The Care Quality Commission's New Inspection Methodology

If you are a provider of adult social care in England, you will be aware that the Care Quality Commission is updating its Inspection Methodology and the system it uses to inspect and decide on ratings for care services.

As a care provider its essential to understand what is being changed and how these changes might affect you.

This short guide gives you the in depth background to these changes, what is being changed and what is staying the same based on all currently available information, so that by the end of reading it you and your care service will be as prepared as possible for those changes.

I have utilised and pulled together information obtained from the regulator, local inspectors and from various guides available on the internet from other people and organisations.

Mark Topps – December 2023
Version 3

Contents

Why are they changing?

Focussed on four strategies:

- People and communities
- Smarter regulation
- Safety through learning
- Accelerating improvement.

The strategy aims to make the regulation of Adult Social Care services more flexible and relevant.

The CQC's strategy sets out an ambitious future that will ensure they keep delivering their purpose. To deliver that strategy effectively, they stated that they need to change how they work.

They know that it's important to understand the quality of care in a local area or system in order to improve it and keep people safe. It's often when people move between care services that they fall through the cracks and have a poorer experience.

They now have new regulatory powers that allow them to offer the public and Parliament a meaningful and independent view on care at a system and local authority level and they need to make sure that they use their new and existing powers effectively to improve people's care and deliver their strategy, so they are changing how they work and how they regulate to do this.

Before the pandemic, CQC were clear that they needed a way to look at the quality of care across health and care systems. They knew their regulation needed to be less complex and more efficient. They wanted to regulate in a smarter way – being able to adapt and respond to risk, uncertainty and demand, with data and information at their fingertips. The pandemic highlighted the areas that they already knew needed to change.

As they emerge from the pandemic, the health and care sector itself has changed and is struggling to recover along with new challenges and risks. They want to work with the sector, as an effective partner and know that they cannot stand still – they have stated that they must transform to adapt to the changing nature of health and care provision and the changing needs of people who use services.

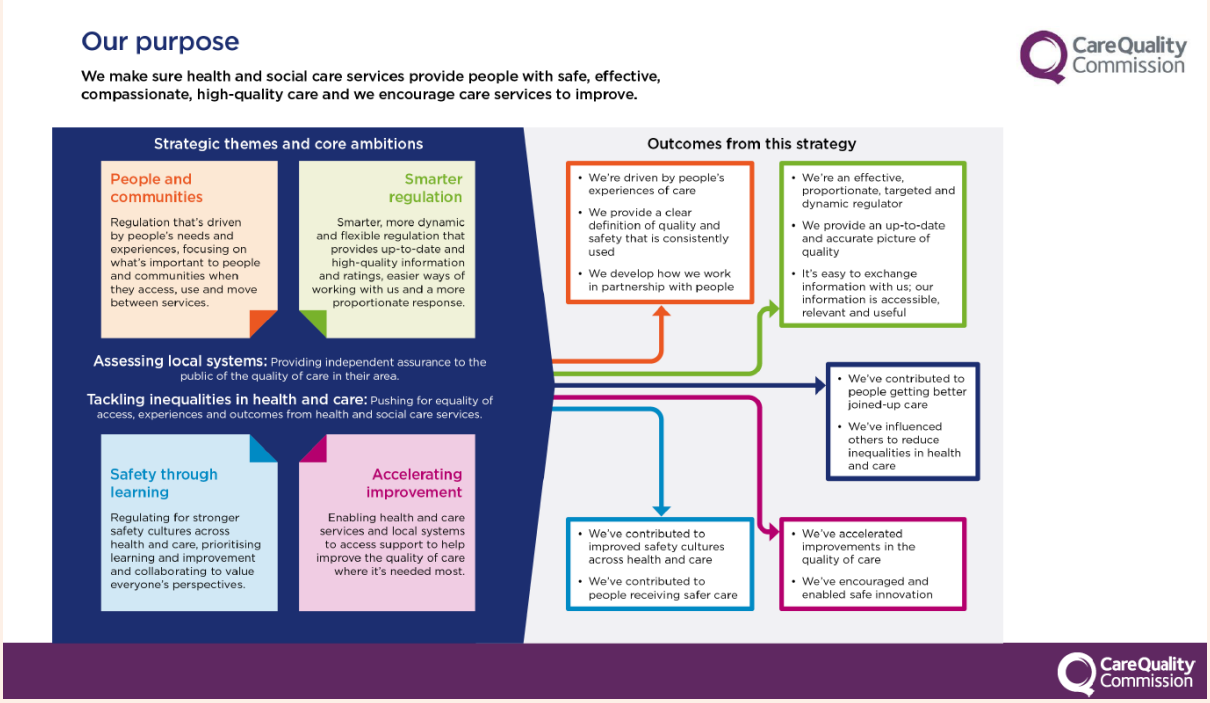
The regulator wants to have clear ratings which are current and meaningful for providers and public. They want ratings that are more transparent for providers to understand how they are calculated and to help them target the improvement needed whilst ensuring that they are more easily understood and useful to the public.

