CareQuality Commission

The state of health care and adult social care in England 2015/16

ADULT SOCIAL CARE

STATE OF CARE

Adult social care

Key points

- Services that were rated good and outstanding engaged well with people who use services, their families and carers, and the community to design care plans, facilities and activities that meet people's diverse needs and preferences.
- The quality of care continued to vary. Particularly striking was the difference between the key question about caring, which performed best, and the comparatively lower performance of safe and well-led. Good systems and management are important drivers that support caring staff to deliver better services.
- The adult social care sector continues to experience financial strain. Further efficiencies are difficult to achieve, due to staffing being a high proportion of costs, and profitability is reducing, leading to some services exiting from the market. The potential impact of these exits are people having less choice or experiencing a lack of continuity of service, and delays in securing them a package of good quality care that meets their needs and preferences. It is also likely to lead to greater use of unpaid care.
- Some of the services we rated inadequate have subsequently closed and are no longer operating. Of the inadequate services we re-inspected, more than three-quarters (77%) were able to show us that they had improved the quality of their care. This improvement is closely linked to good leadership that helps shape a more positive culture within a service.
- Of services that we re-inspected after initially rating them as requires improvement, 43% were able to improve, while 8% had deteriorated to inadequate.

Introduction and context

The regulated adult social care sector in England is large, with services being delivered in more than 25,000 locations. We regulate:

- accommodation and personal care provided in residential care homes, nursing homes and specialist colleges
- services provided in people's homes through domiciliary care services
- services provided in the community through extra care housing, Shared Lives schemes and supported living services
- inpatient hospices, day hospices and community-based hospice services.

As described in part 1 of this report, the sector continues to be under pressure from increased demand, coupled with financial strain and difficulties in recruiting and retaining staff. This puts many adult social care services in a fragile position. The reports of our inspections monitor the quality of care delivered and the experiences of people who use services.

We have a number of concerns about the current state of adult social care in England:

Recruitment is a problem for many providers, both in terms of attracting and retaining staff

- Recruiting nurses remains a significant concern. Some providers have considered providing residential but not nursing care, because they could not recruit enough staff. Others have responded by training and developing other care staff to expand their roles and making links with universities to encourage nurse recruitment as well as offering apprenticeship schemes.
- It is estimated that non-British EU workers made up 7% of the adult social care workforce in 2015/16 – equating to around 90,000 jobs – and it is uncertain as to the extent to which they will be affected by the vote to leave the European Union.

Many providers are under considerable financial pressure

- Many directors of adult social services (84%) reported that providers are facing financial difficulties now.
- The introduction of the national living wage is increasing financial pressures. In adult social care, staff costs are a high proportion of total costs. Our analysis of some of the largest providers suggests that staff costs are around 60% of total costs in residential care homes, and around 80% in domiciliary care.
- The funding and staffing pressures are leading to reduced profitability – especially for providers more reliant on local authority funding. Analysis of some of the largest providers shows that care home providers where over half their turnover is funded by local authorities, on average, achieve 10% less fee income per bed and 28% less profit per bed compared with all providers. This data has also shown that the profit margin for domiciliary care providers has continued to fall.

These pressures have led to services exiting the market

- 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. For example, Mears Group has served notice to both Liverpool City and Wirral councils for offering hourly rates of £13.10 and £12.92 respectively, compared with the minimum £16.70 recommended by the United Kingdom Homecare Association. They said this would "lead to unworkable pay and conditions for care workers" and "the people who will suffer the most are those receiving care".
- Smaller providers are particularly susceptible to closures, and we are concerned that reduced capacity limits people's choices in an area and may force local authorities to use poorly-performing providers.

Adult social care providers were often frustrated at the lack of integration with other providers

- A lack of joint working on admission and discharge from hospitals was a key issue. When not done well over a period of time, this could result in an entrenched reluctance between different providers to develop and maintain closer working relations.
- However, innovation in this field exists – for example, there is an initiative in a domiciliary care service where GPs or community professionals can make referrals to the service to try and prevent people having to be admitted to hospital.

Despite the pressures on services, people should still expect and receive safe, effective, compassionate, high-quality care that responds to their needs. Our findings show that some types of service are more resilient than others – both in terms of their quality and their ability to remain in the market. We have also found that certain characteristics help a service to improve, which can lead to it becoming good or outstanding.

Overview of quality

We now have a much stronger baseline of information that tells us about the quality of adult social care across the country. From October 2014 to the end of July 2016, we inspected and published ratings for more than 16,000 adult social care services.

At the end of July 2016, 72% of all services were rated good or outstanding (figure 2.1), compared with 60% when we published our findings for last year's *State of Care* report. Correspondingly, 2% of services were inadequate at the end of July 2016, compared with 7% when we published our last report.

These figures give a more positive picture of performance this year. They can partly be explained through our inspection programme being aimed at visiting those services where we had greater concerns first. But they also reflect the improvements that we have seen when we have gone back to re-inspect services that were first rated inadequate or requires improvement – we returned to 2,370 such locations rated up to the end of July 2016. However, overall 28% of services still need to improve, putting people at risk of poor care.

We saw variation in the quality of care across our key questions, and in the type of services, the size of services and the type of care needs.

