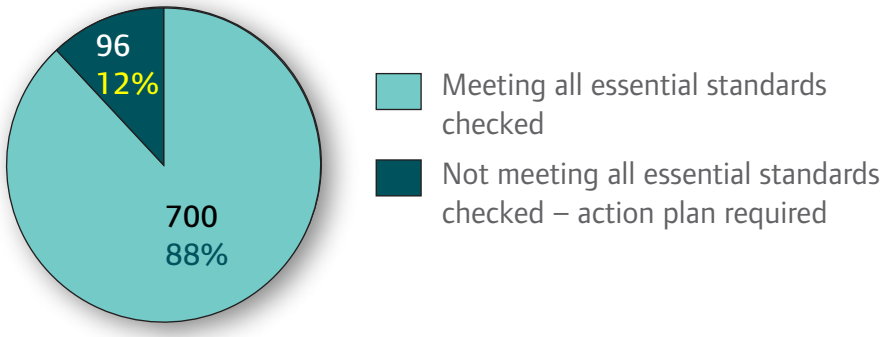
Dental care services

We completed the registration of almost all primary dental care providers in the summer of 2011 and by the end of March 2012 we had inspected around 16% of dental surgeries.

We present here our very early findings about levels of compliance. Note that these are based on the 796 inspection reports published by 31 March 2012, and the proportion of dental care locations this represents is too small to give a detailed breakdown of compliance figures by outcome at this stage.

At 31 March 2012, of the primary dental care services that had been inspected, 88% were meeting all the essential standards we had checked. In 12% of cases (96 locations) on that date, the service was not meeting at least one standard and we required an action plan telling us how they were going to improve. On 31 March 2012, there were no serious concerns that led us to use our stronger enforcement powers to protect people from harm or hold the provider to account (see figure 5).

Figure 5: Compliance in dental care locations inspected as at 31 March 2012



Primary dental care (796 locations inspected)

The outcomes we have checked most often in our first dental care inspections have been those relating to respect and involvement of patients, their care and welfare, safeguarding patients from abuse, and cleanliness and infection control. The initial compliance figures are shown in table 8.

Table 8: Dental care services – selected outcomes, as at 31 March 2012		
Outcome		% non-compliant
1	Respect and involvement	1%
4	Care and welfare of people who use services	2%
7	Safeguarding people from abuse	7%
8	Cleanliness and infection control	6%

Independent ambulance services

By 31 March 2012, we had inspected and published reports on 19 of the 323 independent ambulance locations registered with us. As this number is still quite low both in absolute terms and as a proportion of all independent ambulance locations, we will wait until a later Market Report before reporting levels of compliance and the detail behind them.

Focus on: Maternity services

Following our registration of NHS trusts in 2010, we identified and responded to concerns in maternity services in a number of trusts. The concerns shared a number of common elements including staffing levels, quality of clinical care, and learning from incidents.

We looked at the issue of NHS maternity services, to help our inspection teams understand where the risks of non-compliance lie. We looked at the data we held in the key areas of staffing, experience of women using services, clinical outcomes and contextual risk, to check our understanding of the risk factors across the broad range of NHS maternity services.

Challenges facing maternity services

We considered the concerns we had previously seen in the context of the challenges facing maternity services. These challenges can compromise the safety of mothers and babies, leading to poor outcomes in terms of health and quality of experience. The number of babies born in England has increased significantly during the past decade, and reached over 687,000 in 2010. The 2011 NHS survey of maternity patients suggested that poor care of some kind was experienced by between 4% and 8% of women. There are three main challenges facing maternity services:

- **Rising birth rate** – the number of live births in England rose from 563,744 in 2001 to 687,007 in 2010, an increase of over 123,000.[2] The number of births has risen throughout the decade, with year-on-year increases occurring each year except for 2009.
- **Births are increasingly complex** – both pregnancies and births are increasingly complex as more women with high risk factors for complications – such as age, weight, or co-morbidity – are having babies. Over the last 20 years, the number of live births in England and Wales to women aged 40 and over has nearly trebled from 9,717 in 1990 to 27,731 in 2010.[3] The rising proportion of high risk and complex cases and higher levels of dependency (for example, increased monitoring, ante-natal screening and blood-borne virus screening) have placed greater demands on the staffing levels of maternity wards.[4]
- **Midwife staffing levels** – midwife numbers are not increasing in line with the rising birth rate. Although births in England increased by over 21% between 2001 and 2010, the number of midwives only increased by around