They want to use data and insight to help them focus their scarce resources and allow them to spend more time with providers on improvement activities.

They want to address the concerns from providers and ensure a consistent approach that can be flexible and can respond to changes, for example it will be that same method that they use to assess ICS's and Local Authorities.

They aim to:

- Have greater focus on care across local areas and systems.
- To use their new regulatory powers to effectively improve people's care.
- To make their regulation less complex and more efficient.
- To regulate in a smarter way.
- To work better with the sector as it changes and recovers.



By delivering this strategy, they aim to achieve 12 outcomes:

People and communities outcomes:

- Our activity is driven by people's experiences of care.
- We clearly define quality and safety in line with people's changing needs and expectations. This definition is used consistently by all people, and at all levels of the health and social care system.
- Our ways of working meet people's needs because they are developed in partnership with them.

Smarter regulation outcomes:

- We are an effective, proportionate, targeted, and dynamic regulator.
- We provide an up-to-date and accurate picture of quality.
- It is easy for health and care services, the people who use them and stakeholders to exchange relevant information with us, and the information we provide is accessible, relevant, and useful.

Safety through learning outcomes:

- There is improvement in safety cultures across health and care services and local systems that benefit people because of our contribution.
- People receive safer care when using and moving between health and social care services because of our contribution.

Accelerating improvement outcomes:

- We have accelerated improvements in the quality of care.
- We have encouraged and enabled safe innovation that benefits people or results in more effective and efficient services.

Core ambitions: Assessing health and social care systems, and tackling inequalities in health and social care

- We have contributed to an improvement in people receiving joined-up care.
- We have influenced others to reduce inequalities in people's access, experiences and outcomes when using health and social care services.

What's Staying the Same?

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Fundamental Standards (Regulations 9 to 20) have not changed and remain in place.

Whilst this has not changed, there is a requirement for all health and social care providers who carry out regulated activities to ensure that their staff receive specific training appropriate to their role on learning disabilities and autism. The Secretary of State (SofS) is also required to produce a Code of Practice with regards to training on learning disability and autism.

The CQC will continue to use:

- The five key questions (safe, effective, caring, responsive and well-led)
- The four-point ratings scale (Outstanding, Good, Requires Improvement and Inadequate)

What's Changing?
Summarised

Their new assessment approach means they are moving away from separate 'monitor,' 'inspect' and 'rate' steps. Instead, they will use information from a range of sources to assess providers more frequently and in a more flexible way, without being driven by a previous rating. This is key for them to achieve their strategic ambition of providing an up-to-date view of quality.

New Policy – The regulator will use a new single quality assessment framework for all service types and at all levels, from registration through to provider assessments and assessments of integrated care systems (ICSs) and local authorities. This will be the basis for their judgements about quality.
They have already improved how their notifications work, making providers' lives easier, as well as ensuring that the information they receive comes in a structured way so that they can analyse it quickly.

Alongside this, they are also making it easier to interact with them through the portal, allowing people to do simple things they couldn't previously.

They have made progress towards delivering a seamless registration service which they feel is a vital part of the regulatory model and a crucial first step in ensuring services deliver safe, effective, compassionate and high-quality care.

This technology will be transformative to how they work. They have taken a few important steps and over the coming months and want to start sharing these with stakeholders.

New powers - The CQC now have new powers to oversee local authorities and integrated care systems under the Health and Care Bill. It will be based on three key themes for assessment:

- Leadership.
- Integration.
- Quality and Safety.

This will support them to deliver the objectives in their strategy by allowing them to look more effectively at how the care provided in a local system is improving outcomes for people and reducing inequalities in their care. They have engaged extensively on how they will do this, including two large workshops with around 400 representatives from across the country and establishing an expert advisory group to provide dedicated input. This will be transformative in how they bring together a view of quality across a local area, put people at the centre and help drive improvement in care.

With the new powers, it creates a duty for CQC to enforce the NHS food and drink standards. The Bill imposes requirements on NHS hospitals in connection with food or drink provided or made available to any person on hospital premises in England that are used in connection with the carrying on of a regulated activity. Further regulations will be made which will specify the nutritional standards or requirements which are to be complied with.

New Framework - The CQC currently has three different assessment frameworks for the three main provider sectors. CQC will change to a single assessment framework. This assessment framework will apply to all health and social care providers, e.g., NHS and Independent Healthcare, Primary Medical Services, Adult Social Care, and local authorities and integrated care systems.

Introduction of Quality Statements – Whilst their ratings and five key questions will stay the same, they will replace the KLOEs (Key Lines of Enquiry) with the new quality statements. These will sit under each key questions of Safe, Effective, Caring, Responsive and Well-Led. This will reduce the duplication that's in the current assessment frameworks and will allow them to focus on key topic areas under each key question. More information is provided on the Quality Statements in this guide.