In terms of our key questions, services remained stronger in some areas of care than others. The key question about caring performed best – 92% of services we rated were good (90%) or outstanding (2%) at being caring, meaning that staff are involving and treating people with compassion, kindness, dignity and respect. However, we think that the difference between this high performance and the performance of safe and well-led, with only 68% and 71% being good or outstanding respectively, is striking. In too many services, good staff are not supported by good systems that can protect people from abuse and avoidable harm, or by leaders who promote high quality and an open and fair culture. For example, a culture of failing to notice problems and of "doing just enough to get by" was seen by our inspectors as being a significant barrier to improvement.

Some types of services performed consistently better than others. Services that specialise in community social care and hospices performed highest: 84% of community social care locations (92% for Shared Lives services) and 93% of hospices were rated as good or outstanding overall. Domiciliary care services and residential homes performed similarly to each other. Nursing homes remained the biggest concern, with 41% being rated inadequate (4%) or requires improvement (37%). They were particularly poor in our assessments of being safe and being well-led, due to failings in areas like medicines management and staffing.

There was also variation in performance depending on the size of services. Figure 2.2 shows that,

generally, small care homes performed better than medium or large ones. This pattern may be partly, though not wholly, attributable to smaller services being dominated by provision for people of all ages with a learning disability. The pattern could be emerging for domiciliary care agencies as well, but we need to gather more information and explore this further.

Our registration data shows that there has been a 12% drop in the number of small residential homes (1 to 10 beds) and a 27% rise in large homes (50 beds or more) since 2010, although large homes still only make up 6% of locations. Since smaller homes perform better overall, we are monitoring these trends further to understand their effect.

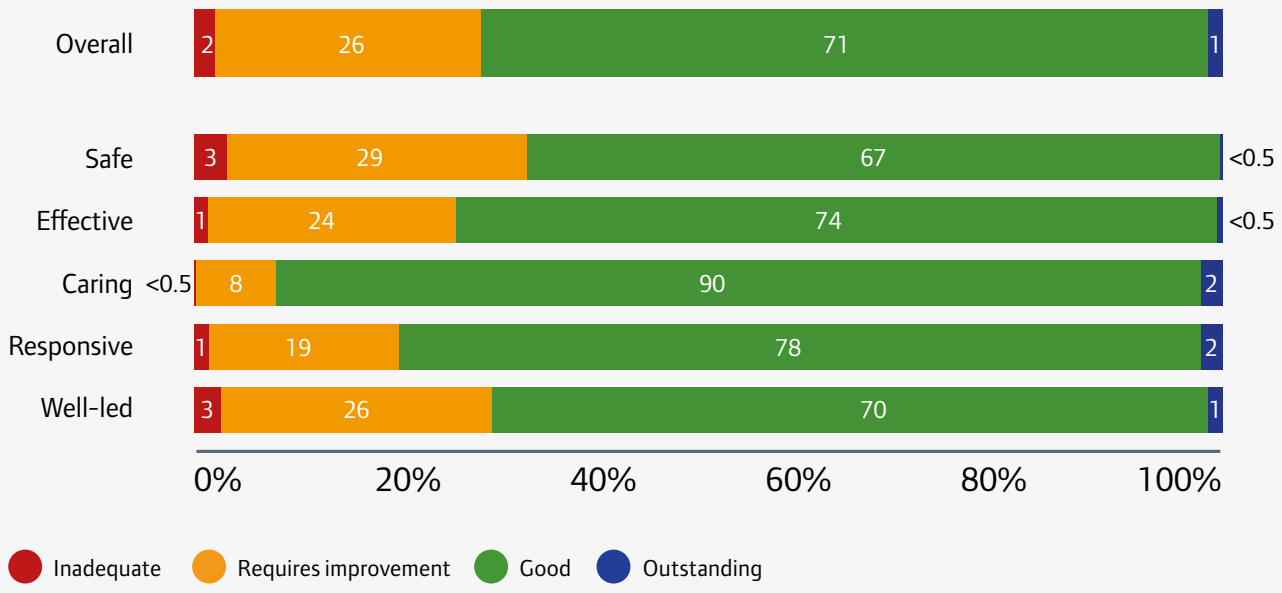
Our analysis also shows services that care for smaller numbers of people often found it easier to demonstrate a good level of responsiveness, for example through a more tailored approach to their support for activities. This was linked to smaller services finding it easier to coordinate staff to deliver person-centred care.

In contrast, larger providers that were performing well had effective internal quality assurance processes, for example electronic systems to simplify management reporting and reduce the administrative workload. These systems could then be used effectively to spot early warning signs of problems.

People may also experience a different level of care, depending on their care needs. Figure 2.3 shows the much smaller proportions of inadequate and requires improvement ratings for services that are registered to care for people with a learning disability, compared with those that are not, in domiciliary care and residential care homes. This positive performance is encouraging and supports the work that national partners, including CQC, have set out through the Transforming Care programme to improve services for people with a learning disability.

The costs of services for people with a learning disability are considerably higher compared with care for older people: for example, in 2014/15 the average cost for nursing care was £552 per week for adults aged 65 and over with physical support needs, compared with £1,119 per week to support adults aged 18 to 64 who have a learning disability.