2 *Birth summary tables, England and Wales – 2010*, Office for National Statistics, July 2011.
3 *Births and Deaths in England and Wales 2010*, Office for National Statistics, July 2011.
4 *Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour*, Royal College of Obstetricians and Gynaecologists, October 2007.

15%, from 18,048 to 20,790.[5] For the NHS, the most recent workforce figures show that in September 2011 there were 20,519 midwives, an increase of 394 since 2010 and an increase of 2,948 (16.8%) since 2001.[6]

What compliance with the essential standards tells us

There are 141 NHS trusts that provide maternity and midwifery services. We looked at those trusts that were not meeting at least one essential standard on 31 March 2012, and where we had asked for an action plan. The most common concerns related to staffing levels, support for staff, and care and welfare of patients.

The following extracts from our inspection reports typify the kinds of issues we found within maternity and midwifery services that led to our making judgements of non-compliance with the standards.

5 *Submission to NHS Pay Review Body, Royal College of Midwives*, September 2011. Figures are for full time equivalent (FTE) numbers.

6 *NHS Workforce Summary of Staff in NHS Results from September 2011 workforce census*, Health and Social Care Information Centre (formerly NHS Information Centre), March 2012. Figures are for full time equivalent (FTE) numbers.

Pinderfields General Hospital, Mid Yorkshire Hospitals NHS Trust

Staffing (outcome 13)

"The antenatal/postnatal ward has four beds allocated as the triage area. Midwives we spoke with were concerned that there is sometimes extra pressure on them when they have to staff the triage area and are called to support the labour ward. There is no system of monitoring the daily redeployment of staff within the hospital; if staff are called to other ward areas, the ward they were originally allocated to can be left short-staffed. We observed that midwives had been called to other areas on the day we inspected, but there was no record of this. For this to be appropriately managed, a record should be kept when staff are redeployed.

Staff told us that there are times when only one midwife is left on the ward area. This was particularly apparent during night shifts. Some staff told us some women can go for long periods without being seen. We checked records and saw an instance where one prescription chart showed that IV antibiotics were given later than required. Staff said this was due to staff shortages, as midwives from the antenatal/postnatal ward were called away to other ward areas in maternity to assist."

Action we took

We asked for an action plan to tell us how the hospital would tackle these issues. In our follow-up inspection report in April 2012, we noted that the trust had implemented a risk assessment form for moving staff between clinical areas. These are completed before any moves can take place, and completing them ensures that the staff member is not leaving a particular ward area short-staffed. We saw evidence of how this was communicated and used.

The trust had also implemented a change in the way the staff work across maternity services, by rotating and working between Pinderfields and Dewsbury and District Hospital. A new twilight shift will also give extra cover during shift handovers, so there are more staff at critical times such as mealtimes. We judged that the hospital was now meeting outcome 13.

Castle Hill Hospital, Hull and East Yorkshire Hospitals NHS Trust

Staffing (outcome 13)

"We found that the trust's vacancy rate for qualified nurses and both midwifery and health visiting staff was greater than that of other trusts. Ongoing vacancies could have the potential to add strain to the existing staff in covering the service and does not assist in fully meeting people's needs…

…The trust provided us with additional information following the visit regarding vacancy levels and staffing across maternity services. They told us that there were a total of 199 midwife posts, with 11.46 vacancies. They also told us that, in the two weeks following our visit, the centre would have to be closed on four separate occasions due to a lack of staff. On two occasions, people had to be transferred to Hull Royal Infirmary when there were not enough staff at the centre to ensure meeting their needs.

When we spoke to the staff on the ward, they told us about the times when the birthing centre would have to be closed for a period of time. This had the potential to cause great distress and did not promote patient choice; women had made a positive choice to have their baby at the centre, but staffing levels had prevented this."