New Ways of Working – they will be working in teams with a mix of expertise and experience of different health and social care sectors to make sure they can share specialist skills and knowledge about all sectors. This means bringing people together who have different perspectives to give them the best view of services across a local area.

Gathering Evidence – they will make much more use of information, including people's experiences of services. They will gather evidence to support their judgements in a variety of ways and at different times – not just through inspections. This means inspections will support this activity, rather than being their primary way to collect evidence.

More information is found later in the document.

Frequency of Assessments - They will no longer use the rating of a service as the main driver when deciding when they next need to assess. Evidence they collect or information they receive at any time can trigger an assessment.

Assessing Quality – They will make judgements about quality more regularly, instead of only after an inspection (as we do currently). They will use evidence from a variety of sources and look at any number of quality statements to do this. Their assessments will be more structured and transparent, using evidence categories and giving a score for what they find. The way they make their decisions about ratings will be clearer and easier to understand.

Inspection/assessment Mythology - If you are a residential care provider, the CQC will still physically 'cross your threshold' to inspect, but they will also gather evidence from you and others at different times and in different ways and these will be called an assessment. Some of these methods will include:

- Providers submitting specific evidence.
- Direct contact with people using the service.
- Structured conversations with managers and other leaders.
- Provider information returns.

This means CQC will be able to reassess your quality and safety without always physically inspecting your service. This can lead to changes in one of your key ratings and your overall rating. This is to ensure CQC can provide an up to date view of the quality and safety of the care people receive.

Local CQC Teams - There will be multidisciplinary teams consisting of inspectors and assessors who specialise in either hospitals, primary care or adult social care. CQC has stated that the relationship will be with the team rather than with an allocated lead inspector.

Factual Accuracy Check – renamed from the Factual Accuracy Challenge, this process is described as a 'review and submit further evidence' and is the route open to providers to challenge the CQC report and ratings and is based on your ability to provide evidence that either counters the factual basis for the CQC's judgement or that you believe should be considered. On receipt of the draft report, you have ten days to respond.

More detail can be found further on in this document.

New Technology - The CQC will be able to harness what they hear from people using services through new skills and technology for data and insight, supporting their colleagues to make decisions. This is coupled with a better experience for providers through the new online portal, to reduce burden and increase the quality of data collected from them.

The regulator has built on the technology they developed during the pandemic to create the early stages of a new regulatory platform. Using a strong base of user research and other engagement work, they are now planning how they will roll it out in a limited and controlled way over the coming months.

The CQC's approach to smarter regulation is only possible because it's underpinned by technology.

New Portal - The CQC have created a new online portal that will be simple and intuitive to enable providers to submit information to them. They want to make it easier for providers to work with them, so they will collect data in a more structured format. They will ask providers to validate the information they hold and ask for the information that they cannot get elsewhere in a way that makes it easy to get right the first time – both for registration and assessment use.

More detail can be found further on in this document.

Up-to-date, transparent assessments of quality - By using their assessment framework as part of their regulatory approach, they will have the flexibility to:

- Update the ratings for key questions and overall ratings when things change, based on more frequent assessment of evidence.
- Collect and review evidence in some categories more often than others. For example, they may collect evidence of people's experiences more often than evidence about processes.
- Be selective in which quality statements they look at – this could be one, several or all.

The Regulators New Structure

The CQC has begun to reorganise themselves by establishing their new Operations group and Regulatory leadership functions.

Their regulatory leadership function will be led by the Chief Inspectors, and focus on raising standards, having oversight of policy and playing a more influential role externally to support quality improvement and innovation.

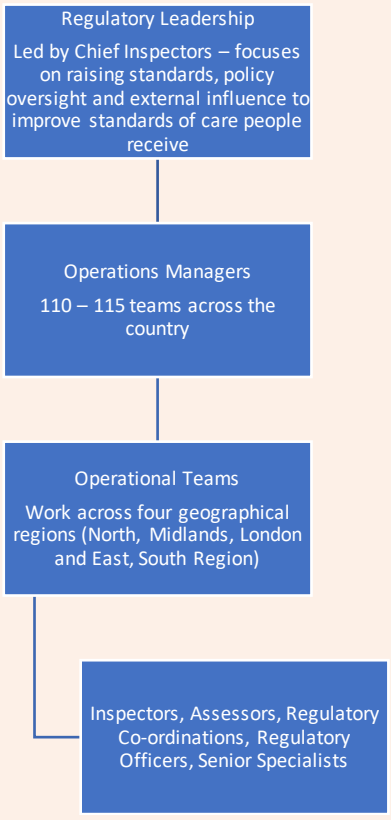
Their Operations group will be responsible for our regulatory activity and has brought together three sectors. Their operational teams now work across four Networks or geographic areas (North, Midlands, South and for Essex, they are part of the London East of England network). This will help them build a better picture of quality across an area.