Figure 2.1 Adult social care current ratings, as at 31 July 2016



Source: CQC ratings data, total of 16,764 services

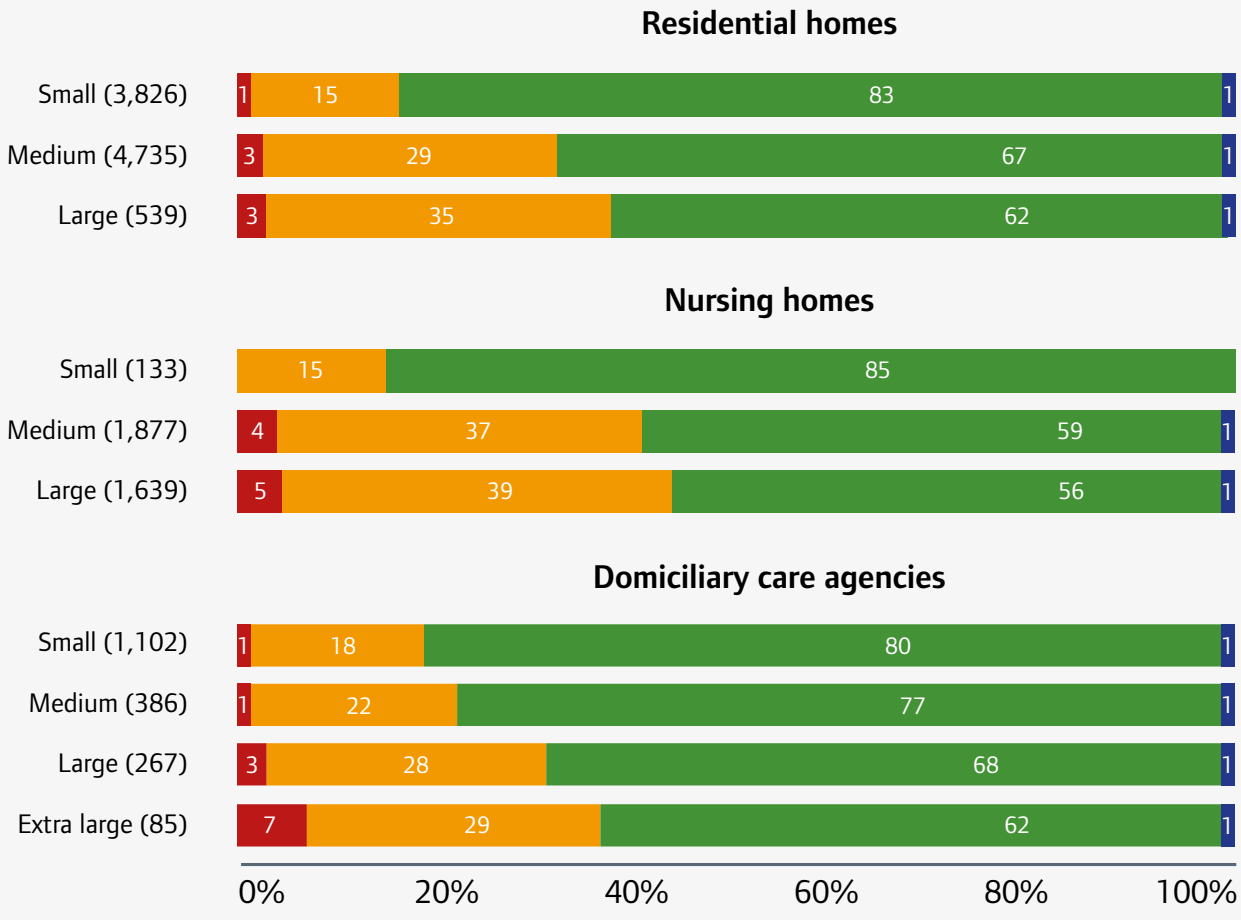
"A home from home"

Vida Hall, Harrogate

Vida Hall in Harrogate, rated as outstanding, is a large nursing home that provides accommodation for up to 70 people who live with dementia. It is purpose built and consists of a main reception area with four 'houses': Woodlands, Orchard View, The Glades and Meadow View. Despite its size, its design helps it to be, in the words of a relative, "a home from home" with "a homely atmosphere".

During our inspection, relatives told us how the manager led the team by example. We saw them speak with people on friendly, first-name terms. Relatives said, "The manager makes all the difference" and "For the rest of my life I will be grateful that my Mum lived here and enjoyed her life." A healthcare professional told us, "Four or five staff have told me that the manager is the most amazing mentor", leading one member of staff to say, "I love it here, it is the best job I have ever had."

Figure 2.2 Current overall ratings by size and type of service, as at 31 July 2016