Action we took

We asked for an action plan to tell us how the hospital would tackle these issues. In our follow-up inspection report, we noted that the birthing centre had been closed permanently and services transferred to Hull Royal Infirmary. We inspected three other wards at Castle Hill to see if compliance was now being maintained there, and were satisfied that the hospital was now meeting outcome 13.

Queen's Hospital, Barking, Havering and Redbridge University Hospitals NHS Trust

Care and welfare of people who use services (outcome 4)

"Staff on the postnatal ward recognised there had been an increase in staffing but overall did not feel there had been much of an improvement. The midwives considered this was mainly because of the number of women on the ward classed as 'high risk' or who had social needs. It was also the perception of staff that the discharge system did not work effectively as there were not enough paediatricians to make sure the women were discharged promptly. One midwife told us, 'To give the required level of care it is really difficult and the sheer activity has gone through the roof. We don't stop'. Another said, 'Women go into the discharge lounge too soon if we have an urgency for beds'."

Action we took

We issued a number of warning notices to Barking, Havering and Redbridge University Hospitals NHS Trust in 2011. Despite these, we continued to identify concerns at the trust and we continued to receive information and reports of poor quality care from patients and the public. We took the decision to carry out a formal investigation of the trust, including maternity services at Queen's Hospital. We published our investigation report on 27 October 2011 and made 16 key recommendations to the trust. We have just published a progress report which shows that some improvements have been made, although there is still more to do.

The Royal College of Nursing has published several reports relating nurse staffing levels to patient outcomes, and issued guidance in 2010 on how to plan the nursing workforce.[7]

Indicators we use to identify staffing risks

As seen above, and in line with our general findings across health and social care, staffing issues are the biggest area of concern when assessing the risk of poor quality care. We analysed a number of indicators that affect the area of staffing in maternity:

- The ratio of midwives to births
- The midwife vacancy rate
- The ratio of supervisors to midwives.

We continue to use this type of data to inform our inspectors' understanding of risk and to help them spot any early signs of non-compliance. Note that these are not findings about poor care – they are just one of a number of factors that affect the delivery of care.