They have realigned their teams to create integrated assessment teams with specialist skills and knowledge, meaning they are able to regulate in a way that mirrors how care is delivered today, with insight across a whole area and not just within the adult social care sector, GPs, hospitals or mental health services.

Each team will be led by an Operations Manager who may also be supported by Senior Specialists with specific expertise in specific areas.

They will align themselves better to the ICS structure.

There will also be a national operation central hub set up, which will be there to ensure lessons learnt from inspections and look at patterns, demographics etc.



The Transformation

The CQC's transformation and new approach is built on three key pillars:

1. Strategy.
2. Risk-based approach during the pandemic.
3. New statutory roles.

Underpinned by the data they gather, they will use their new and existing powers to improve people's care.

The rollout started on 21st November 2023 in the South of the country, and lessons learnt will be captured and feedback used to drive changes before rolling out into other regions. By the end of March 2024, all regions will be on the new inspection system.

The South region includes services registered in these counties: Berkshire, Buckinghamshire, Cornwall, Devon, Dorset, Gloucestershire, Hampshire, Kent, Oxfordshire, Somerset, Surrey, Sussex and Wiltshire.

They will then expand their new assessment approach to all providers based on a risk-informed schedule:

- 5th December 2023 - The South Region, Bedfordshire, Luton and Milton Keynes ICS area.
- 9th January 2024 - London & East Region.
- 6th February 2024 - North & Midlands region and NHS Trust Well-Led Assessments everywhere – although a small number of providers will be earlier)

The CQC are sharing more information with providers in the south separately to get experiences of their new ways of working and to hear feedback about the process. The regulator has confirmed that they will use feedback to review and adapt as they roll out across the country.

The CQC will be in touch with providers in other areas of the country to confirm when they will start using their new approach with them shortly. Meanwhile, they will continue with their current methods to monitor, assess and rate providers.

The CQC will use intelligence to determine which services in the South (and then each region) to inspect first and this will be based on the length since last inspection, level of risk and history of enforcement.

The regulator wants to ensure providers are updated and so far they have released:

- The new quality statements.
- Evidence categories.
- The scoring approach.

In the coming weeks they will also be publishing:

- Information about the registration process.
- Policy around frequency of inspections.
- The transition plan from the old model to the new.
- A guide on the evidence that will be used during inspections.
- How they will regulate services that have not been inspected before such as NHS trusts and dentists.

This information will be shared via:

- Social media.
- Email bulletins.
- Communications and marketing strategies.
- Monthly webinars up till March 2024.

They appreciate more information is needed for Nominated Individuals.

Digitisation in Social Care: Why it Matters.

The Department of Health and Social Care and NHS England lead the NHS Transformation Directorate's Digitising Social Care programme. CQC have made it clear that whilst they will not mandate systems, they full support the programme, which aims to encourage and support adult social care providers registered with us to adopt digital social care records.

The regulator has said:

- Good quality records underpin high-quality care.
- They communicate the right information clearly, to the right people, when they need it.
- Digital records far exceed capabilities of paper and capture information more easily at the point of care.
- Support staff to respond more quickly to people's needs.
- Share important information quickly, safely, and securely between care settings.
- Minimise risks to people's safety.
- It helps providers to minimise the risks to peoples' safety.
- They support their staff to respond more quickly to peoples' needs.
- It allows the sharing of important information quickly and safely.
- Efficiency, automation, reporting and sharing.
- They are an essential part of achieving good outcomes for people who use services.

And for providers they do not just help underpin good quality care, they:

- Help them operate more efficiently.
- Give management information and insight not possible with paper records.

And that is just the start, when you look at the systems available, you will see they are innovating with other digital features that help improve the quality of care for service users and their families.

In CQC's State of Care report last year the CQC said 'better data and data sharing are the critical components' before providers can begin to address system-wide issues in a meaningful way.

The CQC know that the integrated nature of health and care demands that they have a full picture of the people's experience, so they can understand and address these issues.

The regulator appreciate that it can seem daunting, but they encourage providers who have not already done so to take advantage of the considerable support on offer now. At the time of writing, the support available includes, financial, guidance and an approved digital record systems provider list.

The CQC have stated that implementation is important and will encourage providers to make use of the data security protection toolkit in preparation for moving to digital records.

Their new assessment framework is pitched at good which sits above the threshold of meeting the regulations. The assessment framework will set out our expectations for good practice and focus on how this links to good outcomes for people using services. They want to encourage the adoption of digital social records through our assessment framework.