Inadequate
Requires improvement
Good
Outstanding

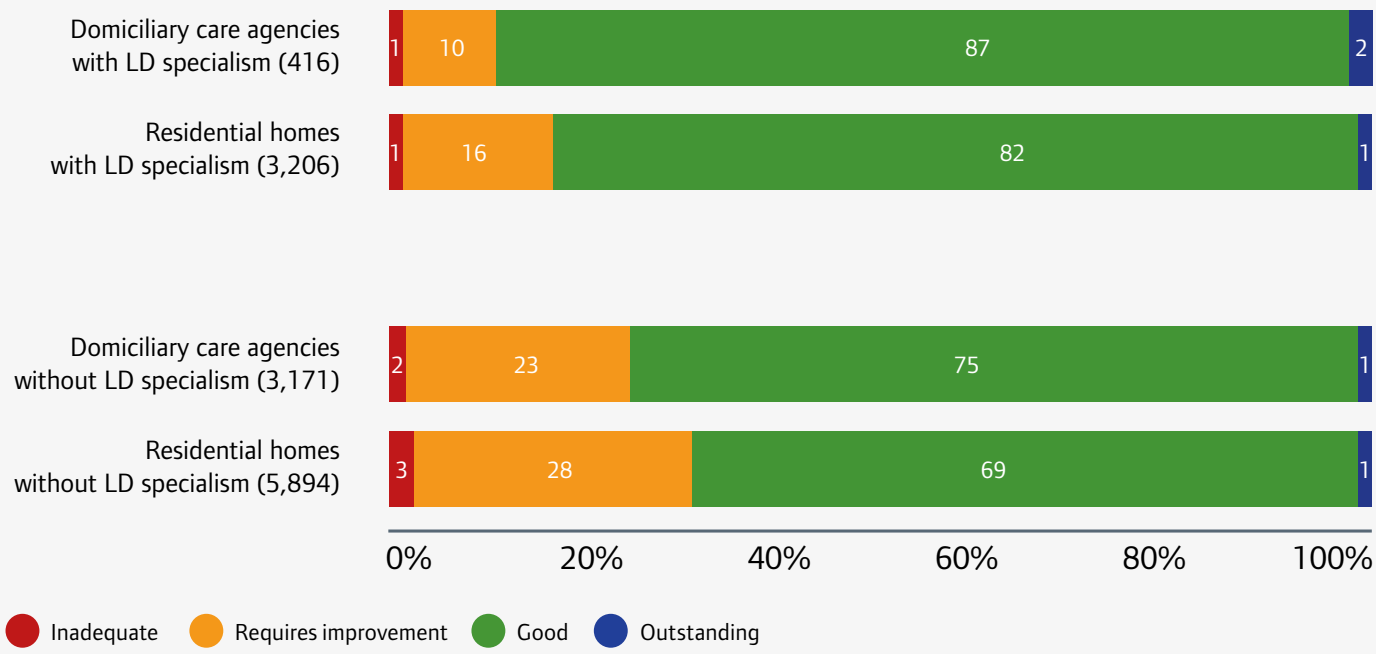
Source: CQC ratings data

Figures in brackets are numbers of locations rated

For nursing & residential homes:
Small = 1 to 10 beds
Medium = 11 to 49 beds
Large = 50+ beds

For domiciliary care agencies:
Small = 1 to 50 people
Medium = 51 to 100 people
Large = 101 to 250 people
Extra large = 250+ people

Figure 2.3 Overall ratings for services with and without a learning disability (LD) specialism, as at 31 July 2016



Source: CQC ratings data

Market trends

Our ratings information above shows how different parts of the adult social care sector have performed. By looking at this alongside our registration information, we can see what patterns are emerging in the sector, which may point to how services are responding to financial and resource pressures, and which services are more resilient than others.

This information will be of interest to local authorities, which have new duties placed on them by the Care Act to promote and shape efficient and effective adult social care markets that meet the diverse needs for care and support of everyone in their area.

Since September 2010, there has been a 47% increase in the number of domiciliary care agencies in England – from 5,780 to 8,517 (figure 2.4). During the same period there has been a 12% reduction in the number of residential (non-nursing) care homes, along with an 8% decrease in total beds – from 255,289 to 235,799. The corresponding figure for nursing home beds has been a 9% increase – from 205,375 to 224,843. With an increasing population of older people, this suggests that more people with low care needs are accessing care in their own home or not receiving a service at all.

However, a closer view of the data for the last 16 months in figure 2.4 suggests that the trend towards increasing numbers of nursing home beds has come to a halt. The maps in part 1 of this report (page 44) show how these changes in nursing home provision have played out across the country. They also reflect the small trend that we have noted of some providers changing their focus from the north of England to the south, where (outside of London) there may be more people self-funding their care.

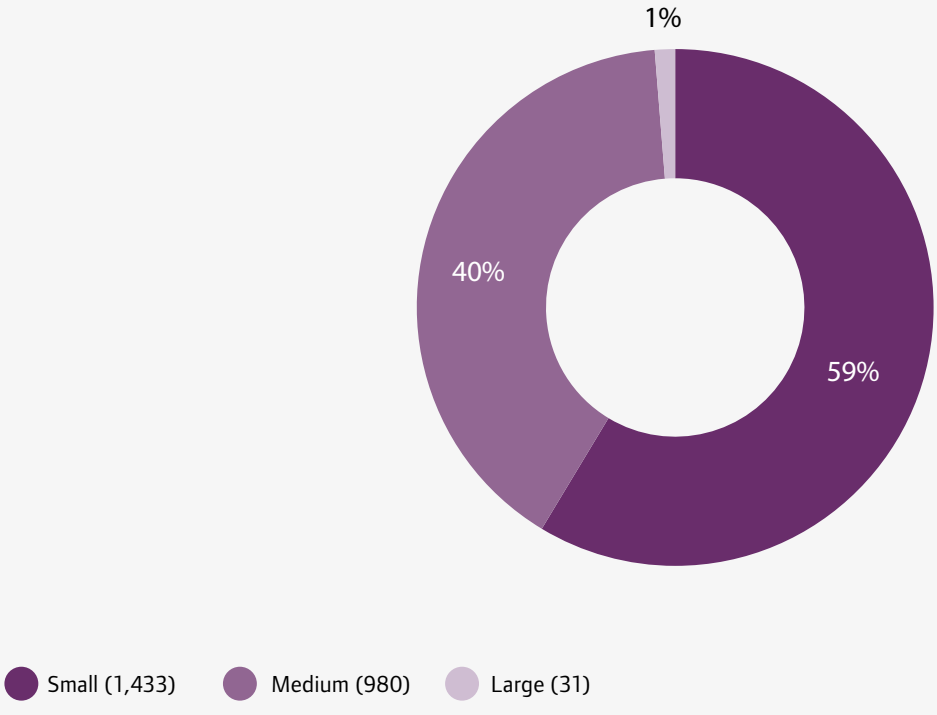
The decline in residential homes can be examined

further by looking at our information on care homes that have exited the market. As shown in figure 2.5, the majority of residential homes that closed were small, which our ratings show perform better than larger ones overall. As mentioned earlier, they are less resilient to financial and resourcing pressures, making them more susceptible to exiting the market. The size profile of these closed homes was different to the size profile of all care homes across the country. For example, 43% of residential homes are 'small', compared with 59% of those that closed.