Ratio of midwives to births

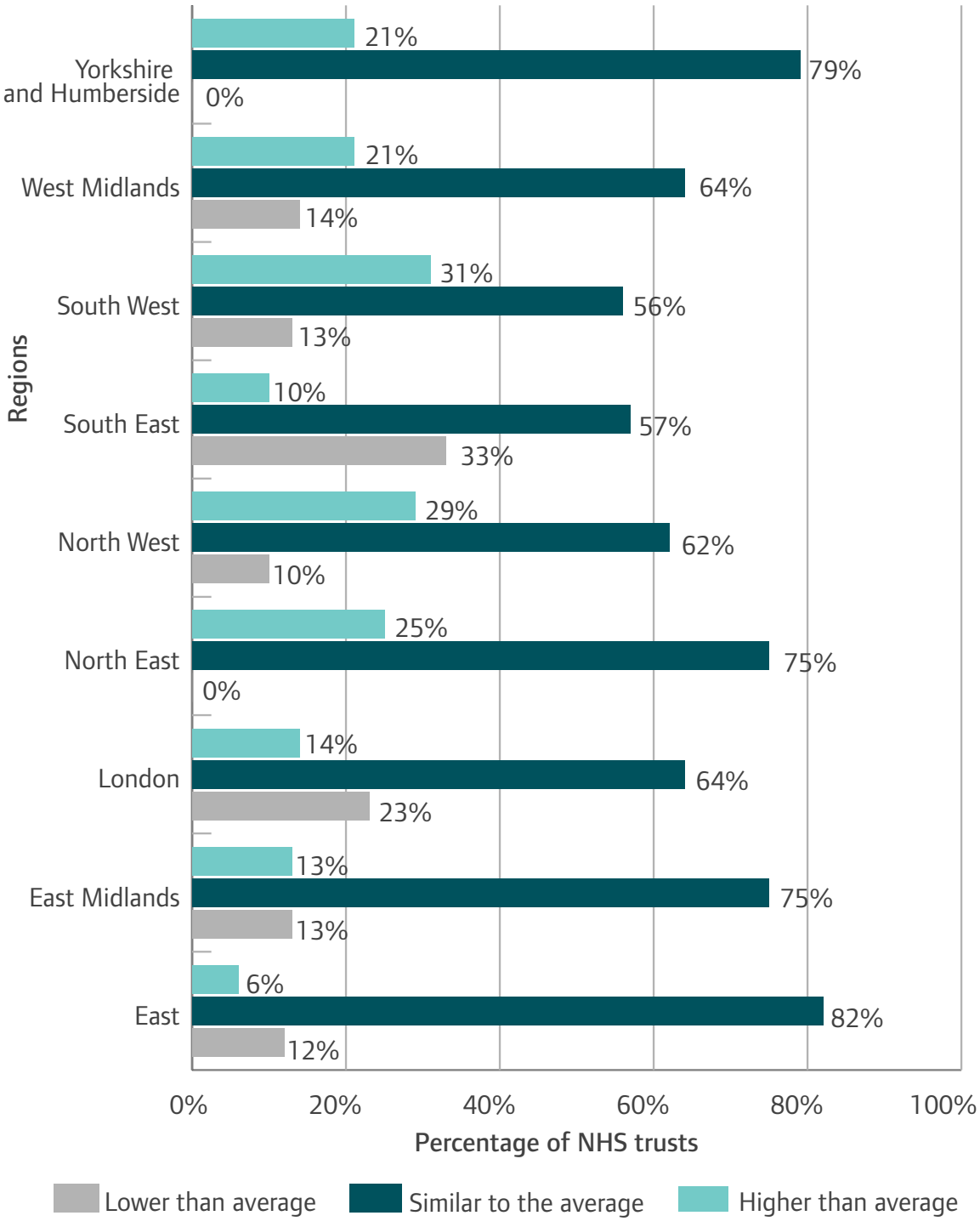
For the calendar year 2011, we found that:

- 26 trusts (18%) had a ratio of midwives to births that was higher than average
- 94 (67%) had a ratio that was similar to the average, and
- 21 (15%) had a ratio that was lower than average.

Note that this provides an overall comparison of NHS trusts. They are not in themselves a measure of performance and must be taken into consideration with other performance data. CQC only ever uses this information as a guide to performance.

7 *Guidance on safe nurse staffing levels in the UK*, Royal College of Nursing, December 2010

Figure 6: Regional comparison of midwife to birth ratio, 2011



Note: where percentages do not sum to 100%, this is due to rounding

Source: CQC April 2012, Base: 141

Analysing by region, we found that:

- The South West had the highest proportion of trusts with a higher than average ratio of midwives to births (31%), followed by the North West (29%).
- The South East had the highest proportion of trusts with a lower than average ratio (33%), followed by London (23%).
- Yorkshire and Humber and the North East were the only two regions where all trusts had a ratio that was similar to or higher than the average.

Midwife vacancy rate

The most recent official figures for NHS midwife vacancies were published in 2010.[8] At the end of March 2010, there had been a fall in long-term vacancy rates across all major staff groups except midwives and GPs. The NHS Information Centre noted that long-term vacancy rates for midwives had steadily increased in recent years.

The official figures show that in March 2010 the overall vacancy rate for midwives in England was 2.7%, and ranged between 0.5% and 5.9% in different regions. The overall long-term vacancy rate (vacancies unfilled for three months or longer) for midwives was 1.2%, ranging between 0% and 2.6% in different regions.[9]

Official NHS vacancy statistics were not published in 2011, as the collections are being reviewed. However, the Royal College of Midwives (RCM) conducts an annual survey of heads of midwifery services, and has used the 2011 responses to produce its own figures for midwifery vacancies. The RCM's figures for midwifery vacancies are traditionally higher than official NHS vacancy figures; the RCM has pointed out that the annual NHS snapshot could underestimate vacancies if trusts are using temporary staff to fill them, but conversely could overestimate vacancies if posts are left open for staff who are temporarily not working but due to return, or if posts remain unfilled because of long recruitment processes.

