Care Quality Commission

The state of adult social care services 2014 to 2017

Findings from CQC's initial programme of comprehensive inspections in adult social care

STATE OF CARE

Our purpose

The Care Quality Commission is the independent regulator of health and adult social care in England. We make sure that health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve.

Our role

- We register health and adult social care providers.
- We monitor and inspect services to see whether they are safe, effective, caring, responsive and well-led, and we publish what we find, including quality ratings.
- We use our legal powers to take action where we identify poor care.
- We speak independently, publishing regional and national views of the major quality issues in health and social care, and encouraging improvement by highlighting good practice.

Our values

Excellence – being a high-performing organisation

Caring – treating everyone with dignity and respect

Integrity – doing the right thing

Teamwork – learning from each other to be the best we can

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Foreword from the Chief Inspector

In my first month in post in October 2013, I wrote:

> *"To make sure that our regulatory approach is truly personalised I want us to consider for every service we look at – is this good enough for my Mum (or any other member of my family)? If it is, that is fantastic. If it's not then we need to do something about it."*

The 'Mum Test' has guided our work ever since. I wanted CQC's regulation and indeed, the commissioning and provision of adult social care, to be truly personalised and firmly focused on the people receiving it. After extensive co-production, engagement and testing, CQC formally rolled out its new inspection framework for adult social care in October 2014, when, for the first time, we rated services as outstanding, good, requires improvement or inadequate. By February 2017, we had inspected all adult social care services registered with us in October 2014 – many more than once. That's more than 33,000 inspections of around 24,000 different locations, including care homes, care in people's own homes, Shared Lives schemes and supported living services.

What have we found? Are adult social care services meeting the Mum Test? When we choose care for ourselves or our loved ones, can we be confident that it is safe, effective, caring, responsive to our needs and well-led? The wealth of information gathered from our inspections means that the picture of adult social care – its successes, its failures and the challenges ahead – is clearer. I can say that most of the adult social care sector is meeting the Mum Test, providing safe and high-quality care that we would be happy for anyone we love, or ourselves, to receive.

Over three-quarters (77%) of adult social care services are good – this should be and is celebrated. These are services with leaders who inspire a positive culture focused on providing person-centred care – treating people as people and not just as recipients of care. These leaders motivate, develop and value their staff who work tirelessly and skilfully to support people to live their lives to the full, with dignity and respect. The lives of people using adult social care can be transformed or their final days remembered for the care and compassion they and their families and carers experienced.

However, quality across England is undeniably variable. We have completed our initial comprehensive inspection programme with only 2% of services being rated as outstanding. While we make no apology for setting the bar high, this is considerably lower than we originally expected. It is clear that it is more difficult to achieve this highest standard of quality.

And there is too much poor care: 2% of services are currently rated as inadequate, and 19% of services are rated as requires improvement and are struggling to improve. Through our inspections, we have seen examples of unacceptable care, occasionally resulting in actual harm to people using services.

This is awful for people receiving this care, as well as their families and carers. But it also undermines the public's confidence in the sector as a whole – a sector that we are becoming increasingly reliant on as our population ages and people's needs at all ages become more complex.

Quality regulation is playing its part to ensure people receive the safe, high-quality and compassionate care they have every right to expect. We can see that many providers are responding to our concerns and rising to the challenge. Eighty-one per cent of services rated as inadequate improved their overall rating following re-inspection, which is testament to the commitment of staff to deal with problems and achieve better care. In particular, we have found that having a committed and consistent registered manager can have a big influence on the quality of care that people receive – for example, by making sure staff have training to understand the needs of people in their care.

However, too many services are not improving or seem incapable of improving. Thirty-eight per cent retain their rating of requires improvement following re-inspection, despite knowing from our inspections what needs to change and 5% of these services had deteriorated. Not all services that were originally rated as good maintain quality. Where we have re-inspected them, usually prompted by concerns, over a quarter (26%) have received a lower rating.

In our report *The state of health care and adult social care in England* last October, we gave a stark warning that adult social care in England was 'approaching a tipping point'. This was driven by a growing and ageing population, more people with increasingly complex conditions and in a challenging economic climate a greater demand on services but more problems for people in accessing care, and further issues across the health and care sector. The risk of adult social care approaching that tipping point is still real. We will explore what effect this is having on people using services and the wider health and care landscape in our next report in the autumn.

CQC will keep its relentless focus on quality by sharing successes, identifying failings, taking action to ensure areas in need of improvement are tackled, and at all times, by being transparent and acting in the public's best interests. To achieve this, our regulation of adult social care will become even more targeted, risk-based and intelligence-driven over the next few years.

I hope people using adult social care services, their families and carers will find this report helpful and that providers, commissioners and funders, improvement bodies and the government will use our information to place quality firmly at the heart of the continuing debate about the future of adult social care. There are stories to inspire, lessons to learn and warning signals to heed. With everyone at CQC, I remain committed to shining a spotlight on quality, encouraging and recognising improvement and holding providers to account. But we cannot do it alone. Everyone must play their part in transforming adult social care and making sure that all services pass the Mum Test so that people using services, their families and carers can be confident that **quality matters** and will be delivered.

Andrea Sutcliffe
Chief Inspector of Adult Social Care

1. Introduction

In 2013, CQC set out its plans to radically transform the regulation of adult social care services. A year later, we began our new programme of comprehensive inspections, with ratings to make it easy for people to understand the quality of care and to help them choose care; a focus on identifying, highlighting and celebrating good practice; and a determination to drive improvement and hold providers to account for poor care.

Understanding the experiences of people who use adult social care services is key. They are often in very vulnerable circumstances and their care can affect every part of their lives. Social care supports older people coping with several health conditions; some are living with dementia while others may be isolated and lonely. But adult social care is not just a service for older people; meeting the needs of people with mental health issues, younger people with a disability and people with a learning disability is also very significant. People using adult social care services have different needs, aspirations and circumstances.

This incredible diversity in the adult social care sector means that personalisation is critical so that people can identify their individual needs; be empowered to take control; and make informed choices about the way they live their lives. Good services recognise this by delivering truly person-centred care.

We have now completed this initial programme of comprehensive inspections and ratings – some 33,000 in all across two and a half years. This report sets out what we found: are our adult social care services safe, effective, caring, responsive and well-led?

1.1 How we work

We register providers that apply to CQC when they are able to satisfy us that they meet the requirements.

We make intelligent use of data, evidence and information, including information shared with us by staff and people using services, their families and carers to decide when, where and what to inspect.

Our inspectors use their professional judgement, supported by objective measures and evidence, to assess services against our five key questions. Supported by people who have experience of using care services (Experts by Experience) in the majority of inspections, our inspectors use feedback from people who use services, their carers and families to inform their judgements.

We always ask the following five questions of services.

- Are they safe?
- Are they effective?

- Are they caring?
- Are they responsive to people's needs?
- Are they well-led?

We rate services to highlight where care is outstanding, good, requires improvement or inadequate. We rate services at two levels:

1. We rate each one of the five questions.
2. We aggregate these separate ratings to give an overall rating for the location.

This approach to comprehensive inspections was launched on 1 October 2014. It was developed through testing and consultation with the public, people who use services, providers and organisations with an interest in our work. We are continuing to refine our approach and in June 2017 published a new, consolidated assessment framework, which will be adopted from November 2017.

Our enforcement policy sets out what action we take to require services to improve and, where necessary, the action we take to make sure those responsible for poor care are held accountable for it.

1.2 Background to the sector

Adult social care can make a real difference to people's lives. It is the largest sector that CQC regulates, with a large number and range of providers, a strong private and voluntary sector, and wide differences in the size and types of services and care provided. The sector covers:

- accommodation and personal care provided in residential care homes, nursing homes and specialist colleges (around 16,000 locations, with the capacity to provide care for around 460,000 people)
- personal care provided in the community for more than half a million people, of which the majority is care provided in people's homes through domiciliary care services (around 8,500 services), as well as extra care housing, Shared Lives schemes and supported living services.[a]

Adult social care is estimated to contribute £20 billion to the economy[1] and employ around 1.4 million people – 5.3% of the total workforce in England[2]. It can help individuals and the families of people who need care and support to carry on working.
Adult social care services are facing a number of challenges. These include:

[a] We will be publishing a separate report later this year that looks at quality in hospice services. From 2017/18 hospices services be assessed under the healthcare assessment framework. They will therefore become part of the responsibility of the Chief Inspector of Hospitals. Hospice services are included in the data for 'all' adult social care services in this report.

- An ageing population with increasing needs.
  - The number of people aged 85 or over in England is set to more than double over the next two decades.[3]
  - More than a third of people aged over 85 have difficulties undertaking five or more tasks of daily living without assistance, and are therefore most likely to need health and care services.[4]

- Difficulties in recruiting and retaining staff to care for people.
  - In 2015/16 the overall staff vacancy rate across the whole of the care sector was 6.8% (up from 4.5% in 2012/13), rising to 11.4% for home care staff. Turnover rates have risen from 22.7% to 27.3% a year over the same three-year period.[5]
  - Potential changes to immigration policy resulting from the vote to leave the European Union could have serious consequences for the social care workforce. Around one in 20 (6%) of England's growing social care workforce are non-British European Economic Area nationals – around 84,000 people.[6]

- Rising costs of adult social care.
  - In 2015/16, the gross expenditure of all councils with adult social services responsibilities was £16.97 billion. Although this is 18% higher in absolute terms than in 2005/06, after accounting for inflation it is 1.5% lower than in that year.[7]
  - Findings from the most recent Association of Directors of Adult Social Services budget survey have estimated that the National Living Wage will cost councils around £151 million plus at least £227.5 million in implementation and associated costs in 2017/18. This will affect both direct council costs and increased provider fees.[8]

- Concerns about funding to meet these costs and a reliance on those who pay for their own care.
  - Age UK estimates that an additional £4.8 billion a year is needed to ensure that every older person who currently has one or more unmet needs has access to social care, rising to £5.75 billion by 2020/21.[9]
  - Some providers, particularly in domiciliary care, have withdrawn from local authority contracts where they felt there was too little funding to enable them to be responsive to people's needs.
  - Despite additional funding that has been made available for adult social care, only 7% of directors of adult social services are fully confident that savings targets will be met in 2019/20.[10]
  - The public have expressed concerns over the higher charges self-funders tend to pay, compared with state-funded residents. A sample of care home groups operating in 12 English counties in 2015 found self-funders pay over 40% more on a like-for-like basis.[11]

In this challenging context, CQC's role as the quality regulator is ever more important. We have to make sure that we do not compromise on the quality of care and ensure that people using services, their families and carers are at the heart of everything we do.

1.3 This report

This report looks at what we found about the quality of care across the whole range of adult social care services that we regulate.

Our report is based on more than 33,000 inspections of around 24,000 different locations published up to May 2017. It is one of a series of reports across the sectors that CQC regulates, which aim to give an in-depth review of services based on our initial programme of comprehensive inspections. We illustrate the quantitative findings from our ratings data[b] with qualitative information and examples from a sample of inspection reports.

We recognise there is fragility in the adult social care sector influenced by funding and resource pressures. But as the quality regulator, our focus in this report is on the quality of adult social care services and the impact that this has on people who use services.

[b] Although we completed our initial programme of comprehensive inspections in January 2017, we have used data extracted on 5 May to allow time for inspection reports and ratings to be published.

2. What have we found in our inspections?

Key points

- At the end of our initial comprehensive inspection programme, almost four out of five adult social care services in England were rated as good or outstanding overall. Nearly a fifth of services were rated as requires improvement. We are particularly concerned about the 343 locations (2%) that were still rated as inadequate.
- We have observed differences in performance from region to region, with the East of England showing almost 10% more locations rated as good or outstanding than the North West.
- Of the five key questions that we asked all services, safe and well-led have the poorest ratings, with around a quarter requires improvement and inadequate.
- Caring was the best rated key question – 92% good and 3% outstanding.
- Community social care services (such as supported living and Shared Lives) were rated the best overall. Nursing homes remain the biggest concern.
- Generally, smaller services that are designed to care for fewer people were rated better than larger services.
- The public values the information in our inspection reports.

2.1 Introduction

Since October 2014, when CQC completely overhauled and transformed our regulatory approach for adult social care services in England, people have been using our inspection reports and ratings as an important source of information to support their choice of care services.

This was reflected in CQC's 2016 public inspection report survey that showed 90% of people who were looking at residential adult social care reports said they found them useful.

CQC's judgements published in inspection reports are informed by a range of detailed information that we gather from providers, partners, commissioners and, importantly, people's own experiences of care and the views of their families and carers. Our inspection teams are trained and equipped to support a consistent and robust approach to making these judgements by asking five key questions – is this service safe, caring, effective, responsive to people's needs and well-led – so that we are really getting under the skin of care services in a more consistent, detailed and thorough way than ever before.

Our approach not only supports people to make informed decisions about care, but the detail of CQC's inspection reports also highlights shortcomings in the quality of care for providers and commissioners to respond to and act on. If providers do not respond well enough and fail to give people who use their services the standards they have a right to expect, we will take action to enforce improvement.