You can watch the CQC alongside Mark Topps, The Caring View and Digitising Social Care talking about Achieving Good Outcomes and Digital Social Care Records here - https://youtu.be/-EY6ZQuwOF8?si=mc2kd7w146H0Oy1j

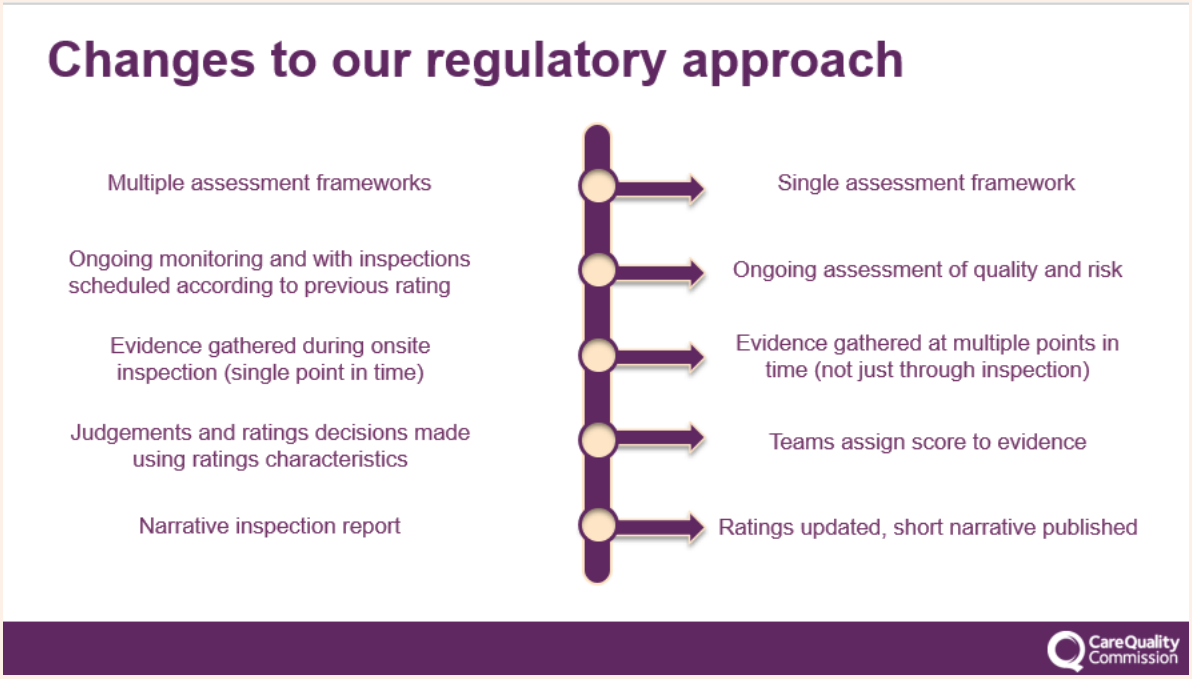
You can read more about digitisation on the CQC website: https://www.cqc.org.uk/guidance-providers/adult-social-care/digital-record-systems-adult-social-care-services

The digitising social care website is managed by NHS England's digitising social care programme. Further information and reading can be found here: https://beta.digitisingsocialcare.co.uk/

The changes to the regulatory approach - visually

The CQC know that it's helpful to see how their future model relates to what they have been doing over the last 8+ years and here are some examples of what could feel different.

On the left hand side of the screen you have how things are now, on the right is how it will work in future.



The assessment framework

Now: they have three different frameworks (registration, health, ASC) covering their five key questions – they are duplicative (e.g. across the KLOEs) and are not fully relevant to health and care today.
Future: They will have a single assessment framework that cover all sectors, services, levels – this will simplify things greatly for providers and the regulator themselves. What they look at won't change significantly, but how they do it will feel very different.

The assessment approach.

Now: They have separate 'monitor,' 'inspect' and 'rate' steps and they inspect at a set point in time, based mainly on the previous rating.
Future: They are moving away from separate 'monitor,' 'inspect' and 'rate' steps in our model and will instead use the information they receive, collect and analyse to assess providers more frequently, without being tied to set dates.
The information will come from multiple sources and gathered in a variety of ways. The regulators operational colleagues will have a key role in increasing the flow of information into the regulatory platform. This will be a dynamic process and presented to colleagues in a clear and accessible dashboard through the regulatory platform, helping them make better decisions.
This does also not mean fewer inspections for high risk services. CQC colleagues will have a greater ability to identify the best course of action - this could be that they work in the local area to find out more information or schedule a site visit to the service to observe care or speak to staff. It is important to note that in settings where there is a higher likelihood of a closed culture developing they would prioritise these services for site visits. More flexibility and improved prioritisation across all services means they can focus our activity where it's most needed.