Based on its survey responses, the RCM found there to be an overall midwife vacancy rate in July 2011 of 4.8% across England, ranging from 1.6% to 7.3% in different regions. The RCM found a long-term midwife vacancy rate of 3.2% across England, ranging from 0.9% to 5.9% in different regions.

Ratio of supervisors to midwives

The supervision of midwives is a statutory function, and standards are set by the Nursing and Midwifery Council (NMC). In England, there are 10 local supervising authorities (LSAs) for midwives, currently located in the strategic

8 *NHS Vacancies Survey England 31 March 2010*, NHS Information Centre for Health and Social Care, August 2010. The NHS and GP vacancy collections and publications were suspended for 2011, pending review as part of the Fundamental Review of NHS data collections.

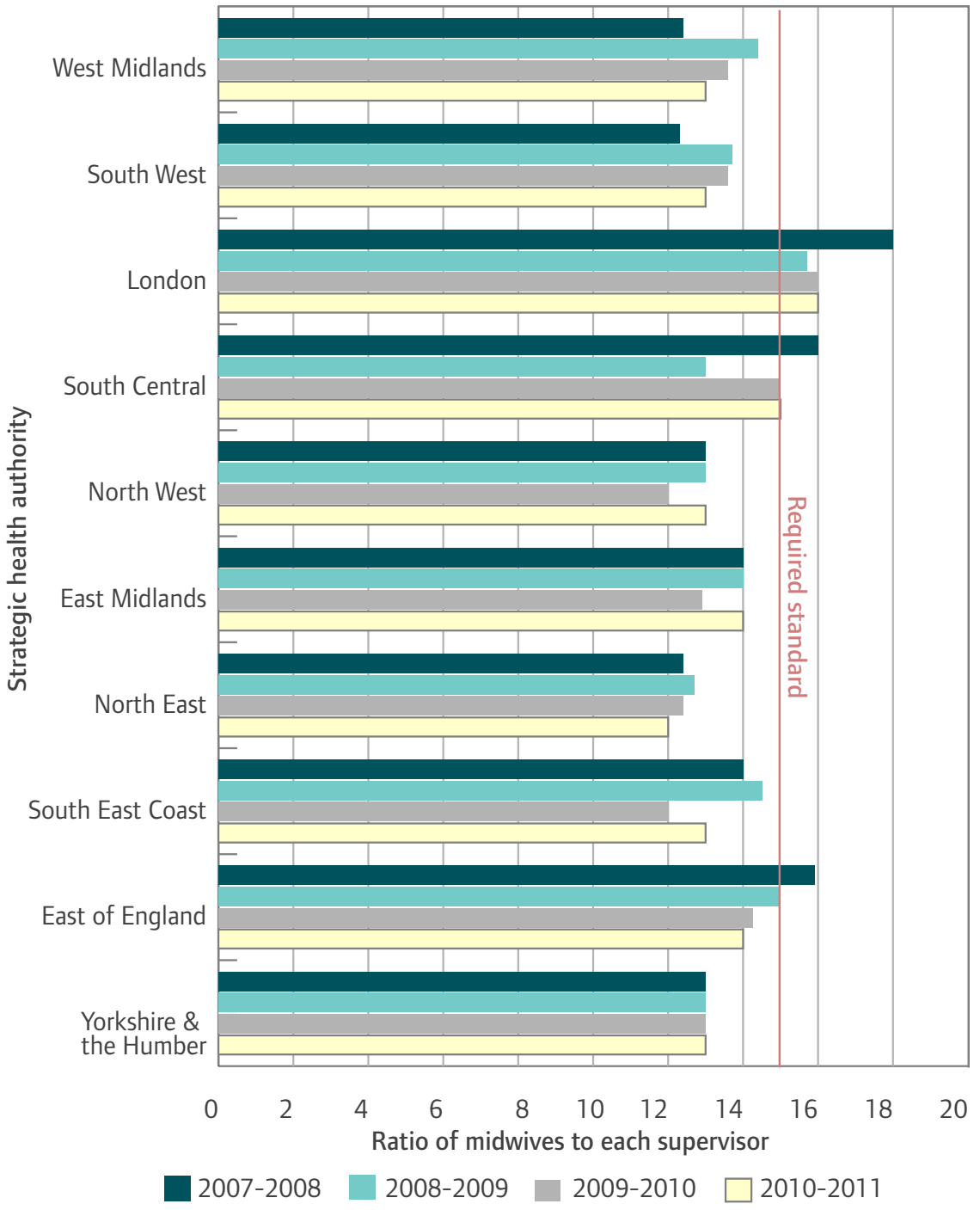
9 *NHS Vacancies Survey England*, NHS Information Centre, 31 March 2010