Of the care homes above that had closed since we started our new inspection methodology (October 2014), 139 had been rated: 37 nursing homes and 102 residential homes. Despite this being a small sample, figure 2.6 shows that the majority of those closures had received an overall rating of inadequate or requires improvement – especially in the case of nursing homes.

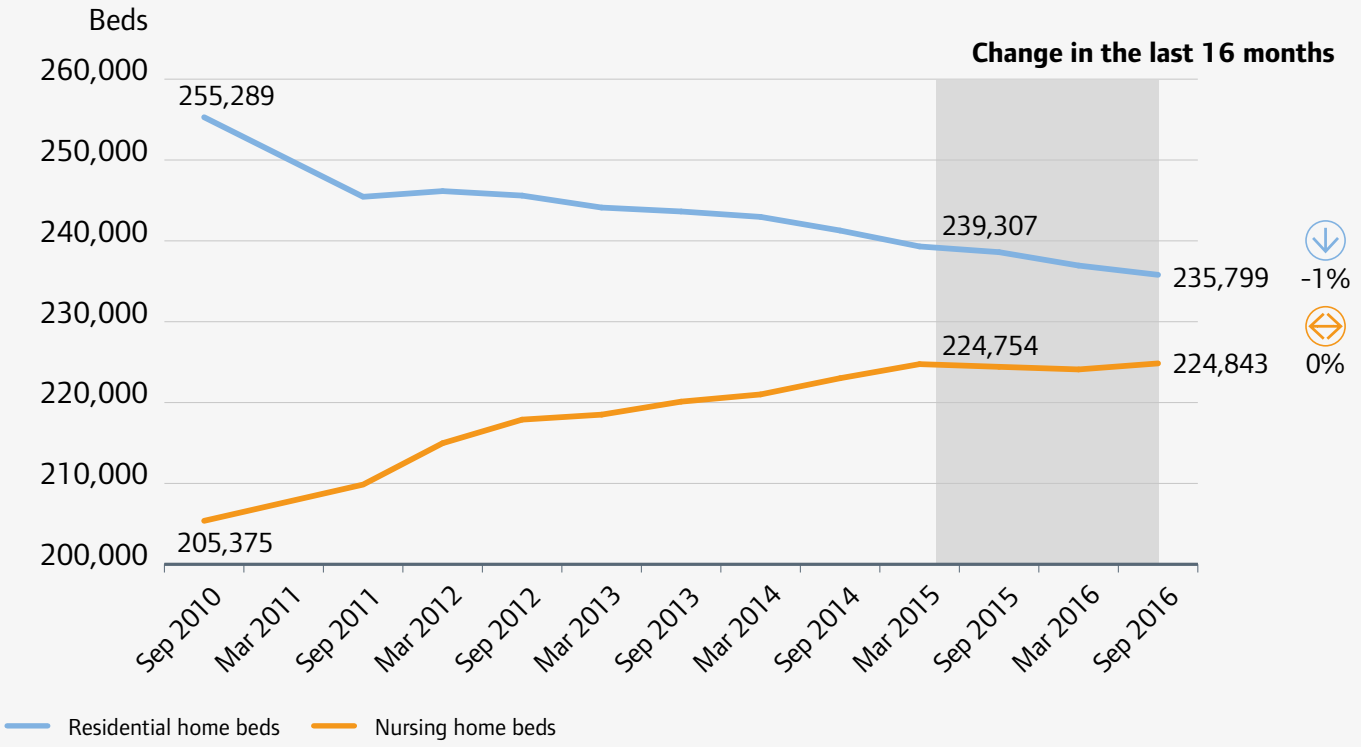
Care home closure can cause a great deal of disruption and anxiety to residents, as well as their families and carers. CQC, alongside partners including NHS England, the Association of Directors of Adult Social Services, the Care Provider Alliance, organisations representing people who use services and carers, providers and Experts by Experience, the Local Government Association and the Department of Health worked together in 2016 to create a good practice guide that seeks to minimise the impact of care home closures on the individuals affected, their families and carers. It starts with the principles that prevention is better than closure, but when it is necessary, all partners need to know what to do to work effectively together and communicate well. Above all, the needs of people who use services must be at the heart of everything we do.