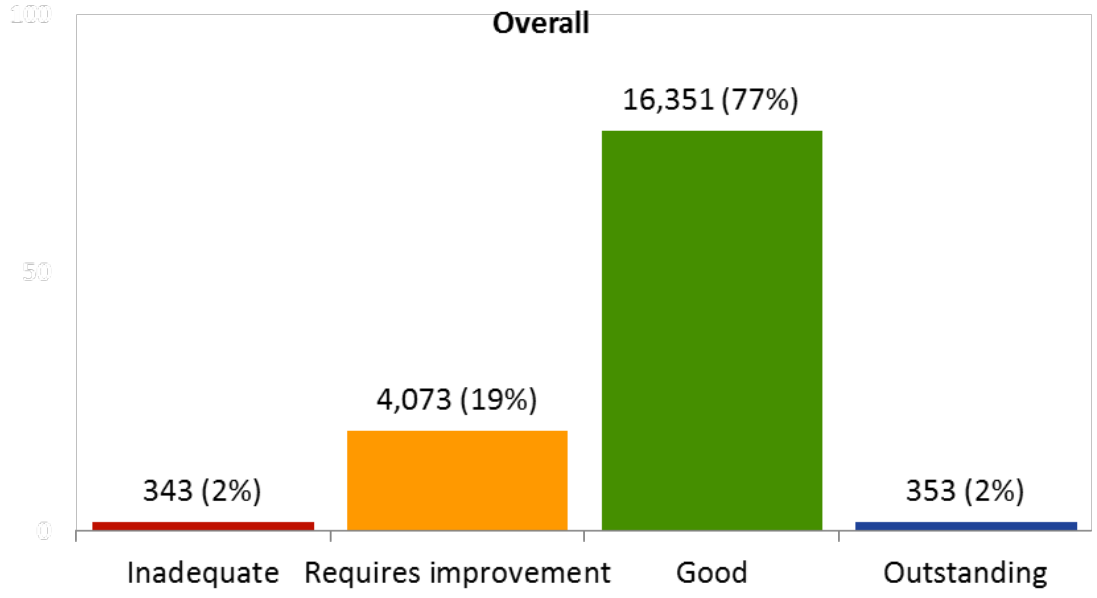
2.2 Overall ratings – all England

A service's overall rating is very visible. All services are required to show it on their websites and in their services. Where services are good or outstanding, many providers have been keen to promote this further – on banners, on literature and through local media. We welcome this; it's right that providers should be proud of their good and outstanding services, and of the staff who help to achieve this.

By the end of our initial comprehensive programme of more than 33,000 inspections, almost four-fifths of adult social care services in England were rated as good (77%) or outstanding (2%) overall. Nearly a fifth of services were rated as requires improvement. This proportion is too high. As part of our next phase of inspections we will target these services to make sure that providers do not view this overall rating of requires improvement as acceptable and, alongside commissioners, they work hard to improve care.

We are particularly concerned about the 343 locations (2%) that are currently rated as inadequate (figure 1). We estimate that these services may collectively have the capacity to care for almost 20,000 people. Since poor care can have such a shocking impact on people's day-to-day lives, it has to be everyone's responsibility to make sure that people's care is safe, compassionate and of high quality. CQC will work with providers and commissioners to ensure the necessary changes to improve care are made.

Figure 1: Adult social care overall ratings



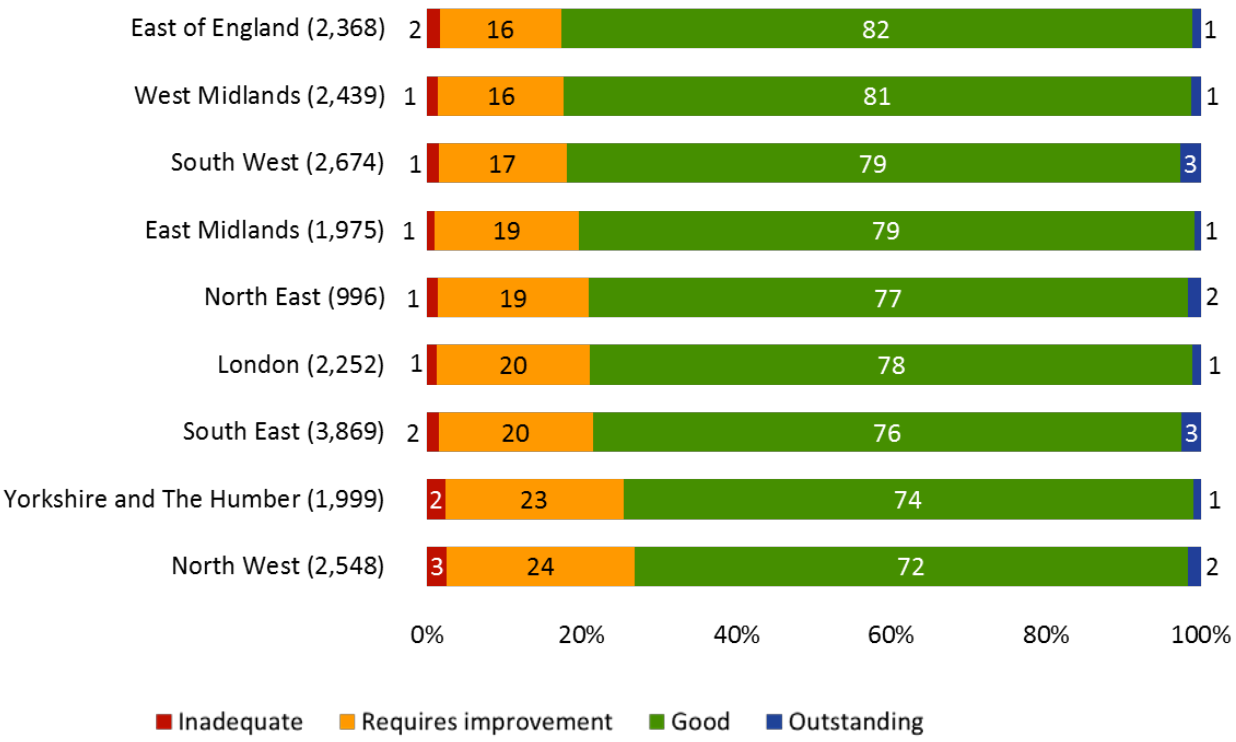
Source: CQC ratings data, 5 May 2017. Numbers above bars show total active locations rated

2.3 Overall ratings – regional breakdown

Completion of our initial comprehensive inspection programme has provided the public with a full picture of performance for their area. As well as detailed inspection reports for each adult social care service – searchable by postcode – there is a map on our website that enables people to see and compare the ratings of services in their area.

Region-by-region analysis shows that there was a difference between the region with the best ratings (East of England, where 82% of locations were rated as good and 1% as outstanding), compared with Yorkshire and the Humber (74% and 1%) and the North West (72% and 2%) (figure 2).

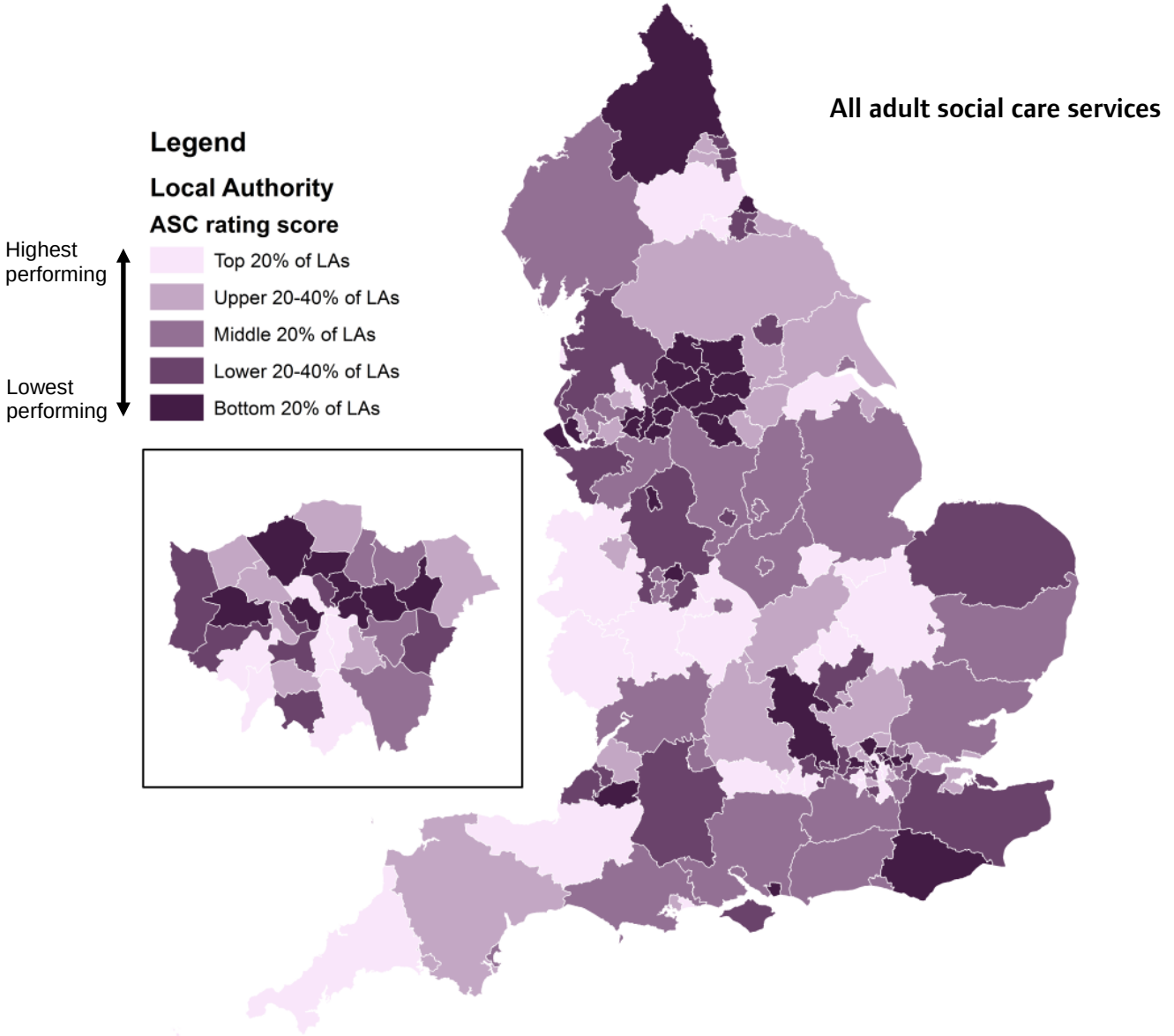
Figure 2: Overall adult social care ratings by region



Source: CQC ratings data, 5 May 2017. Figures in bars are % of rated locations. Numbers in brackets show total active locations rated

Figure 3 maps this regional performance across the local authorities in England. The lighter areas on the map show where, on average, we found the highest rated adult social care services – note the clusters in the midlands. And the darker areas show where the lowest rated services were – note the clusters in areas of the North West and West Yorkshire and some of the London boroughs in the North and East. This map, as well as the other maps and charts in this report, can be viewed in a separate document on our **website**.

Figure 3: Adult social care ratings by local authority area



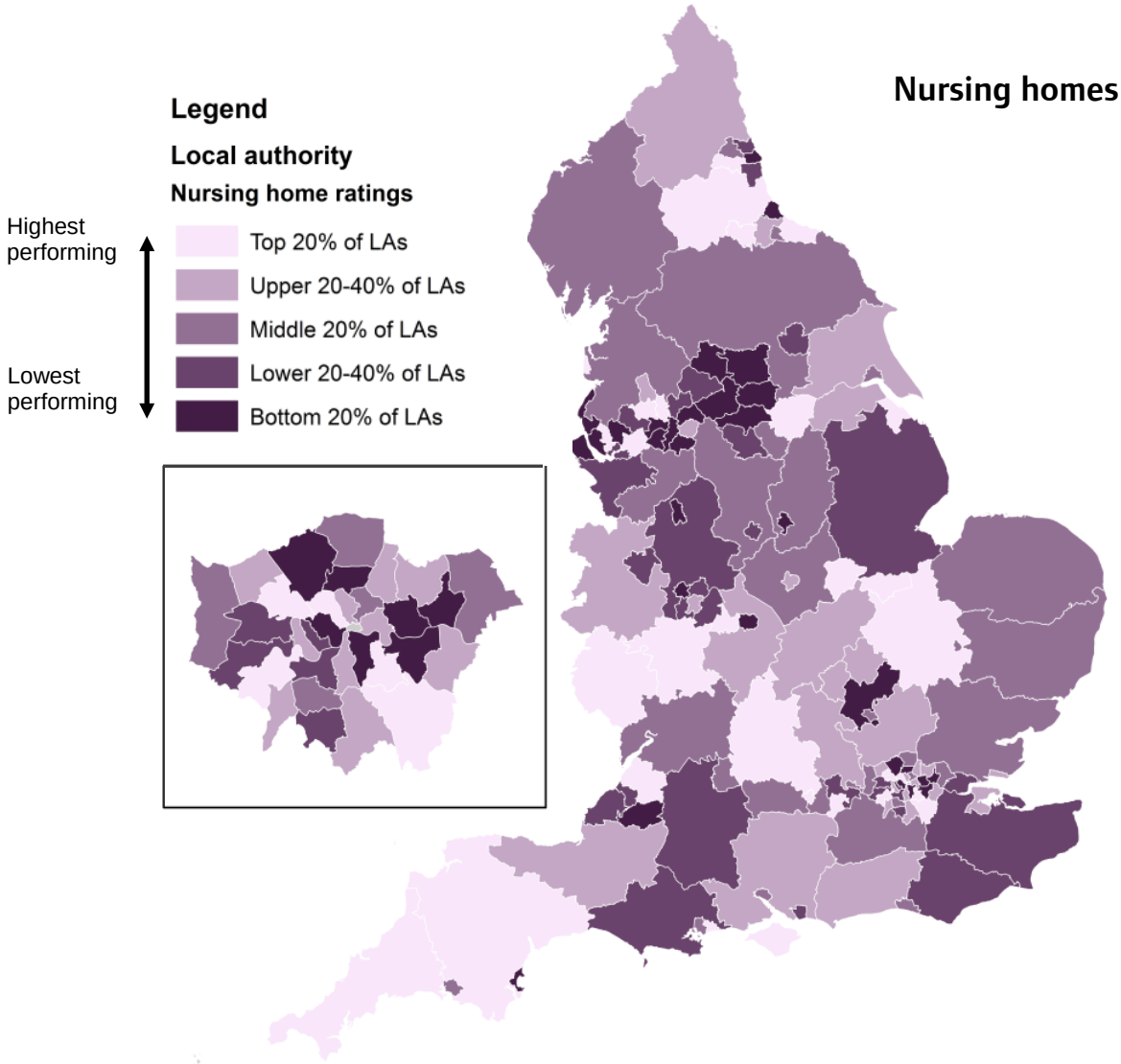
Source: CQC ratings data, 5 May 2017. Quintiles are based on local authority ratings scores, based on all key question ratings for each adult social care location