health authorities. They are responsible for ensuring an effective framework for supporting and monitoring the quality of supervision of midwives and midwifery at local level. Each midwife is required to have a named supervisor, and the LSA should ensure that support, advice and guidance are available for midwives 24 hours a day to promote the safety of women and babies. The NMC standard says that the ratio of supervisors to midwives should reflect local need and circumstances, but will not normally exceed 15 midwives for every one supervisor.

Figure 7 shows the regional breakdown of supervisor to midwife ratios, for the four years to March 2011.[10] The figures show that London is the only region that has consistently failed to meet the required standard, and the only region where the standard was not met in 2010/11. However, the NMC has said: "Although nine of the ten LSAs in England meet the ratio of 1:15 or less, it is clearly reflected in individual LSA annual reports to the NMC that many trusts continue to experience challenges in the recruitment and retention of sufficient new supervisors of midwives to replace those retiring or resigning."

10 Data provided by the NMC, April 2012

Figure 7: Midwife to supervisor ratio for England (2007 to 2011)



Source: Nursing and Midwifery Council 2012

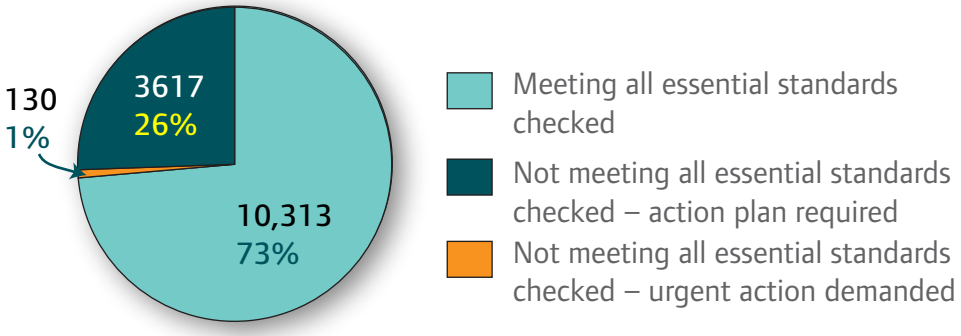
Overall performance across all sectors

Overall, across all sectors on 31 March 2012, the majority of locations – just under three-quarters (73%) of locations that had been inspected since the start of the Health and Social Care Act – were meeting all the essential standards we had checked. In a number of cases, providers used innovative practices in meeting the standards.

In a quarter of cases (26%, or 3,617 locations) on that date, the service was not meeting at least one standard. We required an action plan from the provider to tell us how they intended to address the problem. The vast majority of providers worked positively with CQC to make sure they were taking all the necessary steps to improve.

On 31 March 2012, there were 130 locations (1% of cases) where serious concerns meant we had to use our powers on a more urgent basis to protect people from harm or hold the provider to account (see figure 8).

Figure 8: Compliance in all locations inspected as at 31 March 2012



All locations inspected (14,060 locations inspected)

Note: this chart includes 19 inspections of independent ambulance locations.

The same areas of poor performance were apparent across both health and adult social care sectors:

- Medicines management
- Care and welfare of people
- Staffing and supporting staff
- Record keeping.

Similarly, the outcomes with the best performance tended to be the same across the sectors:

- Cooperating with other providers
- Handling of complaints
- Safety, availability and suitability of equipment.

