

Quality of Care management in England

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Adelina Comas-Herrera
Director, Global Observatory of Long-Term Care
Care Policy and Evaluation Centre
London School of Economics and Political Science

a.comas@lse.ac.uk
@adelinacohe

Measuring quality of care (Donabedian)

Structure – process – outcome



Responsibility for Quality of Care in England

- Care services are regulated by an independent national body: Care Quality Commission (CQC), same body for hospitals, GP practices, dentists, ambulances, care homes and home care agencies.
- Before a provider can carry out activities, they must register with CQC and demonstrate they meet legal requirements
- CQC assesses whether providers are safe, effective, caring, responsive to people's needs and well led
- CQC undertakes inspections of providers and publishes ratings for each provider as either outstanding, good, requires improvement or inadequate, and has the power to close services where necessary.
- Previously different sectors were inspected separately, but creation of a single assessment system and non-specialised teams.
- Single Assessment Framework: 34 areas of care quality aligned to 5 key questions/domains.

CQC fundamental standards that people have a right to expect (1)

1. You **must have enough to eat and drink** to keep you in good health while you receive care and treatment.
2. You **must have care or treatment that is tailored to you** and meets your needs and preferences.
3. You **must be treated with dignity and respect** at all times while you're receiving care and treatment.
4. The **place** where you receive care and treatment **and the equipment** used in it **must be clean, suitable and looked after** properly.
5. You (or anybody legally acting on your behalf) **must give your consent** before any care or treatment is given to you.
6. You **must not be given unsafe care or treatment** or be put at risk of harm that could be avoided.
7. You **must not suffer any form of abuse** or improper treatment while receiving care.

CQC fundamental standards that people have a right to expect (2)

7. The provider of your care **must have a system to handle and respond to complaints.**
8. The provider of your care **must have enough suitably qualified, competent and experienced staff** to make sure they can meet these standards.
9. If something goes wrong with your care and treatment, the provider of your care **must tell you what has happened, provide support and apologise.**
10. The provider of your care **must have plans that make sure they can meet these standards.**
11. The provider of your care **must display their CQC rating** in a place where you can see it.
12. The provider of your care **must only employ people** who can provide care and treatment **appropriate to their role.**

CQC: inspection and quality ratings

Once a service has been registered with CQC it is monitored continuously

Inspections: involve talking to staff and people who use the services, observation of care, checking systems and processes, including looking at individual records.

Five key questions:

1. Is it safe?
2. Is it effective?
3. Is it caring?
4. Is it responsive?
5. Is it well-led?

Quality ratings

-  Outstanding
-  Good
-  Requires improvement
-  Inadequate

If services are failing, CQC does the following:

- Give care providers notices setting out what improvements they must carry out and when
- Hold the care providers to account by:
 - Issuing cautions
 - Issuing fines
 - Prosecuting cases where people are harmed or put in danger
- Limit what the care provider can do
- Place a care provider in “special measures”, which gives them a clear timetable by which they must improve, or they will be de-registered.

How is the CQC working? Not so well

Concerns about how CQC is working in practice led to an independent review into their operational effectiveness in 2024. Findings:

- **Poor operational performance:**
 - Huge backlog of assessments and long waits for registration of new providers
 - Long wait for re-inspections, so providers stuck with negative rating despite having carried out inspection.
 - Very outdated ratings
- Significant challenges with the online platform
- Loss of credibility within the sector due to loss of sector expertise
- **Concerns about the Single Assessment Framework:**
 - No clear description of “what good, or outstanding, looks like”, providers don’t understand what inspectors are looking for
 - Lack of focus on outcomes (narrow set of metrics), not including social care-related quality of life (which is available at Local Authority level).
 - Lack of transparency on how data on user experience is collected
 - No encouragement of adoption of innovation
- Lack of clarity about how the ratings are calculated and concern about use of outcomes from previous inspections to calculate ratings.

Assessing the quality of the system by measuring outcomes of care:

The Adult Social Care Outcomes Framework (ASCOF)

- ASCOF is used locally, regionally and nationally to measure progress against key priorities, with the aim to drive continuous improvement.
- Data is collected at council, regional and national level (using a survey) for each outcome, for Local Authority funded people (does not collect data on self-funders) and shared publicly.
- It includes outcomes for unpaid carers as well as for the person who uses care.
- However, while the data is valued by council staff, data not used to its full potential due to lack of resources, and lack of understanding of how to identify the causes of reported outcomes.

Adult Social Care Outcomes Framework (ASCOF)

Examples:

1A: Social care-related quality of life score (out of 24):

- North East has the highest overall quality of life score (19.4), London has the lowest (18.5). At national level, males report a higher overall quality of life score than females, with 19.3 compared to 18.9.

5A2: The proportion of Carers reporting that they had as much social contact as they would like:

- Proportion has increased to 30.0% in 2023-24 from 28.0% the last time the measure was produced in 2021-22. The proportion is higher for those carers aged 65 and over (31.2%) than those aged 18-64 (28.2%).

2B and 2C: Long-term support needs met by admission to residential and nursing care homes, per 100,000 population:

- The number of people whose long-term support needs were met by admission to residential and nursing care homes, per 100,000 population increased to 15.2 for ages 18-64 and 566.0 for ages 65 and over in 2023-24, from 14.6 and 560.8 respectively in 2022-23.

2D1: Reablement for service users aged 65 and over:

- The proportion of older service users (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services was 83.8% in 2023-24, an increase from 82.3% in 2022-23. London has the highest proportion (87.9%) with the South West region having the lowest (79.6%).

Focus on Outcomes, but how are they used?

- Outcomes defined as the effect of support on the wellbeing and quality of life of people who use services (including people with support needs and unpaid carers)
 - Unpaid carers are considered “co-clients” and are entitled to a needs assessment of their own
- Outcomes data is collected routinely
 - Needs assessment and care planning
 - Commissioning services or applying for grants and contracts
 - In-house monitoring for service planning and delivery
 - Providing feedback as part of local accountability
- Perception of care professionals that collecting data on outcomes is beneficial to demonstrate impact, but challenging to implement and to account for contextual influences on outcomes.

Process matters: study on the influence of perceptions of care experience on Quality of Life (measured using ASCOT)

- Interpersonal aspects of care have the strongest relationship to ASCOT, more important than organisational aspects.
- This suggests that measures of the interpersonal experience may be used as proxy for outcomes, but this is not so much the case for organisational aspects of care.
- For people with higher care needs and whose homes were not well designed to meet their needs, the effects were stronger, which may reflect more important role of services in their lives.

Why structural and process factors matter

- Study matching a national staffing database of LTC providers with local area information on needs and supply and quality ratings.
- Found that wages positively affect the quality ratings of care homes.
- A 10% increase in the average hourly rate results in 7.1% increase in the probability of having a high -ranking.

Final considerations from the English experience

- The outcomes of care depend on structural and process factors, it is important that a system recognises this link when measuring quality and to be able to use outcome data to inform continuous improvement.
- Accreditation and regulation bodies need to have sufficient capacity so as not to worsen problems with supply of care.
- The English experience suggests that it is important that inspectors have expertise on the long-term care sector.
- It would be helpful that the instruments used to assess quality at provider level are connected to the data collected through national/regional/local surveys of people who use care and family carers.

Gracias!

Adelina Comas-Herrera

a.comas@lse.ac.uk