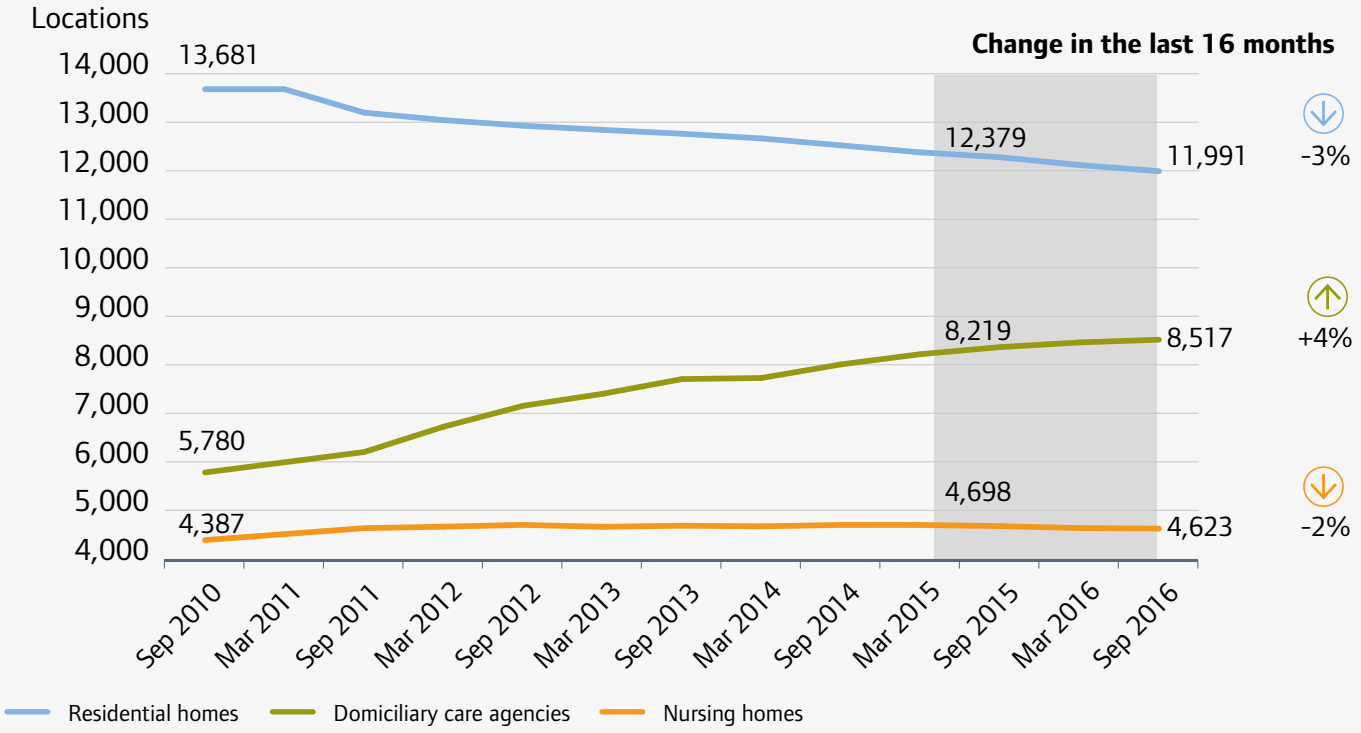
Figure 2.5 Residential home closures by size, October 2010 to December 2015



Source: CQC registration data

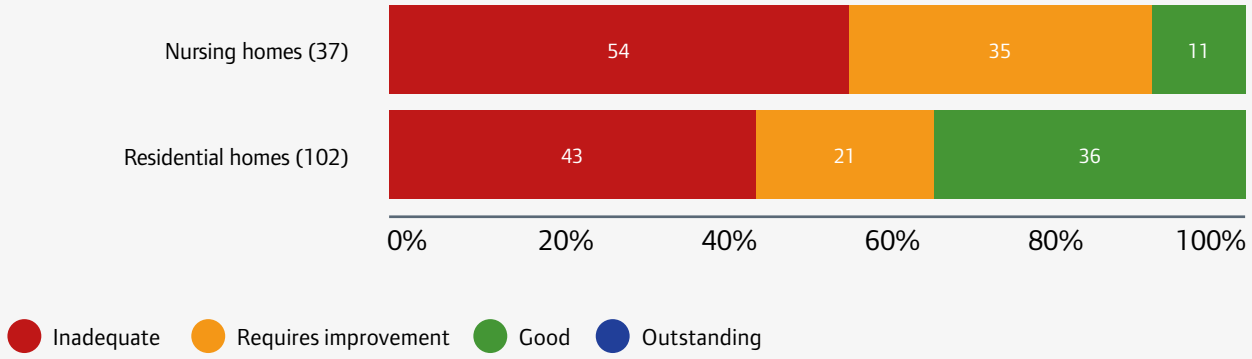
Figure 2.4 Adult social care market trends, September 2010 to August 2016





Source: CQC registration data

Figure 2.6 Care home rating by type of home, prior to market exit, October 2014 to December 2015



Source: CQC registration and ratings data

How to be good or outstanding in responding to people's needs

As at July 2016, there were 156 adult social care services with an overall rating of outstanding, and almost 12,000 that were rated as good. We can now see where certain practices, processes, innovations and cultures can make a real difference to people who use services, their families and carers, and the staff working in them. Where we find outstanding care, we share this through the media and on our website so that the local community can celebrate the difference that outstanding leaders and staff can make to the lives of the people using their services.

Engaging with people who use services and their families and carers is central to designing care plans, facilities and activities that meet their diverse needs and preferences. Good and outstanding practice included:

- personalised care planning that focuses on the whole person, their history, preferences and wishes
- tailoring activities to suit people's wishes, interests and aspirations, and to develop new and existing skills – for example, making best use of the arts to find creative and innovative ways to enable people to have a fuller life
- continuous engagement with people, their families and carers that demonstrably improves the service – for example, involving them to work out how services are provided and to help recruit and train staff
- welcoming families and carers as partners in supporting people and in the life of the service
- homes working in partnership with hospices to develop their ability to enable people to die at their care home rather than in hospital
- bringing the community into homes, and supporting people to remain active citizens by going outside of their home and participating in local facilities and events.