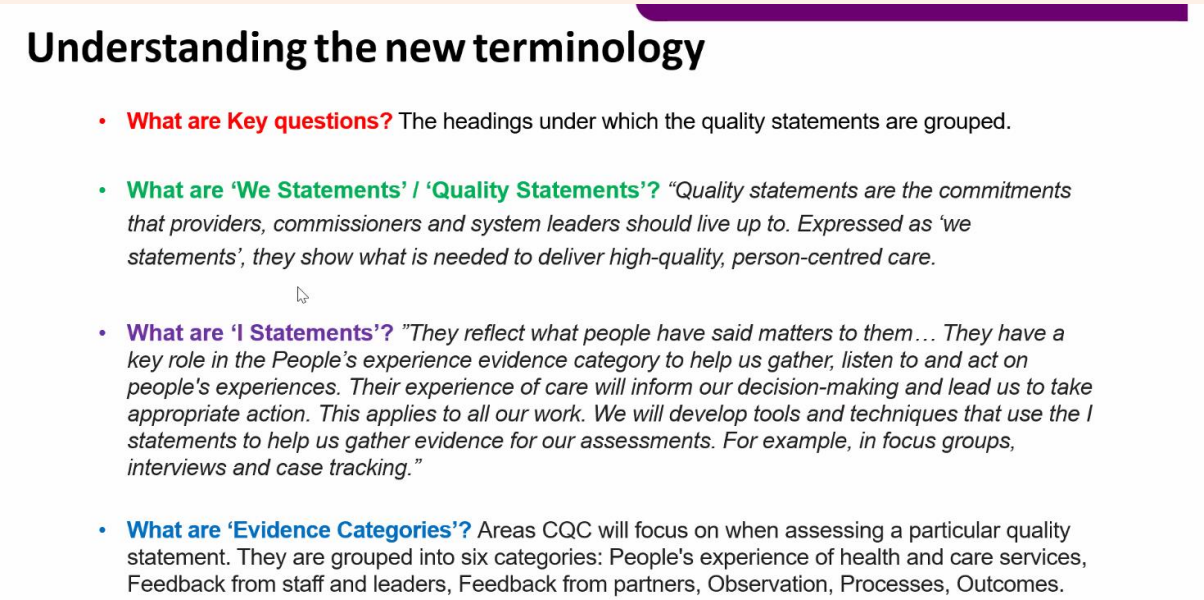
Categorising and scoring evidence.

Now: make judgements against the ratings characteristics and the key question ratings aggregate to give an overall rating.

Future: They want to be more consistent and transparent in their approach and how they make judgments on quality. They want their ratings to better reflect the care people are receiving and be clearer about where a provider or service sits within a rating. To address this, they are developing a way to categorise and score evidence as part of our assessments.

Reporting and outputs from our assessments

Now: they publish long pdf reports that are not very accessible and take time for them to write and for the public to read.
Future: they are moving away from long pdf reports – they know that they don't work for the public or for providers. They are inaccessible and not fit for what people expect from them. They also know that they take up much of the inspector's valuable time to produce them in the first place.
They will be able to give a much more up to date view of quality. They can't do that unless they streamline the processes around publishing reports. They want to make them shorter, and more tailored to the audiences that use and read them. People will be able to make better choices about their care as information will be presented more clearly and detailed benchmarking information to help the provider improve will use the provider portal, rather than be published online.