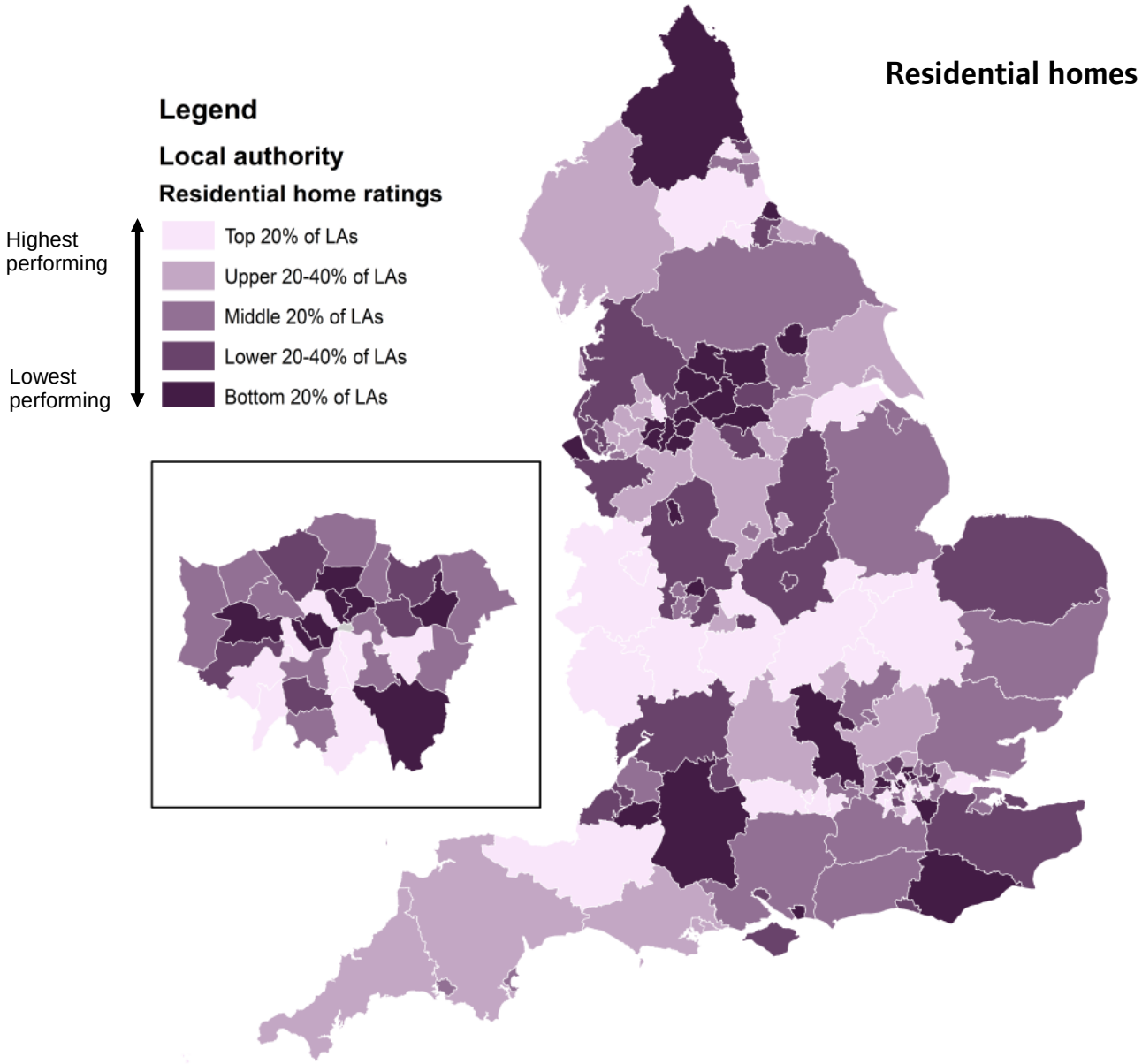
Figure 3 shows average ratings across all adult social care services, but we can look at the three main types of care in more detail. Figure 4 maps nursing home, residential home and domiciliary care performance across local authorities. Compared with all services, the cluster of high performance in the midlands is even more notable in residential homes, and for nursing homes high average ratings are particularly grouped in the far South West. Parts of the North West and West Yorkshire stand out as areas of poorer care, although this is more marked among residential and nursing homes than in domiciliary care. However, it is worth noting the cluster of poorer domiciliary care services in Greater London; 14 London boroughs feature in the lowest fifth of average ratings for domiciliary care, compared with eight boroughs for residential homes and seven boroughs for nursing homes.

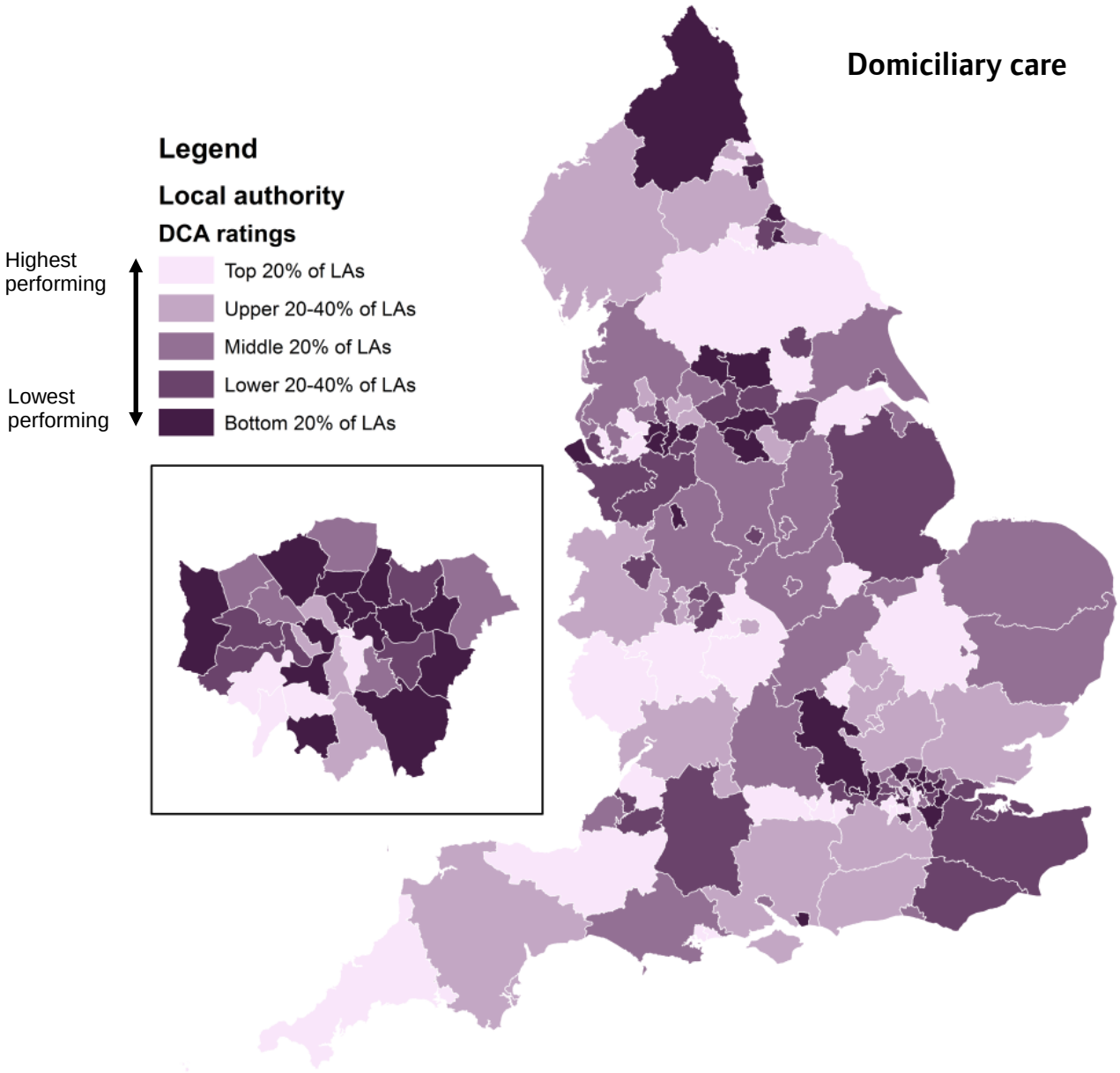
Beyond the clusters of patterns in performance, the maps below show many examples of variations in types of service within the same local authority. For example, Northumberland is in the highest performing 20-40% of nursing home provision, whereas it is among the lowest performing authorities in its residential home and domiciliary care provision. At the other end of the country, the London Borough of Bromley shows a similar pattern of performance.

We continue to observe these geographical differences in quality, and while the differences on average between the poorest fifth and best fifth of areas is not enormous, we are seeing that there are parts of the country where good quality adult social care may be harder to access. We will continue to analyse this data in discussion with partner organisations to see if we can explain the variation we observe.

Figure 4: Nursing home, residential home and domiciliary care ratings by local authority area




Residential homes
Legend
Local authority
Residential home ratings
Highest performing
Lowest performing
Top 20% of LAs
Upper 20-40% of LAs
Middle 20% of LAs
Lower 20-40% of LAs
Bottom 20% of LAs



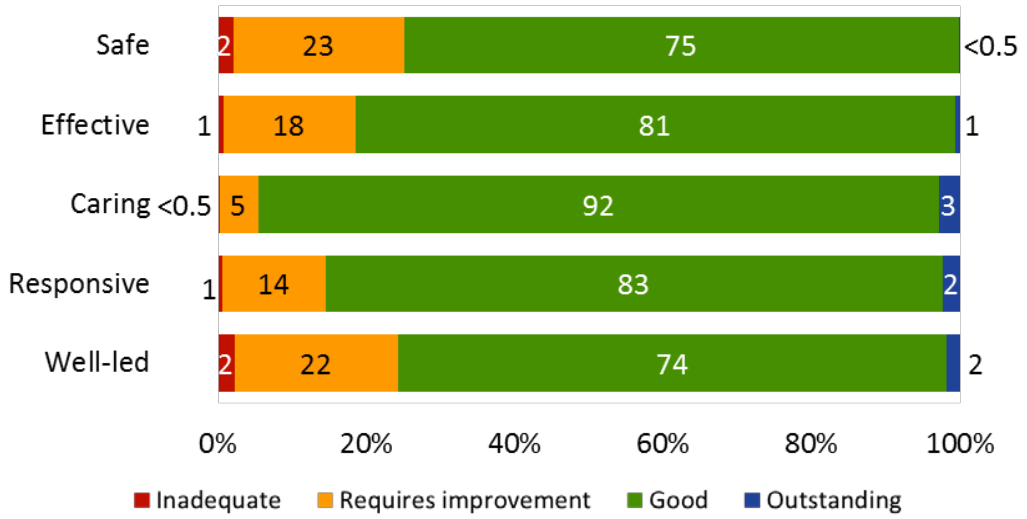
Source: CQC ratings data, 5 May 2017. Quintiles are based on local authority area ratings scores, based on all key question ratings for each adult social care location

2.4 Ratings by key question

As well as the overall rating, we give all adult social care services a rating for each of the five questions we ask of all care services. These allow us to look into greater detail at the issues that matter to people: are services safe, effective, caring, responsive to people's needs and well-led?

Figure 5 shows how all adult social care services were rated against the five key questions.

Figure 5: Adult social care ratings by key question



Source: CQC ratings data, 5 May 2017. Figures in bars are percentages

Safe

When we ask whether a service is safe, we find out if people are protected from abuse and avoidable harm.

SAFE IN AN INSPECTION REPORT

'One member of care staff told us, "We try to build a trusting relationship so if people had any problems or concerns they would come to us and tell us." One person told us, "If anyone hurt me I would talk to the staff about it."'

However, of the five key questions that we asked all services, safe had the poorest ratings, with 23% rated as requires improvement and 2% as inadequate.

Low ratings are concerning and indicate poor quality that can have a real impact on people using services. For example, poor safety can mean systems and processes that are not adequate for managing medicines or determining staffing levels. This can result in people not getting their prescribed medicines to help keep them well. In domiciliary care agencies, for example, staff that do not have enough time on home visits to have meaningful discussions with people about their needs and preferences will not be able to give them good person-centred care.

Effective

When we ask whether a service is effective, we find out if people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

EFFECTIVE IN AN INSPECTION REPORT

'Care workers were proactive in identifying if people's needs changed. For example one person told us, "I usually make all my medical appointments, but one day the carer noticed something wrong with my ankle and called in the district nurse for me."'

More than four out of five services were able to show that their care was effective and that people's care, treatment and support enables them to have a good quality of life. This has been achieved, for example, by involving people in training, to help staff understand the needs of those in their care. Eighty-one per cent of services were rated as good and 1% as outstanding for the key question 'are services effective?'.

Caring

When we say that a service is caring, we find out if staff involve and treat people with compassion, kindness, dignity and respect.

CARING IN AN INSPECTION REPORT

'People who used the service and their relatives confirmed they were treated with dignity and respect by carers who empathised with them. One person said, "I'm very slow on my feet now and they know that – they never rush me." Another person told us how their carer, "always helps me do as much as I can – they're very tactful". In a questionnaire returned to CQC one relative stated, "The carers and managers have provided an excellent service underpinned by total respect and dignity."'

In the majority of cases, our inspectors have seen and heard that staff involve people in their care and treat them with compassion, kindness, dignity and respect. When people may not be able to fully describe this themselves – for example, people with a learning disability and those living with dementia and other conditions that may affect their ability to communicate – our inspectors have used our Short Observational Framework for Inspection, which helps us to analyse how well staff interact with and support the people they are caring for. People using services were often very keen to tell us of the close relationships built up over time with staff who know their likes and dislikes. These factors led to 'caring' being the most highly rated of all the questions we ask services. More than nine out of 10 services were rated as good (92%) or outstanding (3%) for caring.

Responsive

When we ask whether a service is responsive, we find out if services are organised so that they meet people's needs.