This sort of engagement leads to a culture of delivering person-centred care. We describe an outstanding service as one that is "flexible and responsive to people's individual needs and preferences".

We found that learning disability services particularly grasped the concept of person-centred care by focusing beyond meeting clinical needs and looking at the preferences of people using their services.

As shown in the section of this report about Deprivation of Liberty Safeguards, with a small number of exceptions, staff working in outstanding adult social care services understood the safeguards and incorporated them in everyday practice.

We also found that outstanding care did not always rely on providers spending large amounts of money. Small-scale everyday activities often had a big effect on people's lives. Many examples were simple – such as residents helping with drinks or handing out post.

The important thing was that staff asked people who used the service what they wanted to be involved in, shared this knowledge and then responded to it.

In domiciliary care agencies, a key factor contributing to outstanding person-centred care was staff having enough time on home visits to have meaningful discussions with people about their needs and preferences.

Transforming lives through the arts

The Old Hall, Billingborough, Lincolnshire

The Old Hall is a residential home for up to 20 older people in Billingborough, Lincolnshire. Staff understood the importance of music to stimulate memory in people living with dementia. People were also supported to attend local groups, such as art classes and choirs that they had enjoyed being part of before they moved into the home. A family member told us, "I've nothing but praise. I've seen a transformation [in my relative] since they have been here."

Time to develop relationships

Home Instead Senior Care Agency, Durham

The outstanding Home Instead Senior Care agency in Durham has used its one-hour minimum visits to help develop trusting, meaningful relationships between carers and people using the service. People told us it allowed them time to get to know their carers and feel comprehensively supported. One person said, "They are like family." Families and staff also commented on the benefits of this policy in terms of its impact on people's quality of care. People commended the attitude, patience and dedication of care staff. Relatives described visits by carers as "patient and respectful" and "never rushed". This meant people felt at ease in their own homes and able to build a rapport with care staff.

Improvement

CQC encourages services to improve through our inspections and re-inspections, and our enforcement regime. However, we are only one part of a system that must commit to improving the lives of people who use services. Providers, their leaders and staff have a direct influence on people's experience of care, ensuring their needs and choices are met with dignity and respect. Sustained improvement also depends on commissioning and funding bodies commissioning for quality, as well as all partners in the system working together effectively. Everyone involved needs to ensure that the voices of people who use services, their families and carers are heard and acted on.

Enforcement

Where we find care providers are failing people and breaching regulations, we take action. During 2015/16, CQC took 901 enforcement actions in adult social care, ranging from serving Warning Notices to prosecuting providers. As part of our enforcement framework, we place inadequate services into special measures to give them a clear timeframe in which they must improve, or we will take further action, for example cancelling their registration.

Figure 2.7 shows the number of breaches in each area of the regulations that contributed to inadequate ratings and services being placed in special measures. The most common issue where we took action related to governance, highlighting the need for providers to constantly check the quality of their services, for example by seeking the views of people who use the service, staff, visiting professionals and others, and sharing this to make improvements. Other main issues related to safe care and treatment, and staffing. These findings reflect our feedback from inspectors and inspection reports that showed the main areas of improvement were in medicines management, care planning, safeguarding, quality assurance and auditing, staffing and staff training, and management oversight.

Re-inspections

When we identify those aspects of care that need to improve, we ask the provider what action they will take. We go back to inspect to find out whether they have kept to their commitments and if these have had the required effect.