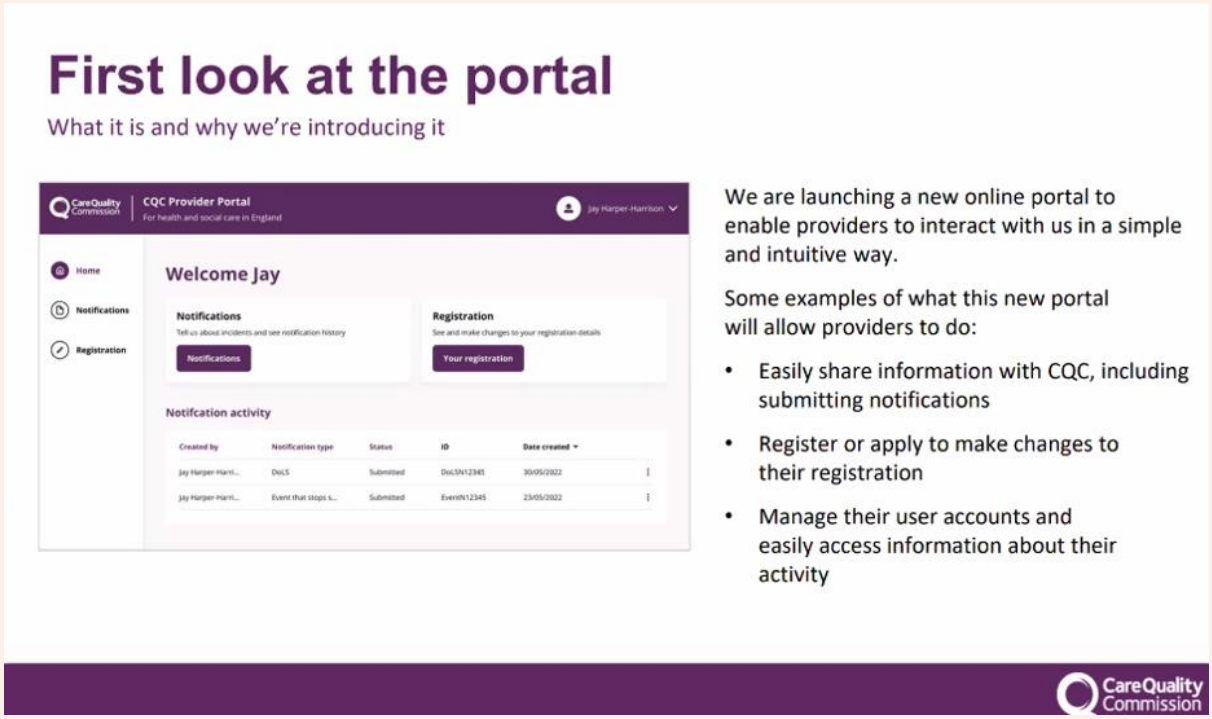
Provider Portal

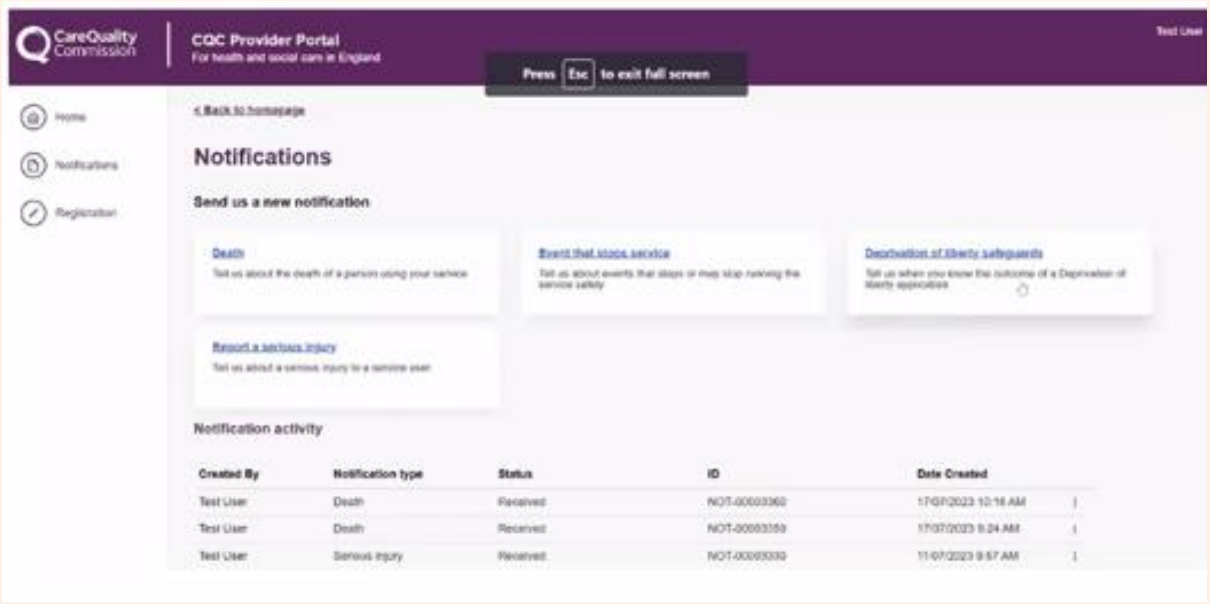
The CQC have created a new online portal that will be simple and intuitive to enable providers to submit information to them. They want to make it easier for providers to work with them, so they will collect data in a more structured format. They will ask providers to validate the information they hold and ask for the information that they cannot get elsewhere in a way that makes it easy to get right the first time – both for registration and assessment use.

The new portal is invite only, and anyone not yet to receive this email will need to continue with the old version for now.

The portal will allow providers to:

- Register with CQC for the first time.
- Submit notifications and share information.
- Apply to make changes to their registration.
- Manage their user accounts and contact preferences online. Providers will be able to access the registration data CQC holds about them and update as required and in time, they will also be able to provide benchmarking information too.
- Delegate access to colleagues in their organisation.
- Factual Accuracy Checks.