RESPONSIVE IN AN INSPECTION REPORT

'All staff went out of their way to maintain family lives and relationships. Relatives' comments included, "I'm always made to feel welcome anytime", "I bring the grandchildren in to visit, we sometimes go in the garden or just spend time in their room, there is plenty of space".'

Our reports show that in high-performing responsive services everyone has equal access to care, regardless of their particular characteristics. Eighty-five per cent of services were rated as good or outstanding for responsiveness, while 14% were rated requires improvement. One per cent of services were rated as inadequate for responsiveness.

Well-led
When we ask whether a service is well-led, we find out if the leadership, management and governance of the organisation assures the delivery of high-quality, person-centred care, supports learning and innovation, and promotes an open and fair culture.

WELL-LED IN AN INSPECTION REPORT
'The registered manager and provider had developed an open and inclusive culture by meeting and working with people's relatives, staff and external health and social care professionals. A comment from a relative read, "The kindness, patience and care shown to my relative is wonderful. The team is led by a truly marvellous manager whose standards are the highest possible."'

Like the safe key question, our assessment of whether services are well-led shows relatively poor performance, with 22% of services rated as requires improvement and 2% as inadequate. Our data shows that if a service is rated as good or outstanding in well-led, it is more likely to be rated as good or outstanding overall, compared with any other key question.

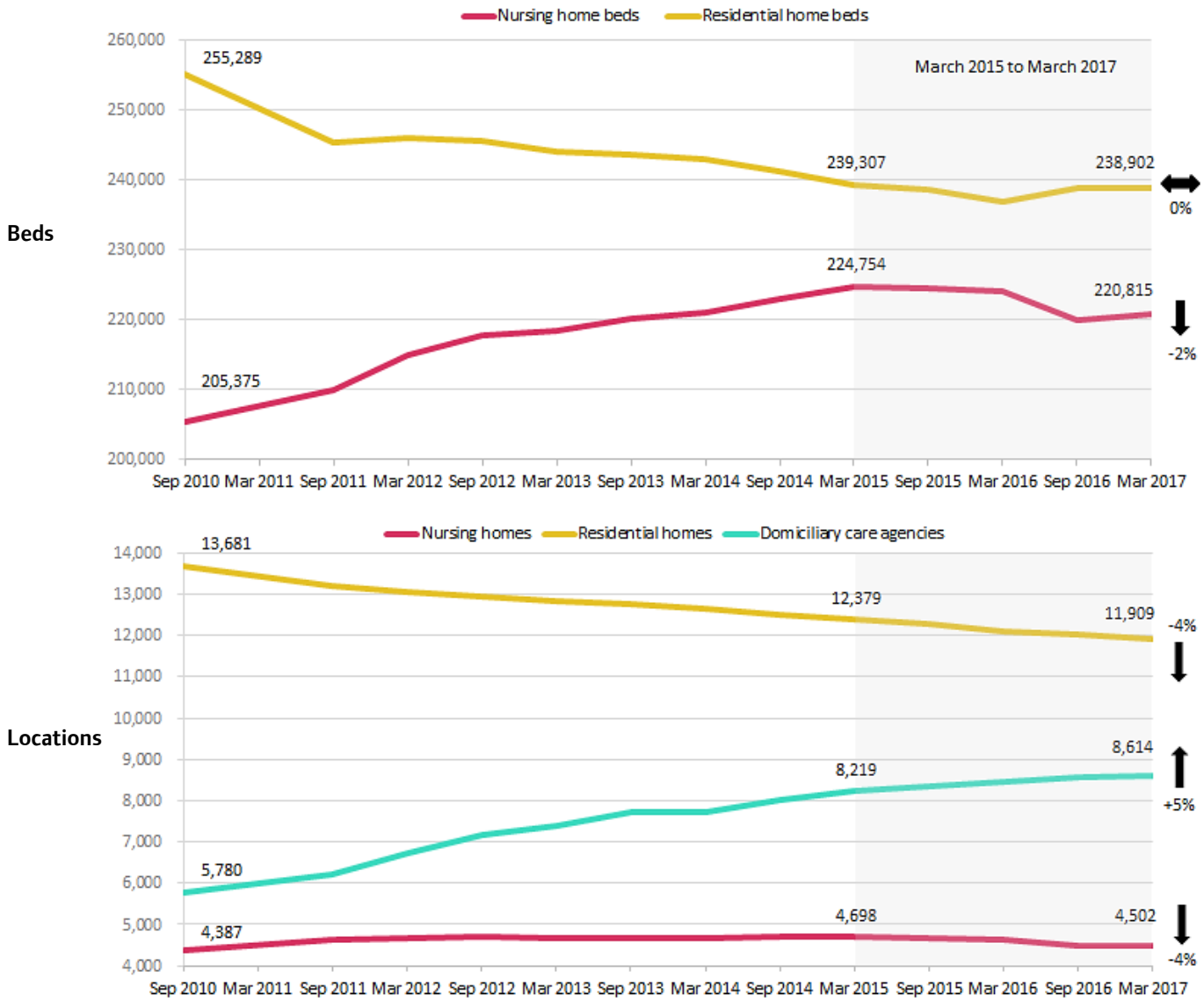
Services that are rated as requires improvement or inadequate in their well-led rating can indicate that staff are not being adequately supported or that people who use services, their families and carers are not being taken seriously if they raise a concern.

2.5 Types of services

People who use services, their families and carers can use these different types of adult social care service, depending on their needs. By looking at the registration data that we collect we can see how provision has changed over the last seven years as different providers enter and leave the market. By following the historical patterns, we get an idea of how services are responding to needs of local populations, and how they are balancing this with financial and resource pressures.

Figure 6 shows a pattern of decreasing numbers of residential homes and increasing numbers of domiciliary care agencies of various sizes. It also shows a long-term trend of increasing numbers of nursing home beds and decreasing numbers of residential home beds. However, we flagged in *The state of health care and adult social care in England* last year that the increase in nursing home beds came to a halt around March 2015. Since then, the provision of nursing home beds has declined and there are nearly 4,000 fewer nursing home beds open than there were at the peak in March 2015. This decline in nursing home beds may have abated; the latest data shows a small rise in bed numbers. As demand increases it will be important for CQC nationally and commissioners locally to monitor the availability of services and understand the reasons for changes.

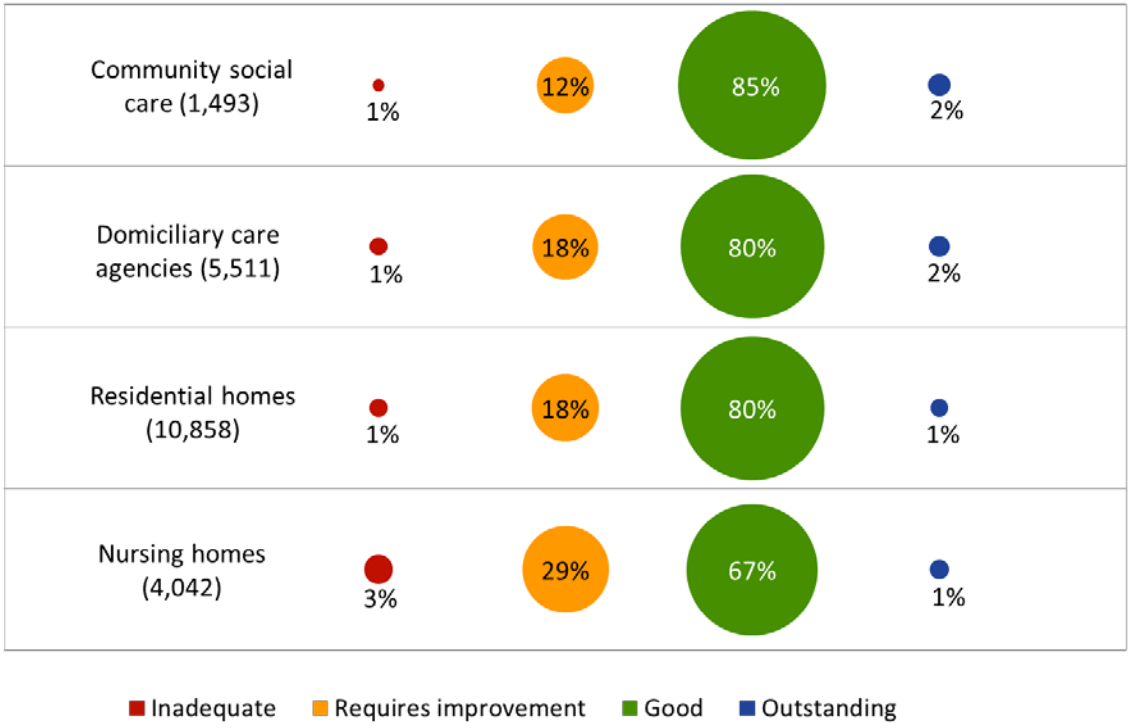
Figure 6: Adult social care market trends



Source: CQC registration data, March 2017. Arrows show movement since March 2015

There is considerable variation if we look at the ratings across different types of services. Community social care services (for example supported living and Shared Lives) were rated the best overall when compared with other services. Domiciliary care services and residential homes received similar ratings, with four out of five services being good. It is nursing homes that remain the biggest concern – 67% were rated as good and 1% as outstanding, with 29% rated as requires improvement and 3% as inadequate (figure 7).

Figure 7: Current overall ratings by service type



Source: CQC ratings data, 5 May 2017. Numbers in brackets show total active locations rated.

2.6 Size of services

Our analysis of our inspections shows that there is variation in performance depending on the size of services. Figure 8 shows that, in both nursing and residential homes, there is a trend that smaller homes are rated better than larger homes, with 89% of both small nursing and small residential homes rated as good or outstanding, compared with just 65% of large nursing homes and 72% of large residential homes. This pattern may be partly because many smaller homes are for people with a learning disability, and these services tend to perform well (see section 2.7). To give an idea of the numbers of people experiencing these levels of care, the 4% of large nursing homes rated as inadequate can provide services for around 5,500 people.

We have found that services that care for smaller numbers of people often found it easier to demonstrate a good level of responsiveness – for example, by being able to offer activities that are based on people's individual interests. This may be a challenge for larger services, but can be achieved as the example below shows.

Figure 8: Current overall ratings by size and type of care home

Source: CQC ratings data, 5 May 2017. Figures in brackets are numbers of locations rated.
Small = 1-10 beds, Medium = 11-49, Large = 50+

EXAMPLE OF PERSON-CENTRED CARE IN A LARGE SERVICE

Deerhurst Care Home is a care home with nursing care for up to 66 predominantly older people in Bristol.

A relative said:

- *"As my mother's needs have changed the staff have changed the way they look after her. Nothing seems to faze them and they always keep us informed [about] what is happening."*

Deerhurst has a 'homemaker' role, which staff take it in turns to fill. They are an extra dedicated member of staff to support and reassure people, and also to monitor what people are eating or drinking.

The service went the extra mile in caring for people when it arranged for a specially adapted

double bed to be provided for one of its residents. This was because the resident had always shared a double bed and missed the cuddles with their loved one. The person was able to spend time with their loved one, watching television, lying on the bed until falling asleep in each other's arms. The relative then returned to the family home knowing their loved one was settled for the night.

Read the whole report at www.cqc.org.uk

When looking at domiciliary care services, our data shows that locations providing care to a smaller number of people were also performing better than larger services. Our ratings data shows that 85% of small services (for one to 50 people) were rated as good or outstanding, whereas only 73% of larger services (for 101 to 250) achieved the same results (figure 9).

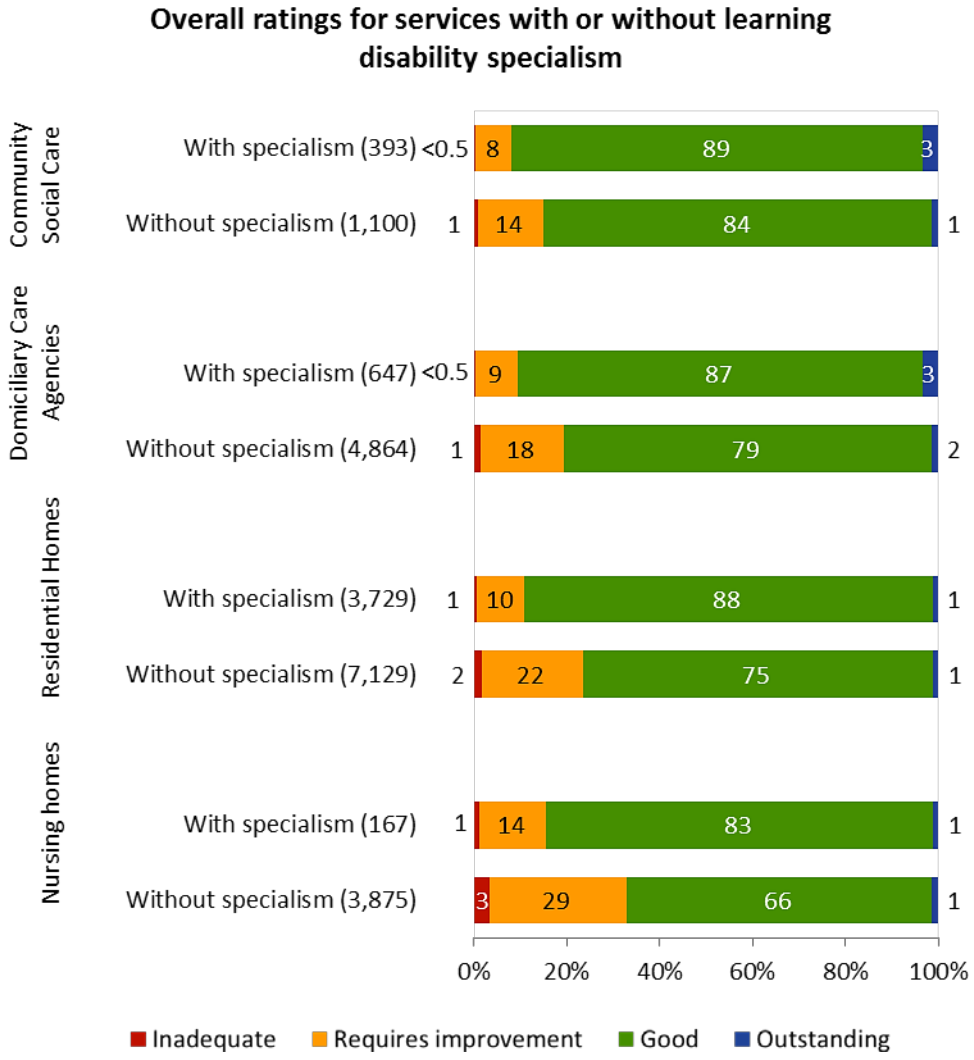
Figure 9: Current overall ratings by size of domiciliary care service

Source: CQC ratings data, 5 May 2017. Figures in brackets are numbers of locations rated

2.7 Learning disabilities

We can see variations in performance when we compare ratings for adult social care locations that specialise in the care of people with a learning disability against those that do not (CQC also inspects learning disabilities services as part of our mental health hospital inspections). Figure 10 shows that across all types of adult social care learning disability services have around half the proportion of inadequate or requires improvement overall ratings compared with services without a learning disability specialism. The caring and responsive key questions were particularly strong for learning disability services, showing that providers are organising their services to meet people's needs, and staff are involving people in their care and treating them with compassion, kindness, dignity and respect.