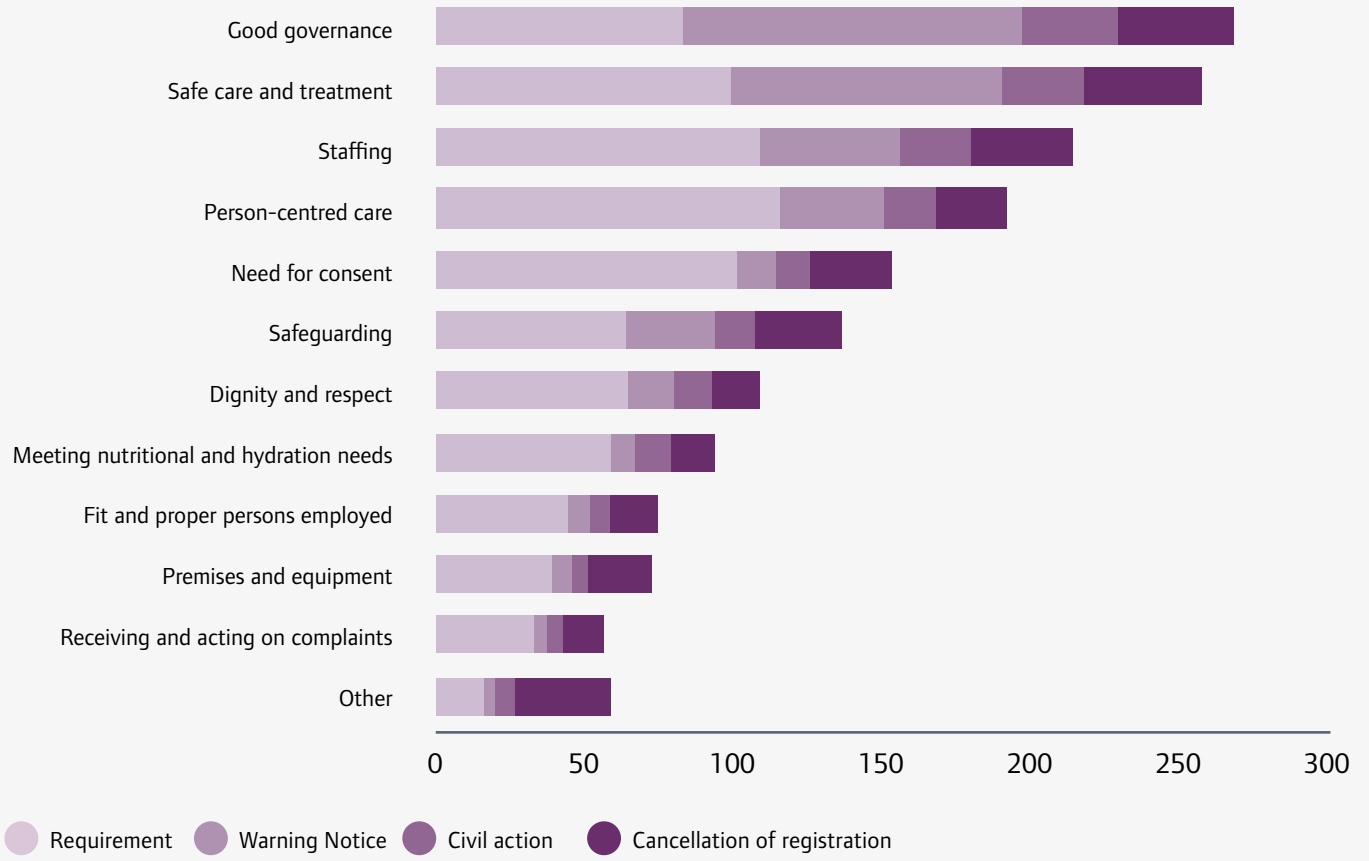
Although some services rated inadequate will have stopped operating, when we re-inspected locations that had a first rating of inadequate, there was a clear

A strong, visible, person-centred culture

ClarkeCare Limited, Suffolk

ClarkeCare Limited (Suffolk) is an outstanding service providing care to people in their own homes. It supports people recovering from an illness or operation as well as people living with life changing conditions such as dementia, multiple sclerosis and Huntington's disease. When we inspected in September 2015, the service had a strong, visible person-centred culture. A relative said how their family member "looked forward to [the care workers'] visit". They put this down to the care workers giving them "a sense of importance, [since the family member] makes the decisions" which validated them as a person, making them feel they were "worth something". Another spoke about how well they "matched their staff" with people and provided examples such as shared interests, which enabled them to "sit and chat, to take the [person's] mind off what is going on". One of the people using the service told us, "I've struck lucky with the carers. They are lovely, I can't fault them, everyone is so nice, I feel when something is good I should sing their praises."

Figure 2.7 Regulatory actions against locations rated inadequate overall, as at 6 April 2016



Note: Locations may have more than one breach.
The average number of regulations breached per location was six.

Source: CQC ratings and enforcement data

picture of improvement. After 520 re-inspections, 399 (77%) locations received improved overall ratings (figure 2.8). Of these 399, 110 locations improved by two ratings from inadequate to good. In care homes alone, which were the bulk of these inspections, services that can care for more than 15,000 people across the country now provide better and safer care.

Locations that were first rated as requires improvement did not improve at the same rate. Of the 1,850 locations re-inspected, 43% had improved. In 49% of cases, there had been no change, and in 8% of cases, quality had deteriorated, resulting in an inadequate rating.

It is good that attention is given to inadequate services to help them address concerns quickly.

But we are clear that the rating of requires improvement is not good enough, and providers and commissioners must work hard to convert those services rated at this level to good and outstanding.

Our analysis has highlighted what some local authorities and clinical commissioning groups, as key influencers of improvement, can do that goes beyond their funding role. Specific initiatives have helped services to improve, such as the provision of a care home team that was set up by a clinical commissioning group to help care homes make changes. One local authority had helped a service to write its action plan to make sure the key issues in its inspection report were addressed.

How services improve

Our ratings show that 29% of services required improvement or were inadequate when we asked whether they were well-led. It is, therefore, clear that good leaders in care services have a big influence on the quality of care that people receive. This is supported through our wider analysis of our inspections.

Good managers 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.

New management and changes in management attitude and behaviours, and a willingness to think imaginatively, were often seen as important factors in bringing about change.

Examples from our analysis included a new manager at a previously failing nursing home who reassessed everyone who remained in the home to make sure the service could fully meet their needs. At other services, new managers put in place improved quality assurance systems, made sure improved policies were being implemented, addressed cultural issues (such as bullying and favouritism), and improved incident reporting procedures.

Managers also made simple improvements, which made them more available to staff and better able to observe care practice. These included introducing regular walks around the service, having an open door policy to both staff and people using the service and their families, and actively involving themselves in all areas of the service.

We also found that existing managers who were open to challenge, who were willing to work with and listen to our inspection findings, and who chose to move forward and learn, were more likely to make changes that would improve services following an inspection.

Figure 2.8 Change in overall ratings on re-inspection in adult social care, where initial rating was inadequate or requires improvement, as at 31 July 2016

Source: CQC ratings data. Note: The width of each cluster of arrows is relative to the number of re-inspections carried out.

Care Quality Commission

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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