We asked our compliance managers and quality and risk managers across England to give us their view of where they saw the most problems emerging. Their responses reflected many of the issues highlighted above.

Of all the responses, the most common concerns were:

- Staffing levels (20% of managers mentioned this as an issue)
- Staff training and knowledge (14%)
- Medicines management (13%)
- Poor management or support for management (11%)
- Protecting people from abuse or the risk of abuse (9%)
- Overall governance and quality assurance issues (9%)
- Premises and environments (8%).

Behind the numbers: our expert's view

Medicines management

CQC's National Pharmacy Manager, Brian Brown, explains some of the main issues across both health and social care in relation to the failure to provide safe management of medicines:

Arrangements for people to look after their own medicines: Although services are usually able to show that they have a policy and procedure available to support this, this is often not translated into practice. Examples include people taking medicines when the staff supporting them are not aware that they are prescribed that medicine; people having medicines left with them when they don't understand what the medicine is for or when they are supposed to take it; and staff making an assumption that the person is looking after their own medicines.

Poor practice in relation to medicines prescribed 'to be taken when required': There is often a lack of a clear plan to indicate how the decision to administer these medicines is to be made or what the desired/expected outcome should be. We also find that a person may be prescribed several similar medicines and there is no clear direction to indicate how to decide which of the medicines is to be administered and in what circumstances. There are also occasions when this may lead to non-compliance with the 'care and welfare' standard (outcome 4). This is particularly relevant where care is being provided to people who may have a significant cognitive impairment.

Incomplete records of medicine administration, accompanied by no supporting record to indicate why a particular dose of a medicine had not been administered: There are occasions when this may lead to non-compliance with the 'records' standard (outcome 21) and 'care and welfare' (outcome 4). This is also linked to times when medicines are not available to be administered. This may happen either when a supply of the medicine has run out and not been replaced, or when an acute prescription is written and then supplies are not sought in a timely manner, or where a person is admitted to a service and there are delays in obtaining their prescribed medicines before administration can commence.

Other areas we have found include the poor provision of appropriate storage facilities. This may relate to either the lack of suitable arrangements to keep medicines secure, or the lack of provision to store medicines within the correct temperature range.

Appendix: Levels of performance, by sector[11]

Table 10: NHS hospitals as at 31 March 2012

Outcome		Number of locations inspected	Number compliant	Number non-compliant	% compliant
1	Respecting and involving people who use services	250	238	12	95%
2	Consent to care and treatment	129	123	6	95%
4	Care and welfare of people who use services	242	212	30	88%
5	Meeting nutritional needs	201	188	13	94%
6	Cooperating with other providers	124	118	6	95%
7	Safeguarding people who use services from abuse	197	182	15	92%
8	Cleanliness and infection control	156	145	11	93%
9	Management of medicines	127	109	18	86%
10	Safety and suitability of premises	131	121	10	92%
11	Safety, availability and suitability of equipment	110	109	1	99%
12	Requirements relating to workers	97	96	1	99%
13	Staffing	191	163	28	85%
14	Supporting staff	189	168	21	89%
16	Assessing and monitoring the quality of service provision	206	191	15	93%
17	Complaints	123	119	4	97%
21	Records	135	115	20	85%

11 In our *State of Care 2010/11* report, we split our initial findings into categories of 'compliant', 'minor concerns', 'moderate concerns' and 'major concerns'. We have refined our regulatory model so that from 1 April 2012 we will judge providers to be either 'compliant' or 'non-compliant'. To establish a comparable benchmark for future Market Reports, this report uses the latter system.

This means that the two sets of data are not directly comparable. In the *State of Care* report, 'compliant' and 'minor concerns' generally equated to legal compliance with the relevant regulations. However, a small proportion of 'minor concerns' (when combined with other concerns at the same location) would have equated to non-compliance with the regulations.

In addition, the figures in the *State of Care* report were based on our batch of compliance inspections that were conducted just after the introduction of the new regulation system. They included a relatively large proportion that were conducted in response to concerns being raised about particular services – and therefore more likely to show disproportionately high levels of non-compliance.