Figure 10: Current overall ratings by services with and without a learning disability specialism



Source: CQC ratings data, 5 May 2017. Numbers in bars are percentages and figures in brackets are numbers of active locations rated

EXAMPLE OF A CARING SERVICE FOR PEOPLE WITH A LEARNING DISABILITY

Mill Green provides accommodation and personal care for people who may have physical disabilities or long-term conditions, acquired brain injury and cognitive or learning disabilities.

One person said:

- *"Staff here are great, but they have a lot to do. I do a bit of washing and drying up. It feels more homely if I help."*

The provider's emphasis on person-centred care was understood by all staff. Staff saw beyond people's medical conditions, and encouraged and supported them to 'be themselves'. One person, who was not able to walk independently, had spent their morning happily painting the garden shelter with staff, while sitting in their wheelchair. People and relatives told us they had noticed a difference in the way people used the garden since a care coordinator had taken ownership of the 'garden project'. People also enjoyed an outdoor exercise class to music because all the staff, including the manager, housekeeper and senior manager joined in, which made them feel less self-conscious.

People were supported to maintain their independence with eating and drinking. Sometimes people chose to eat out and sometimes people chose to buy their own meals to re-heat at home, which promoted their independence.

Staff were committed to personalising the way they communicate with people. For example, one person with limited speech and mobility liked staff to walk in front of them, so they could hold their shoulders while they walked round the home.

Read the whole report at www.cqc.org.uk

3. What can the sector learn from our inspections?

Key points

- All providers can learn from high-quality care services and should know what to do to avoid poor care.
- Strong leaders had a pivotal role in high-performing services. This was seen at registered manager and provider level, where strong vision and values were communicated to all staff, encouraging a culture of openness and transparency.
- Positive and supportive cultures are characterised by staff who were well-trained, caring, skilled, dedicated, enthusiastic and focused on positive outcomes for people.
- A key theme that shone through in terms of high-quality services and improvement was a clear focus on person-centred care. In these services, staff really get to know people as people, understanding their interests, likes and dislikes.

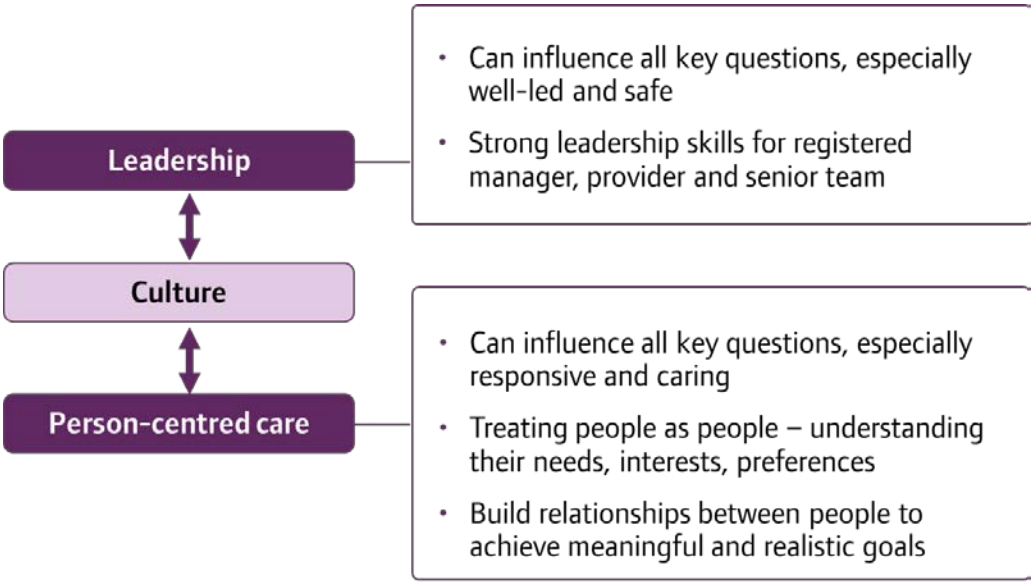
In this section, we focus on the main features of high-quality care that we have seen during our initial comprehensive programme of inspections, illustrated with examples from our inspections of high-performing providers. All providers can learn from each other – especially those that are rated as inadequate or requires improvement. Good and outstanding providers can also learn from the best practice and, as can be seen in the next section, quality in even the highest rated services can decline, so a focus on continuous improvement is vital to maintain quality care for people.

3.1 Characteristics that have led to high-quality care

Good leaders, both at registered manager and provider level, have a big influence on the quality of adult social care that people receive. They have an important role in shaping a positive culture in a service – including creating a supportive environment for staff, listening to their concerns, and communicating well with them, other professionals, and people who use services and their families and carers. They also genuinely appreciate diversity and seek ways to meet equality, diversity and human rights.

Leaders in the highest performing services also inspire a culture where people are at the centre – treating people as people, as opposed to just recipients of care. Staff sought to build relationships with people to find out what works for them. We found that good leadership, based around person-centred care inspired a positive culture (figure 11).

Figure 11: Characteristics of high-quality care



Leadership

Strong leadership has a pivotal role in both high-performing services and bringing about improvement in adult social care. At registered manager level strong leadership was characterised by individuals with an innovative, outward or forward looking approach who were open to feedback and actively sought out best practice to steer improvement. Managers were visible in the service, and known to staff, people using the service, carers and families, for example by sharing an office with all levels of staff and working closely with them.

Good managers truly valued their staff, supporting them to maintain their knowledge of best practice and person-centred care through training and establishing 'champions' in different areas of care.

Strong leadership was not restricted to registered manager level. Managers were supported by providers to communicate a strong vision and values to all staff, encouraging a culture of openness and transparency.

Good and outstanding services were supported by quality assurance systems and processes to monitor standards, such as quality audits and surveys. In well-led organisations leaders would ensure these systems and processes were embedded across the organisation, with clear lines of accountability.

We have also seen that leadership has an impact on the other questions as well as asking if the service is well-led. If a location was not performing well in other areas it was very unlikely to be rated as good or outstanding for well-led. There is a particular link between inadequate for safe and inadequate for well-led.

Innovation was identified as a characteristic of outstanding services, with good leaders described as being 'innovative' or 'creative', especially when adopting really person-centred practice and solutions to individual care needs, instead of simply seeing the risks or barriers.

EXAMPLE OF VALUING STAFF AND INDIVIDUALISED CARE IN A HIGH-PERFORMING SERVICE

Care By Us is a large organisation that offers personal care and other related services in East, West and North Hertfordshire, Essex and North London. They provide a wide range of care services in people's own homes. They serve around 1,600 people, employing about 500-600 staff.

People who used the service said:

- *"Staff do very well at lifting my mood if I'm feeling a bit bad. They are very caring."*
- *"They [staff] are so gentle when they get me out of bed, they don't rush me or seem keen to go. I feel like they're looking after me ever so well. Fantastic service!"*

Beyond the necessary mandatory training, such as safeguarding and food hygiene, a lot more core training was given to staff – especially in their first weeks. For example, staff attended cookery lessons where they learnt basic cookery skills and how to promote healthy eating for the people they were supporting.

Training was supported by appointing Champions across the organisation – for example, for dementia, falls prevention, nutrition and medication. The Champions actively trained and coached staff. One staff member said, "We are learning a lot about safe handling of medicines and what best practice means. If we are unsure we have our Champions, they know how to guide us."

The provider had a very personalised approach to care planning that sought to enable people to live as long as possible in their own home. They sat down with each person and looked at what good care looked like for them. There was a team who went out to talk to people who were not happy with the initial assessment of their care – for example the number or timing of the calls. This team of managers met with people and laid out all the options, talked about these and adapted the plan of care. Staff adapted to the people, not people to the staff. One person told us, "Care by Us came and discussed it [care needs], they did suggest three times a day but we have chosen to have mornings and evenings." One relative told us, "Yes, it was the senior management who came to discuss the care plan and care needs. I was there; it was very professional and very understanding of my [relative's] needs."

Care By Us have their own IT department, which developed technology for their own use. They were using telecare equipment, for example a GPS watch for people who cannot find their way home, so that the service could locate them and pick them up.

Read the whole report at www.cqc.org.uk

Culture

Positive culture was something that characterised good performance and improvement, and the links to the leadership finding outlined above are clear. Both staff, people who use services and inspectors commented on particularly positive and supportive cultures characterised by staff who were well-trained, caring, skilled, dedicated, enthusiastic and focused on positive outcomes for people. The cultures of the services were also highlighted as being open and transparent, with a culture of improvement based on good practice and feedback.

A review of CQC inspection reports carried out by Skills for Care highlighted the importance of creating and maintaining an inclusive culture. It also identified a link between organisational vision and values and quality. It found that in the majority of CQC inspection reports reviewed from services rated as requires improvement or inadequate, there was little or no evidence of the organisation's vision or values. By comparison, it was rare to find an inspection rated as good or outstanding that did not include some positive evidence of how vision and values have helped the service to achieve high standards of care.[12]

Practical examples of how a positive culture was created included:

- Staff not wearing uniforms in recognition that they were in people's home and viewing themselves as 'guests'.
- Involving people who use services in training.
- Staff designated as 'champions' in particular areas.

Person-centred care

The third key theme that shone through in terms of high-quality services and improvement was a clear focus on person-centred care. Good leadership that generates a positive and inclusive culture leads to genuinely person-centred care. These vital characteristics can have a real impact on the lives of people using services, their families and carers.

In high-quality services, staff really get to know people as people, understanding their interests, likes and dislikes. This supports relationships where staff and people who use services work together to set and achieve meaningful and realistic goals. The way these services engaged with and supported carers and family members also showed an inclusive approach to care.

Good person-centred care was achieved through people using services and their carers and families being fully involved in all areas of their care, such as writing care plans. Our report, *Better care in my hands*, used analysis from a literature review and from CQC inspections of outstanding services, and evidence from our national thematic reviews to identify a common set of achievements that have helped services to ensure people are involved in their care (box A).

BOX A: The importance of involving people in adult social care to achieve person-centred care

1. I am involved in discussions about my care, treatment and daily life as I want to be
How is this achieved?
By involving people in all aspects of care is a priority for the organisation and managers take a leadership role, encouraging staff to involve people

Inspection report example
"We saw that people's preferences and views were reflected, such as the name they preferred to be called and personal care preferences such as, 'I like to have a shower every day.' We spoke with this person and they confirmed that they had a daily shower."

2. My wishes and preferences are respected
How is this achieved?
There are management systems in place to monitor how people's wishes and preferences are being acted on

Inspection report example
"The main emphasis was that people were at home; they dressed in their preferred clothes and continued to undertake their individual hobbies. We observed people were able to do what they wished, making their own decisions helped and supported by staff. A member of staff we spoke with told us, 'The residents are not pushed to have a certain routine; we go with the flow so people live the life they choose.'"

3. My family and loved ones help me plan my care and support
How is this achieved?
Services coordinate how they involve people and their families in their care

Inspection report example
"I am always consulted about everything. The manager and staff keep me informed and we always have a six monthly review meeting when we discuss every aspect of my mother's care. I find communication to be excellent." (Relative of a care home resident)

4. Staff in different services work with me to adapt my plans as my needs change
How is this achieved?
Key staff work together across services to coordinate people's involvement in their care

Inspection report example
"A hospital passport was completed for each person. If a person needed to go into hospital other professionals would be made aware of people's preferences regarding their care, support needs and their current treatments that were best for them."

5. I am offered appropriate information, support and advocacy about key decisions for my care and treatment
How is this achieved?
Tailored and timely accessible information is used to support discussions and the involvement of people and their families

Inspection report example
"We observed a member of staff sitting next to a person who had no verbal communication. The staff member was holding the person's hand and pointing out the various picture meal options available for lunch."

6. I am involved in daily life choices in care settings
How is this achieved?
Services are organised to provide continuity of staff working with people using services over time

Inspection report example
"Care staff worked with Mr J and his wife to understand his life story and find out what would make him happier. Mr J had been a firefighter and relished the responsibility of keeping people safe. Care staff supported Mr J to check the environment for safety and standards and also involved him in practical daily tasks."

7. My capacity to be involved is taken into account – wherever I receive care
How is this achieved?
There is flexible advocacy provision as people use different services (when people lack capacity to make a decision or need support to represent their interests)

Inspection report example
"One 17 year old had a continuing healthcare assessment which was very person-centred. His support needs were clearly outlined and recorded in simple language and using his own words. It had a strong focus on his likes, dislikes and wishes. His father told us, 'The team have worked creatively to expand and enrich his social and practical skills. As a result his ability to join in and socialise with his siblings and peers has grown significantly.'"

