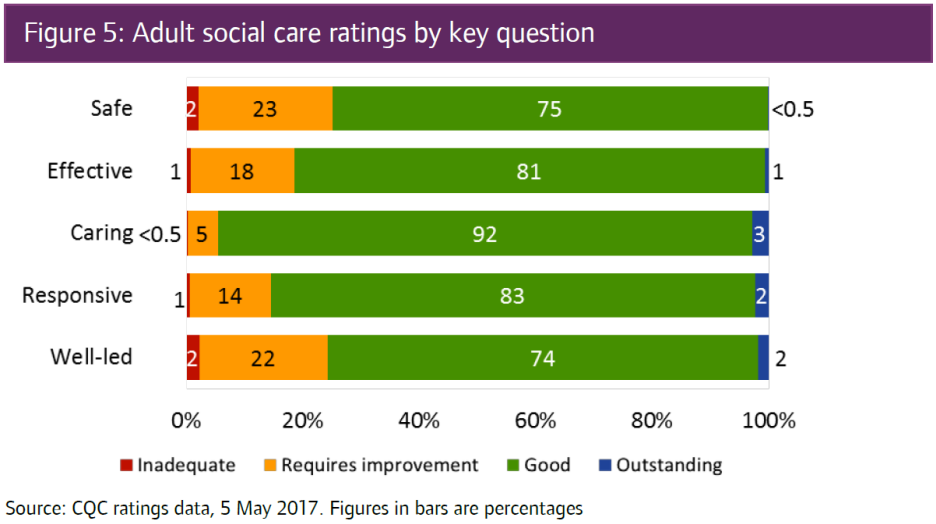
CQC The state of adult social care services 2014 to 2017: reflections from a co-operative care perspective

July 2017

This paper reflects on the latest CQC report from a co-operative care perspective. Reports such as these frame and influence the public and political discourse around care and welling. Knowing what the CQC is saying and considering where co-operative approaches offer something in response is crucial. This paper is intended to be conversational, rather than setting out final positions.

1. Addressing negatives: making 'requires improvement' 'good'



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

Roughly 20 percent of providers require improvement. Underneath this headline will be a variety of human costs, service failures and knock-on costs for the system.

The key areas where the CQC data suggests we need to see systemic improvement at the negative end of the scale are:

- Safety
- Leadership (including culture)
- Effectiveness (outcomes, wellbeing)
- Responsiveness

The CQC report says staff levels, and staff training, along with leadership and culture are key factors:

"Staffing levels were a key factor in providers rated as inadequate or requires improvement for safety.

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

When it comes to dealing with issues at the negative end of the scale, care worker-owned models may have a particularly strong and straightforward offer. We've been told by one leading care worker-owned co-op that it has been able to stay in tough care markets and continue to invest in people because it does not have to generate the 10 percent ROI investor-owned providers do. Care worker ownership also enhances working lives and positively influences cultures and leadership.

This is not to say that multi-stakeholder models could not have huge positive impacts here too, on all fronts. But the clarity of the care worker-owned offer in addressing issues of staffing, basic safety and leadership gives it a particular strength in discourse about the negatives. Perhaps the multi-stakeholder model offers something more transformative for the system than just addressing the 'bottom' 20 percent.

2. Does size matter?

The CQC report suggests that smaller providers are statistically better performers overall.

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

Once provider or provider location sizes are over 100 people, there appears to be a significant increase in these units requiring improvement and also a slightly increased likelihood of them being inadequate.

The data suggests that the main correlation between performance and size is that larger providers or provider locations have a greater risk of developing shortcomings and inadequacies.

However, the CQC noted that the overall ratings of 'corporate providers' (a provider with 20 or more branches), had very similar ratings to providers overall. It also pointed out that corporate providers have been better at improving since a first rating of inadequate. CQC thinks this might suggest that corporate providers are more equipped to step in to support any of their locations that are performing poorly. The CQC reports that some larger corporate providers have quality turn-around teams to address problems at individual locations.

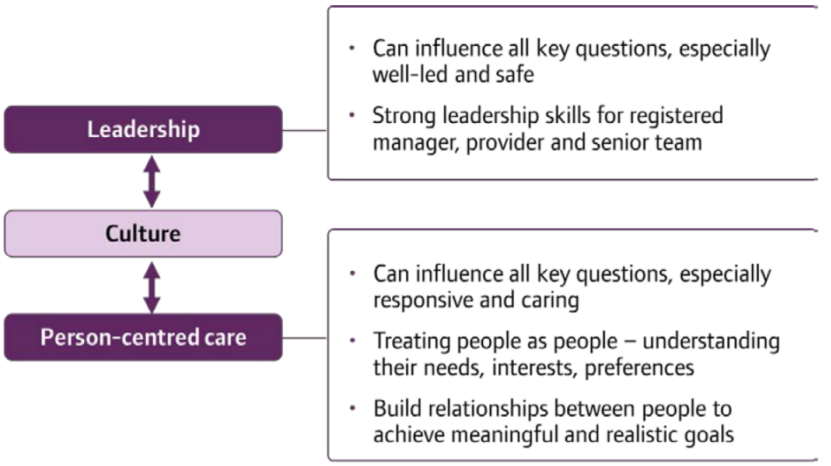
So, perhaps small units are best, but if a unit is bigger, it is better if it is part of a larger organisation.

Co-operative models have a number of things to offer here. As co-ops require less hierarchy and commodification of activities, they can combine the benefits of large corporate groups with small-scale responsive provision. The segmentation and secondary co-operation approaches in particular offer a lot. This could apply both to micro-provider co-ops like Choices4Doncaster and a clustered multi-stakeholder model.

3. What makes for high-quality care?

The CQC identifies leadership, culture and person-centred care as the key features of high-quality care.

Figure 11: Characteristics of high-quality care



We believe, but will need to do better at articulating and demonstrating, that co-operative approaches to care, and multi-stakeholder models in particular, can provide a cohesive organisational structure for enabling all of the above to happen. Co-operative approaches involve:

- **Mutual purpose** – orientating the purpose of the organisation, the lines of accountably and the duties of those in charge, towards the needs and aspirations of members (users, community, practitioners)
- empowering users, family, communities and practitioners with **real agency** in the development and operation of the organisation, including through the exercise of **democratic ownership and control**
- involving users, family, communities and practitioners in **actively co-creating the value** in the organisation, where the starting point is what people can do better together than they can alone

4. Shared Lives

The Shared Lives model has performed particularly well in CQC investigations. The CQC says:

*"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. 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"*

It is important to note that there are many features, outputs and outcomes of the Shared Lives model that we would like to see in co-operative approaches, and which the more ambitious elements of the Care Act would seem to require.

Shared Lives is gaining traction as a model that can make positive impacts on the system in a variety of ways.

Is it a rival remedy to co-operative approaches? Or do we need to consider how co-operative approaches could be applied to Shared Lives? For example Shared Lives Plus has many co-operative characteristics, in terms of bringing Shared Lives carers together and servicing their needs and aspirations.

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