Table 11: Independent hospitals and clinics as at 31 March 2012

Outcome		Number of locations inspected	Number compliant	Number non-compliant	% compliant
1	Respecting and involving people who use services	549	534	15	97%
2	Consent to care and treatment	241	225	16	93%
4	Care and welfare of people who use services	714	657	57	92%
5	Meeting nutritional needs	101	101	0	100%
6	Cooperating with other providers	135	135	0	100%
7	Safeguarding people who use services from abuse	566	515	51	91%
8	Cleanliness and infection control	228	218	10	96%
9	Management of medicines	204	179	25	88%
10	Safety and suitability of premises	185	179	6	97%
11	Safety, availability and suitability of equipment	175	168	7	96%
12	Requirements relating to workers	194	177	17	91%
13	Staffing	226	213	13	94%
14	Supporting staff	505	464	41	92%
16	Assessing and monitoring the quality of service provision	664	630	34	95%
17	Complaints	164	159	5	97%
21	Records	171	148	23	87%

Table 12: Nursing homes as at 31 March 2012

Outcome		Number of locations inspected	Number compliant	Number non-compliant	% compliant
1	Respecting and involving people who use services	2115	1911	204	90%
2	Consent to care and treatment	714	653	61	91%
4	Care and welfare of people who use services	2671	2182	489	82%
5	Meeting nutritional needs	1058	963	95	91%
6	Cooperating with other providers	630	623	7	99%
7	Safeguarding people who use services from abuse	2344	2124	220	91%
8	Cleanliness and infection control	975	840	135	86%
9	Management of medicines	1185	943	242	80%
10	Safety and suitability of premises	1080	922	158	85%
11	Safety, availability and suitability of equipment	700	661	39	94%
12	Requirements relating to workers	934	878	56	94%
13	Staffing	1568	1355	213	86%
14	Supporting staff	1818	1554	264	85%
16	Assessing and monitoring the quality of service provision	2295	2016	279	88%
17	Complaints	713	693	20	97%
21	Records	799	660	139	83%

Table 13: Residential homes as at 31 March 2012

Outcome		Number of locations inspected	Number compliant	Number non-compliant	% compliant
1	Respecting and involving people who use services	5754	5495	259	95%
2	Consent to care and treatment	1528	1440	88	94%
4	Care and welfare of people who use services	6897	6052	845	88%
5	Meeting nutritional needs	2055	1938	117	94%
6	Cooperating with other providers	1434	1412	22	98%
7	Safeguarding people who use services from abuse	6294	5798	496	92%
8	Cleanliness and infection control	2020	1779	241	88%
9	Management of medicines	2597	2171	426	84%
10	Safety and suitability of premises	2629	2232	397	85%
11	Safety, availability and suitability of equipment	1450	1392	58	96%
12	Requirements relating to workers	2177	2042	135	94%
13	Staffing	3475	3129	346	90%
14	Supporting staff	4582	4111	471	90%
16	Assessing and monitoring the quality of service provision	6194	5480	714	88%
17	Complaints	1531	1499	32	98%
21	Records	1726	1489	237	86%

Table 14: Domiciliary care services as at 31 March 2012

Outcome		Number of locations inspected	Number compliant	Number non-compliant	% compliant
1	Respecting and involving people who use services	1514	1460	54	96%
2	Consent to care and treatment	363	352	11	97%
4	Care and welfare of people who use services	1825	1629	196	89%
5	Meeting nutritional needs	330	324	6	98%
6	Cooperating with other providers	347	341	6	98%
7	Safeguarding people who use services from abuse	1686	1568	118	93%
8	Cleanliness and infection control	358	349	9	97%
9	Management of medicines	565	473	92	84%
10	Safety and suitability of premises	278	277	1	100%
11	Safety, availability and suitability of equipment	331	323	8	98%
12	Requirements relating to workers	831	745	86	90%
13	Staffing	599	568	31	95%
14	Supporting staff	1496	1324	172	89%
16	Assessing and monitoring the quality of service provision	1731	1559	172	90%
17	Complaints	468	446	22	95%
21	Records	441	381	60	86%

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