Adapted from: CQC: *Better care in my hands: A review of how people are involved in their care*, May 2016

Tailoring activities to individuals' likes and interests was an important way of achieving person-centred care. This often involved using the arts to find creative ways of enhancing people's quality of life. For example, there is building evidence[13] that music and singing interventions work to improve the wellbeing of adults living with diagnosed conditions or dementia:

- Targeted, culturally relevant music and singing interventions can enhance mental wellbeing and decrease depression in older people with chronic conditions in residential and community settings.
- Participation in individual personalised music listening sessions can reduce anxiety and/or depression in nursing home residents with dementia and that listening to music may enhance overall wellbeing for adults with dementia.
- Participation in extended (12 months) community singing programmes can improve quality of life and social and emotional wellbeing in adults living with chronic conditions.

Practical examples of how person-centred care was achieved included:

- Staff actively supporting links with the wider community and involving volunteers in day-to-day activities.
- Arranging the environment so it provided positive living, learning and social experiences. For example placing objects around the home that were meaningful to people and that they could interact with. One home used iPads to engage with and create a stimulating and fulfilling environment for people living with a learning disability and dementia. This meant that one person, who had no verbal communication, was able to build up a picture/video diary and could tell their family what they had been doing during their visits.

EXAMPLE OF PERSON-CENTRED CARE IN A HIGH-PERFORMING SERVICE

Mary & Joseph House is a care home in Manchester, providing accommodation and personal care to adult men with enduring mental health needs.

A person who used the service said:

- *"The staff here know what they are doing. They have supported me so well, I was close to death when I first arrived, now I am strong and feel great."*

Mary and Joseph House are careful about people having realistic aims and objectives. They want to make sure that, if people are moving out, they have their finances sorted out correctly. There was an example of a person who was due to move out back into his own family home. The service was supporting him over a number of months, to visit his home regularly, to try and build up links with the community, to find new volunteering opportunities, and to know that he can still come back to Mary and Joseph House informally for a cup of tea or have a meal.

Arts and creativity were an integral part of the service provided at Mary and Joseph House:

- The service had a choir and an instrumental band which had been organised by the staff and people.
- A therapeutic gardener and art teacher were employed. The gardening team have worked with the art group to achieve Gold Awards in various Royal Horticultural Society competitions.

We saw one example of a person living with dementia who started a project five years ago to make a ceramic picture of what the home did. He took pictures to show where he was up to with the project. The home continually supported him to finish the project. It was a massive achievement for him.

Read the whole report at www.cqc.org.uk

3.2 Focus on Shared Lives

CQC regulates, inspects and rates Shared Lives services, which match adults who have care needs with approved carers. Shared Lives carers accept people into their own homes and provide care, support and mentorship to people.

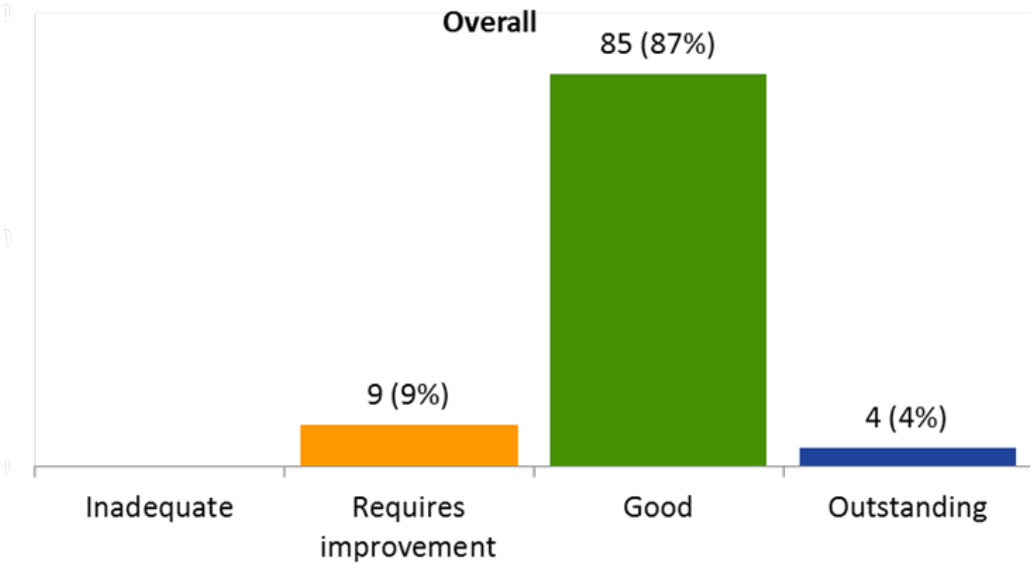
The Shared Lives model of care is geared towards achieving positive outcomes for people who use the service. The placement of people in a family home with carefully selected and screened carers helps create a supportive family environment, which helps to ensure person-centred care that is focused on independence and positive risk taking.

Shared Lives represent a small proportion of the services we regulate. Between October 2014 and May 2017, we inspected and rated 98 Shared Lives services.

According to Shared Lives Plus, this form of care is less expensive than other forms of care, while achieving good outcomes for people. Half of the 12,000 people using Shared Lives are living with their Shared Lives carer as part of a supportive household; half visit their Shared Lives carer for day support or short breaks. Shared Lives is also used as a stepping stone for someone to find their own home.[14]

CQC ratings data shows that they perform very well; over 90% are rated as good or outstanding and there are currently no locations rated as inadequate (figure 12). The key questions of caring and responsive are rated particularly highly compared with all adult social care services (for example, there are no locations rated as requires improvement or inadequate for the caring key question). This reflects the personalised approach of Shared Lives services that can bring positive results for people using them (see the example below).

Figure 12: Shared Lives overall ratings



Source: CQC ratings data, 5 May 2017. Numbers above bars show total active locations rated

The characteristics that have led to high ratings and remarkable support to people using services as shown in the case study below are:

- Strong leadership features again, with managers who maintained strong relationships with other local health and local authority services, who were forward looking and focused on solutions to maintain placements.
- Positivity of staff reflects strong leadership and careful recruitment. Staff were dedicated, enthusiastic and motivated by achieving positive outcomes for people using the service.
- Carers were carefully selected, screened and assessed, ensuring that people were highly suited to the role and able to demonstrate the necessary skills and qualities required. This was followed by a robust process for matching a person with a carer, which took into account a wide range of aspects to ensure that the needs of the person were catered for.
- People who use services, carers and staff were all well supported through effective communications, the availability of training, and monitoring processes to proactively identify areas for support.
- An open and transparent culture was present, which meant that issues could be highlighted and addressed.

EXAMPLE OF A HIGH-PERFORMING SHARED LIVES SERVICE

The Shared Lives Service in Lancashire provides long-term placements, short breaks, respite care, day care and emergency care for adults with a range of needs, within carers' own homes. It is the largest Shared Lives provider in England.

A person who used the service said:

- *"Shared Lives are amazing. This is my home and I am made to feel part of the family. Staff are really nice and friendly."*

One carer said:

- *"We wanted to see what [the person's] potential could be. They have gone from doing almost nothing to being outgoing and making decisions for themselves, including where they want to go and who they want to see. It's been amazing to see the transformation."*

Person-centred model

- One person we spoke with showed us photographs of themselves when they had moved into their Shared Lives home a few years ago to show us they had lost a significant amount of weight. They were proud of this achievement and it was obvious they had been given a lot of support from their carer and support officer to eat well and lead a healthy and active life.

Read the whole report at www.cqc.org.uk

4. What do we do about poor care?

Key points

- When we find poor care, we take action to make sure providers and managers tackle their problems and put things right for the benefit of people using services, their families and carers.
- Adult social care providers say that our enforcement regime encourages services to make sure they meet fundamental standards.
- Poor quality can have a real impact on people using services, particularly in the areas of staffing and medicines management.
- The areas of the regulations that we have taken the most enforcement actions relate to a lack of good governance, and issues with safe care and treatment, staffing and person-centred care.

CQC understands there are financial pressures facing the adult social care sector, but this does not mean that we will compromise on our purpose of ensuring people receive care that is safe, effective, compassionate and high-quality. Our inspections show that services of all types and in all circumstances can provide high-quality care for people. Where there is poor care, we will encourage improvement but if we need to take action that stops unsafe care and protects people from abuse and avoidable harm, then we will do that.

If, during our inspections, we identify aspects of care that need to improve, we ask the provider to evidence how they are going to make sure people receive the care and support that meets the standards they have a right to expect. We go back to inspect to find out whether they have kept to their commitments and if these have had the required effect. If they have not, we will use the enforcement powers we have available to take appropriate action. Our focus is always on the people using services – they have a right to receive safe, compassionate and effective care. When this does not happen we will take action on their behalf.

Our most recent annual provider survey, due to be published in the autumn, showed that providers think that our enforcement regime encourages services to meet fundamental standards that people have a right to expect whenever they receive care. Of the three main care sectors that we regulate, adult social care had the highest results in this area – with 74% agreeing that the prospect of enforcement action is an effective deterrent to encourage services to make sure they meet fundamental standards.

4.1 Characteristics that have led to poor-quality care

Of the five key questions that we asked all services, safe had the poorest ratings, with 23% rated as requires improvement and 2% as inadequate.

Poor quality can have a real impact on people using services, particularly in the areas of staffing and medicines management.

Staffing

Staffing levels were a key factor in providers rated as inadequate or requires improvement for safety. Our inspectors look at safe staffing levels in terms of whether people's needs were being responded to in a timely manner. They do this by talking to people using services and their families and visiting professionals, observing whether people's needs are met and they are safe, checking systems for assessing staffing levels, and talking to a range of staff to hear their views on the staffing at the service. In care homes, for example, inadequate staffing levels led to alarm calls not being responded to promptly, which meant that people did not get the support they needed when they needed it.

The layout of a home and peak times affected the number and deployment of staff. This could have an impact on whether people's needs were responded to promptly, whether medication was given, whether staff were able to spend time in communal areas, and (considering people with challenging needs) ultimately that people were safe. Rotas had shown care staff being deployed to assist in the kitchen for example, during lunch time, when staff were required to safely assist people to the dining room.

The impact of inadequate staffing on care provided for people receiving help from a domiciliary care agency was that they would receive rushed one-to-one assistance instead of the two-to-one support required, and this could be provided by a different carer every day.

Even where appropriate numbers of staff were in place, if they did not have the necessary skills this could have an impact on safety. During one inspection of a service that was rated as inadequate, we found that the manager did not know what skills their agency workers had, and we found that they did not have the skills needed to support the people with complex needs.

Staff training was also a factor on safety, particularly in areas such as infection control, risk assessments, safeguarding and medicines.

We also found shortfalls in staff understanding of the training, with no evaluation of staff competency after the training or practical supervision.

Medicines management

Medicines management was a key factor associated with unsafe care. Specific issues included:

- Medicines not being administered properly

- Staff lacking knowledge of medicines and their side effects
- Issues with record keeping, including timeliness
- A lack of medicines audits
- Medicines being out of date and not being stored correctly.

In some cases poor medicines management were described as having extremely serious consequences, with failure to check that a member of staff was able to administer medicines on an ongoing basis leading to actual harm to people using services. Conversely, staff that have an understanding of the medicines they were administering were able to talk to people about any possible side effects.

The next section discusses what we do when we find poor-quality care, with examples of some of the poor care described above, and what providers have done to make improvements.

Information and resources to support improvement can be found on Care Improvement Works, which is a free online tool developed by Skills for Care, the Social Care Institute for Excellence and the National Institute for Health and Care Excellence.

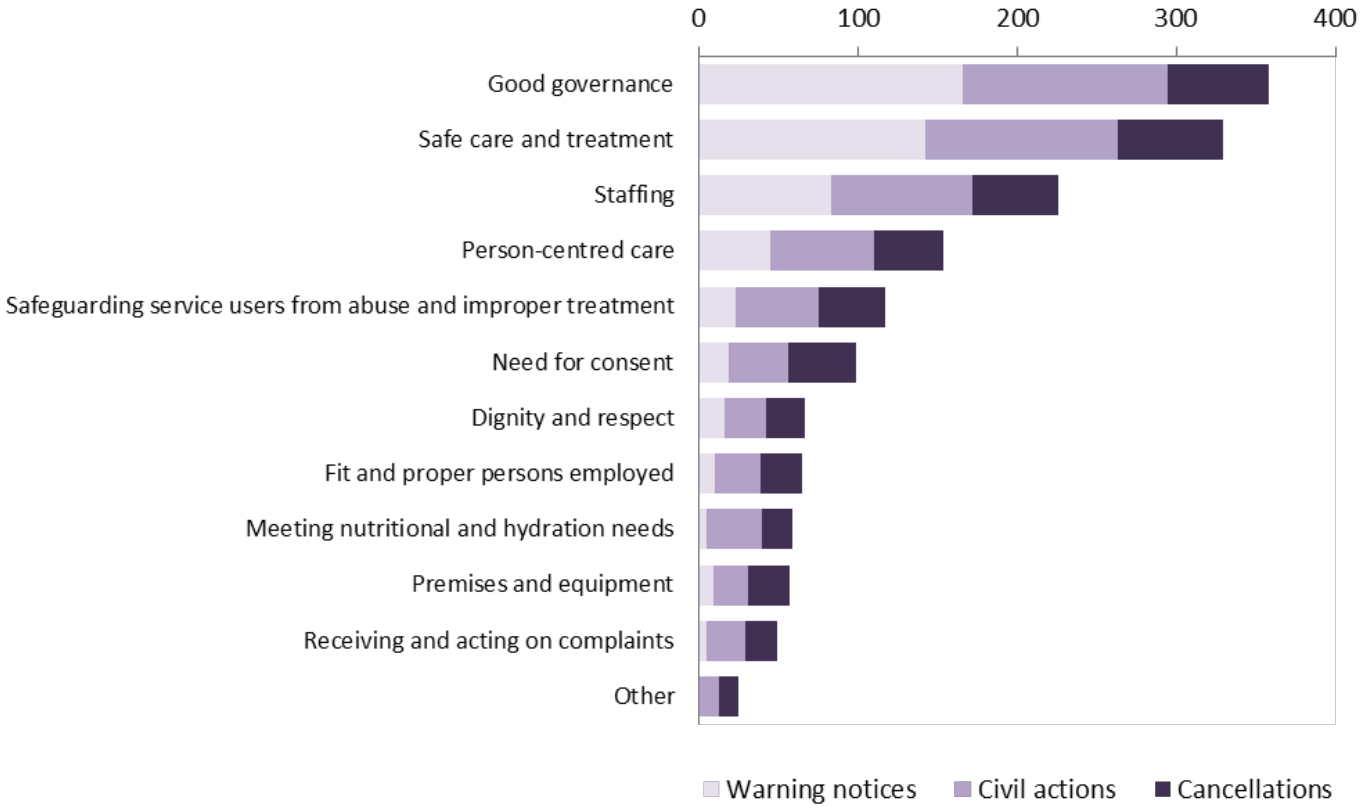
4.2 Using our civil enforcement powers

Where we identify poor care, or where registered providers and managers do not meet the standards required in the regulations, we have a wide set of enforcement powers that allow us to protect the public and hold those responsible to account.

The actions we take depend on how serious the problems we have identified are and how they affect the people who use the service. Actions range from giving providers notices setting out what improvements they must make and by when, to placing them in 'special measures', which gives them a clear timetable within which they must improve the quality of care they provide. If providers do not improve we will take further action (for example, cancelling their registration). The example on page 38 shows the work that is done to ensure continuity of care for people when a registration is cancelled.

Figure 13 shows the number of breaches in each area of the regulations that contributed to inadequate ratings. The enforcement actions we took ranged in severity from warning notices through to cancellation of registration. The most common breaches relate to the issues we have highlighted in this report. In these services there was a lack of good governance, and issues with safe care and treatment, staffing and person-centred care. This may mean that providers and leaders were failing to check the quality of their care, seek the views of people using the service, administer medicines safely, and make sure that staffing levels are adequate to provide care in a person-centred way. A similar pattern emerges for enforcement actions against locations rated as requires improvement, although with fewer civil actions and cancellations.

Figure 13: Enforcement actions against locations rated as inadequate



Source: CQC ratings and enforcement data, 5 May 2017. The numbers relate to regulations breached, not total numbers of locations (which will be fewer as a number of locations breach more than one regulation)

4.3 Using our criminal enforcement powers

Since 1 April 2015, enforcement responsibility for health and safety incidents in the health and social care sector transferred from the Health and Safety Executive and local authorities to CQC. We have subsequently prosecuted five providers using these powers (figure 14). While all prosecutions so far have related to a breach in safe care and treatment requirements, the cases have covered a wide range of safety issues, including medication errors, uncovered radiators and use of bed rails. Recurring themes, which have been highlighted in legal analysis,[15] included:

- Issues with documentation: for example, errors regarding medication dosages and strengths and timings not being accurately recorded.
- Risk assessments: for example, one care home was found to have no proper system for assessing the risks to the health and safety of people using services (including failing to prevent a blind resident repeatedly falling in her room and a resident repeatedly choking).

- Equipment: for example a person living with dementia suffering burns after falling against a radiator through lack of radiator covers or pressure sensor mats to alert staff to the person getting out of bed.
- Staff training: for example, a person fell out of a shower commode chair because staff did not know about a national safety alert about the importance of safety/posture belts and did not understand how to fit chair straps safely.

Figure 14: Successful CQC prosecutions of adult social care services

June 2016	St Anne's Community Services	Prosecution following the death of a 62-year-old man who broke his neck in a fall from a shower chair at a nursing home in West Yorkshire. The provider was fined **£190,000**.
September 2016	Cotton Hill House care home	Prosecution following the death of a resident at Cotton Hill House care home following errors with the administration of his anti-coagulant medication. The provider was fined **£50,000** and the former manager, was fined **£665**.
February 2017	Manor Residential Home	Prosecution following an incident when a 79 year old woman fell against an uncovered radiator and suffered serious burns. The provider was fined **£24,600**.
March 2017	Mossley Manor Care Home	Prosecution following 14 offences for failing to provide safe care and treatment; failure to notify CQC of the deaths of ten residents; and failure to notify CQC of three serious incidents. The provider was fined **£82,430**.
April 2017	Lamel Beeches Care Home	Prosecution following two offences with one resulting in avoidable harm to a resident who died in hospital after falling out of bed at the home and re-fracturing his hip. The provider was fined **£163,185**.

To illustrate the terrible cases of neglect and abuse that are behind these prosecutions, the following example gives the detail of the Mossley Manor Care Home case.

EXAMPLE OF A CQC PROSECUTION

As a result of concerns from the family of a prospective resident, we inspected Mossley Manor Care Home during May and June 2015 and were appalled at what we found. Some residents were unkempt and smelled strongly of urine or body odour, having not received a bath or shower in the previous three weeks. Bedrooms were not being cleaned regularly and some contained mouldy and congealed tea and coffee cups. Carpets were dirty and dusty. Communal toilets did not contain soap, hand towels or bins. When there was no hot water staff had to boil pans of water in the kitchen to wash residents.

The care home had also failed to control risks of serious injury. There was no proper system in place for assessing the risks to the health and safety of individual people. One woman who was blind and had a history of falls was found injured on the floor of her room on three occasions but the provider failed to take action to stop it happening again. A 77-year-old man who was at risk of choking was twice taken to hospital – but there was conflicting advice for staff on how they should support him to eat and drink safely.

Initially we gave the owners 24 hours to submit an action plan to make urgent improvements. On visiting again a few days later to check if this was being implemented there were still serious concerns. CQC applied to Liverpool Magistrates to urgently cancel the provider's registration and close Mossley Manor. We worked closely with Liverpool City Council at the time so that people living at the home could find alternative accommodation.

The registered providers were fined £60,000 for failing to provide safe care and treatment and £20,800 for the 13 offences of failing to notify CQC. They were also ordered to pay the prosecution costs of £1,510 and a £120 victim surcharge.

Taking criminal action and prosecuting providers is a detailed process that involves the care and comprehensive collection of evidence. We test each case on whether there is sufficient evidence to secure a prosecution and, if so, is it in the public interest to prosecute. We currently have two prosecution cases that have been listed for a magistrates' court hearing, and six cases that are likely to be listed for a magistrates' court first hearing by March 2018.

5. Have adult social care services improved?

Key points

- Adult social care providers say that our inspections encourage improvement.
- More than four-fifths (81%) of locations that were initially rated as inadequate have improved their rating after a CQC inspection.
- Only 56% of locations that initially required improvement have improved their rating after a CQC inspection.
- Committed managers, who are supported by the provider, can drive improvement in a previously failing service.

The previous section of this report describes how we use our enforcement powers when we find poor care. It is our expectation that providers should take responsibility for the quality of the care they provide. We expect them to use our findings and reports as an opportunity to tackle their problems and put things right for the benefit of people using services, their families and carers, so that we should not have to resort to the more severe actions in our enforcement policy.

Our most recent annual provider survey showed that providers think that our inspections encourage improvement. Of the three main sectors that we regulate, adult social care had the highest results in this area – with 80% agreeing that inspections help them to identify areas of improvement.

This section focuses on how services have responded to our initial programme of comprehensive inspections in terms of improvement.

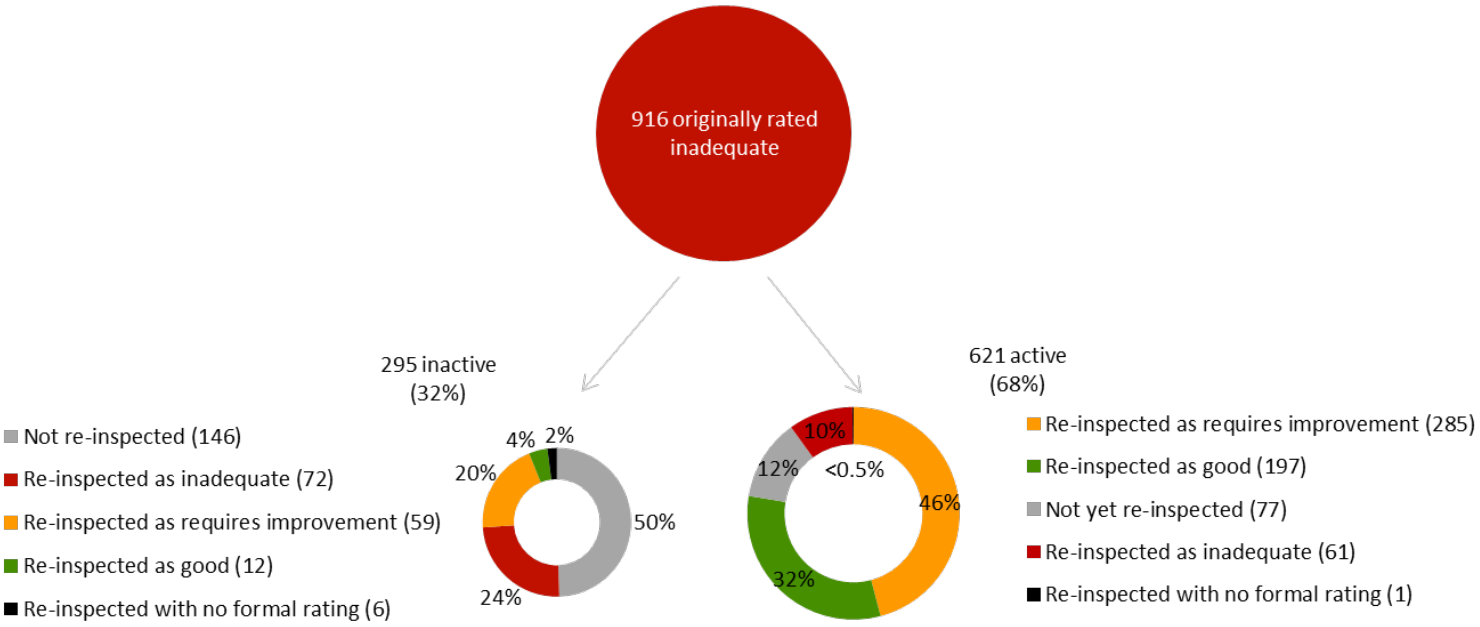
5.1 Inadequate services that improve their quality

Throughout our initial programme of comprehensive inspections in adult social care we have seen improvements across all types of services. This improvement is most evident in services that originally had the poorest quality, and were rated as inadequate. These services may not be keeping people safe – there may be widespread and significant shortfalls in the care, support and outcomes people experience; staff may not treat people with respect, and may sometimes be unkind and lack compassion; people may not be involved in the development of their care; and these things may stem from a lack of good leadership. Whatever factors have contributed to poor care, it is important that providers take action to protect people, improve their service and deliver on the legal obligations they accept when registering with CQC.

Figure 15 shows what has happened to the 916 services where we gave a first rating of inadequate. Almost one-third (295 locations) are no longer active; many of these will be locations that were deregistered by their providers before we could take further action – half of them became inactive before we were able to re-inspect them. Nearly a quarter of the 295 locations (24%) remained inadequate on re-inspection before they became inactive. A small number of locations are now inactive because CQC cancelled their registration – see page 35.

Of the 68% of services (621 locations) that were initially rated as inadequate and continued to provide services, over three-quarters improved (482 services). We continue to monitor the progress of the remaining 22% to make sure that people are protected and will take further action as necessary.

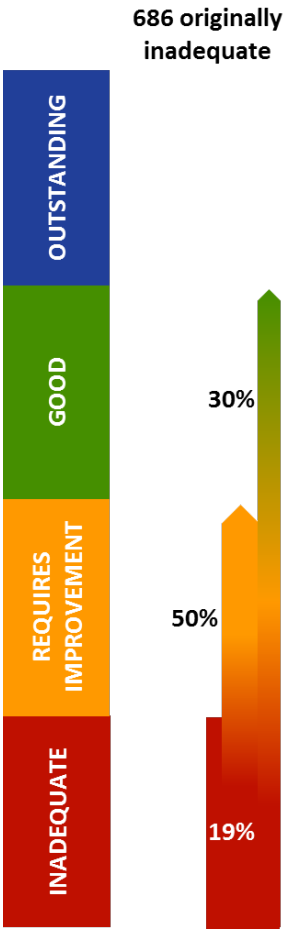
Figure 15: What has happened to services first rated as inadequate?



Source: CQC ratings data, 5 May 2017

Figure 16 shows a simpler picture of performance for those services that were first rated as inadequate and only includes those that have been re-inspected. It is encouraging to see that many providers are responding to our concerns. Eighty-one per cent improved their inadequate overall rating following re-inspection; 50% to requires improvement and 30% moved two ratings to good. We will continue to focus on those services that continue to be rated as inadequate (19%).

Figure 16: Re-inspection of services rated as inadequate – all providers



Source: CQC ratings data, 5 May 2017. Percentages do not add up to 100% due to rounding.

EXAMPLE OF IMPROVEMENT THROUGH LISTENING TO CQC AND PEOPLE WHO USE SERVICES

In November and December 2015, a domiciliary care service was inspected and rated as inadequate overall.

Six months on, in June 2016, the service was re-inspected and 'significant improvements' were found. The service was rated good overall and good in all the areas we assessed. Seventeen people were receiving support from the service at this time.

The first inspection identified a range of issues and risks across the five areas we look at, relating to recruitment, medicines management, staff training and supervision, poor assessments of people's needs and records management. Some people using the service and their relatives also highlighted issues about the delivery and continuity of care.

In preparation for the second inspection, the service had carried out another quality survey, which received positive feedback. When we talked to people using the service and their

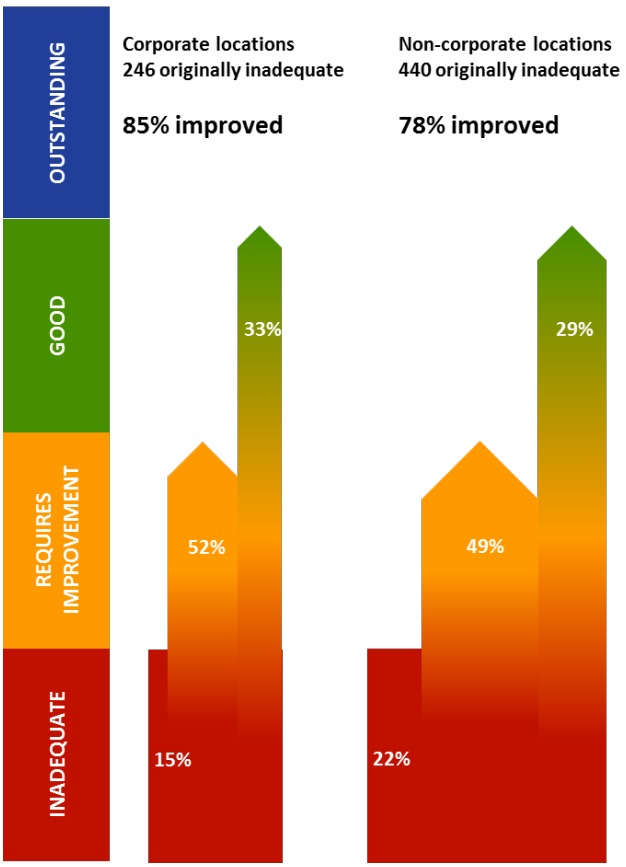
relatives, they confirmed they were now involved in care planning and staff were described as very caring and friendly and found to be proactive in supporting people and their relatives.

Both the registered provider and registered manager remained in post throughout the process, but a fundamental change to the service led to the improvements.

When we look at the overall ratings of corporate providers (a provider with 20 or more locations), they are very similar to the ratings of all providers. For example, 80% of corporate-owned locations were rated good or outstanding overall, compared with 79% of other locations.

Corporate providers, however, have been better at improving since a first rating of inadequate; of the locations originally rated as inadequate, only 15% of locations owned by corporate providers remained inadequate at their last rating, compared with 22% of non-corporate locations (figure 17). This might suggest that corporate providers are more equipped to step in to support any of their locations that are performing poorly and we are aware of larger corporate providers establishing quality turn-around teams to address problems at individual locations. It is important to ensure that the immediate action taken to address problems is sustained once the turn-around team has left. There is also a key role for local commissioners to consider what support they may be able to provide to smaller providers to help them improve.

Figure 17: Re-inspection of services rated as inadequate – corporate locations and non-corporate locations



Source: CQC ratings data, 5 May 2017

Impact of registered manager on improvement

It is clear from section 3 of this report that good leaders have a big influence on the quality of care that people receive. This applies not only to high-quality services, though, but also to services that have improved between inspections.

A committed registered manager, who is supported by the provider, can drive improvement in a previously failing service:

- The presence and capability of the registered manager was key to improvement. One of the examples in this section shows that improvement can be achieved by a consistent manager who is supported to bring about fundamental change. In the other example, improvement was brought about through recruiting a new registered manager who was quickly able to address staff issues by providing training that helped them understand the needs of the people in their care.
- Similarly, acceptance and ownership of the issues raised by CQC by the registered manager and provider was highlighted as important.
- The improvement driven by the registered manager involved moving to a more person-centred approach and culture, for example by involving people more in their care.

EXAMPLE OF IMPROVEMENT THROUGH A CHANGE IN MANAGER

The first inspection of a 58-bed residential care home, providing care to older adults with a range of support and care needs, in December 2015 revealed that the manager in place was not knowledgeable, approachable or responsive. Staff were process driven and did not support people in caring way that protected their dignity and privacy. The combination of these two aspects led to the service being rated as inadequate.

After this first inspection, the acting manager left their post and a new manager was appointed. At the second inspection the manager, with support from the owner, had been able to achieve a great deal of improvement in a short period of time. This included:

- Staff teams were mixed up so that "problematic cliques" could be broken up and staff could be exposed to best practice at other parts of the service.
- Person-centred caring training for staff. This included dignity challenges that aimed to give staff a better understanding of how it feels to be cared for, for example being fed by another person while wearing a blindfold. At the second inspection, staff also commented on how important the training had been for their role.
- More frequent staff meetings and weekly memos to improve communications between staff and the manager.

The overall rating of requires improvement reflected the work that the manager had been able to achieve, but still showed there was more to do.

At the third inspection the inspector saw improvements in the areas identified at the previous inspection and no new issues were identified and was able to rate the home as good.

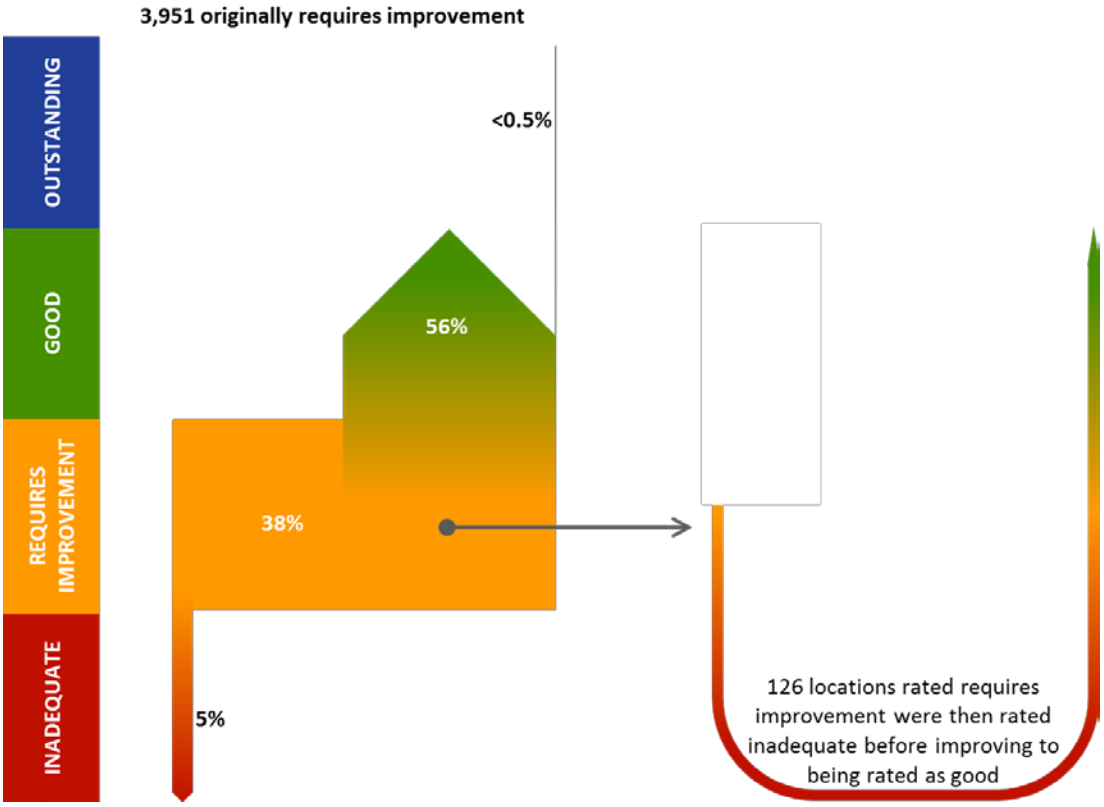
5.2 Services that fail to improve their quality

Although it is very encouraging to see so much attention given to inadequate services that has enabled them to improve, we have not seen the same rate of improvement in services that have been rated as requires improvement. We are clear that providers and commissioners must work to improve services rated as requires improvement to good and outstanding as well.

Of the 3,951 locations originally rated as requires improvement that were re-inspected, 56% (2,211 locations) had improved to a rating of good (figure 18). Of these, 6% (126) first deteriorated to a rating of inadequate, before improving to a rating of good.

However, in 38% of cases, there had been no change, and in 5% of cases, quality had deteriorated, resulting in a rating of inadequate. This means locations that require improvement have improved at a much lower rate than inadequate locations.

Figure 18: Re-inspection of services rated as requires improvement



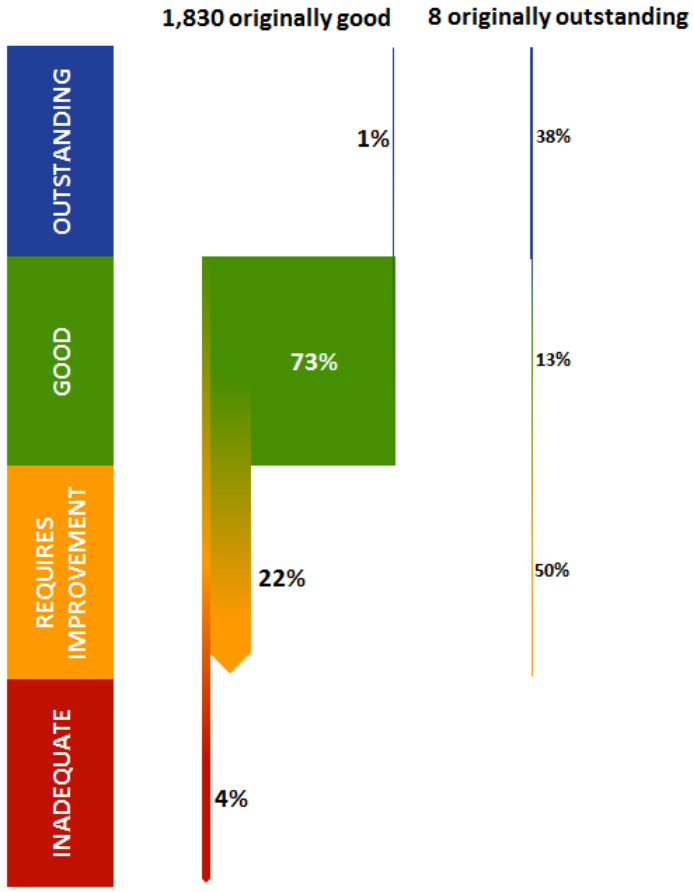
Source: CQC ratings data, 5 May 2017.

5.3 Services where good quality deteriorates

It is important that even good services maintain their focus on quality. Having completed our initial programme of comprehensive inspections, we are now looking at the movement in quality, not only of services rated as inadequate or requires improvement (which we check more frequently), but also those that at first inspection we rated as good. Although these are smaller in number, and the re-inspections are likely to have been prompted by concerns from staff, people using services and their families, or notifications from the provider itself, analysis is beginning to show that even those services that have provided the highest quality can deteriorate.

Of the 1,830 originally good locations that we have re-inspected (some planned as part of our timetable for return inspections but mainly prompted by concerns), only 1% had improved to outstanding. In 73% of cases, there had been no change, but in 26% of cases, quality had deteriorated, resulting in a rating of requires improvement (22%) or inadequate (4%). Even people who use the services of outstanding services can experience a decline in their care – of the eight services originally rated as outstanding that we have re-inspected, half of these have deteriorated by two ratings to requires improvement (figure 19).

Figure 19: Re-inspection of services rated as good or outstanding



Source: CQC ratings data, 5 May 2017

This early information shows that the sector continues to be fragile. Providers cannot afford to be complacent and need to monitor the quality of their services constantly, particularly when there are changes, for example the departure of the registered manager, to maintain a culture of person-centred care supported by well-trained, confident staff.

These findings from our inspections of services originally rated as good mean that we are not as confident as we need to be that services can always sustain their good practice. As we move into a more responsive and targeted phase of our inspections we will keep this under close review. We need to continue to improve the way we listen to and respond to the vital information that alerts us to poor performance, even among those services that have formerly been the best.

6. What is next for the regulation of adult social care services?

6.1 Improving how we work

In *A Fresh Start for the Regulation and Inspection of Adult Social Care* in 2013 we set out how we would change the way we do things – developing our regulatory approach, including ratings, and supporting our staff to deliver a programme of inspections that would build confidence among people who use services, their families and carers; providers; and commissioners.

We have now completed this initial programme of inspections, and we are able to take what we have learned to strengthen our assessments of adult social care services to make sure we continue to find out whether services are safe, effective, caring, responsive and well-led.

In line with our strategy for 2016 to 2021, our regulation of adult social care will also be more targeted, responsive and collaborative so that more people get high-quality care. A new, consolidated assessment framework for all of adult social care was published in June 2017 that reduced duplication between the key lines of enquiry and made more explicit the characteristics of inadequate, requires improvement, good and outstanding services. The consultation also launched in June 2017 seeks your views on the proposed further changes to help us realise our strategy, improve what we do, and to help us adapt to a changing adult social care market.

6.2 Improving services

This report has shown that high-quality services exist in adult social care, and all providers can use the examples here and on our website to strive for excellence. This is positive and to be celebrated but the variability in services means that too many people are experiencing care that we would not want for anyone we love. The difficulties some providers experience in making improvements and the deterioration we have seen in services originally rated as good or outstanding, point to a fragility in the sector that needs to be addressed.

We want more and more services to improve so that people's experiences of care continue to rise. CQC has been working as part of a collaborative group with sector leaders and people using services, their families and carers to create a shared commitment to high-quality, person-centred adult social care – *Quality matters.* This initiative aims to make a difference in care services by working across the sector with people who use these services, carers and families.

One of *Quality matters* central messages is that quality is the responsibility of everyone involved in adult social care. Ensuring people are at the heart of everything we do will help all of us who work in adult social care make a difference for people using services, their

families and carers. This is what CQC will continue to focus on by setting clear expectations; monitoring services, inspecting and rating them; celebrating good care and sharing good practice; ensuring providers know what action they need to take to improve; and taking action if they do not.

The conclusion of our initial programme of comprehensive inspections shows that there is much for the adult social care sector to be proud of but there is still much more for us all to do to ensure the public can have confidence that every service meets the Mum Test.

Acknowledgements

CQC would like to thank the stakeholders in the adult social care sector who have helped us develop this report. We particularly appreciate the support given by the Editorial Panel, which included Ruth Iveson, Jennifer Pearl and Julie Thorpe. They represented the Experts by Experience who have been an important element in our initial programme of comprehensive inspections.

We are grateful to the providers, managers, staff and people who use services that have provided the feedback and practice in our examples in this report that illustrate the very good work that is seen across England in adult social care.

And we would like to thank the CQC inspection staff who have worked hard to complete the initial programme of comprehensive inspections. They have provided a wealth of information, not only for this report, but for individuals looking to choose care and to providers to bring about improvement.

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How to contact us

Call us on > 03000 616161

Email us at > enquiries@cqc.org.uk

Look at our website > www.cqc.org.uk

Write to us at >

Care Quality Commission
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

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