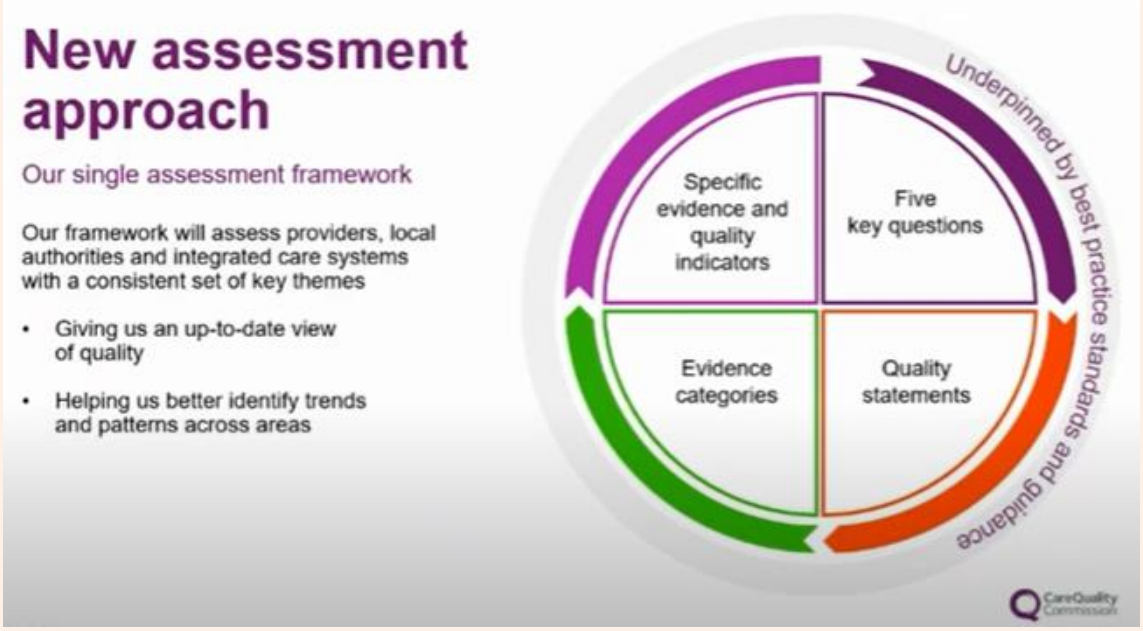




The regulator has stated that the PIR is an important part of the information gathering process, and the portal will make it easier to collate information from providers, NHS England, Local Authorities and other sources. The provider will have access to the information provided to determine the inspection outcome and it is hoped the new portal will create a more real time view of the service.

The Single Assessment Framework

This is the single assessment framework for the regulation of providers, local authorities and systems. It focuses on what matters to people who use health and social care services and their families. It is the key to the CQC providing an up-to-date and accurate view of quality.



The single assessment framework will help the regulator:

- To make things simpler so they can focus on what really matters to people.
- To better reflect how care is delivered by different types of service as well as across a local area.
- Gives one framework that connects their registration activity to their assessments of quality.

They are keeping their 5 key questions – Safe, Effective, Caring, Responsive, and Well-led, but they are introducing a number of quality statements that underpin each of those. Those are expressed as "we statements" which show what is needed to deliver high-quality person centred care.
So for each of those quality statements they will gather evidence and rate those quality statements.

Their intent is to reduce impact on providers but gather information more regularly and have said observation of care is still very important but they will use other data to reduce burden where possible.

With this approach it will enable them to return more quickly to rerate providers who can demonstrate rapid improvement. Providers will be able to benchmark themselves against their peers to enable more collaborative working.

How will the CQC Assess Quality?

For health and care providers, there will be some differences in how we assess the quality of their services:

- Gathering evidence: CQC will make much more use of information, including people's experiences of services. They will gather evidence to support their judgements in a variety of ways and at different times – not just through inspections. This means inspections will support this activity, rather than being our primary way to collect evidence.
- Frequency of assessments: They will no longer use the rating of a service as the main driver when deciding when we next need to assess. Evidence we collect or information we receive at any time can trigger an assessment.
- Assessing quality: They will make judgements about quality more regularly, instead of only after an inspection as they previously have done. They will use evidence from a variety of sources and look at any number of quality statements to do this. Their assessments will be more structured and transparent, using evidence categories and giving a score for what they find.

The way they make their decisions about ratings will be clearer and easier to understand.

By using their assessment framework as part of our regulatory approach, they will have the flexibility to:

- update the ratings for key questions and overall ratings when things change, based on more frequent assessment of evidence.
- collect and review evidence in some categories more often than others. For example, they may collect evidence of people's experiences more often than evidence about processes.
- be selective in which quality statements we look at – this could be one, several or all.

I / We Statements

They have drawn on work done previously by Think Local Act Personal (TLAP), National Voices and the Coalition for Collaborative Care on Making it Real.

They have co-produced a personalised care and support framework that can be used by people who work in adult social care, health, housing and people who use services. Importantly, this sets out what good and outstanding person-centred care looks like and what people should expect from providers, commissioners and system leaders.

The Making it Real framework is built around six themes to reflect the most important elements of personalised care and support:

- Wellbeing and Independence - Living the life I want, keeping safe and well.
- Information and Advice - Having the information I need when I need it.
- Active and Supportive Communities - Keeping family, friends and connections.
- Flexible and Integrative Care and Support - My support, my own way.
- When things need to Change - Staying in control.
- Workforce - The people who support me.

Making it Real:

- Supports personalised care for people who use services.
- Supports people working in health, care and housing.
- Contains a jargon-free set of personalised principles that focus on what matters to people.

Each of the six themes have a number of 'I statements' that describe what good, citizen focussed, personalised care and support looks like from the point of view of people themselves. These 'I Statements' are linked to each of the Quality Statements and will be used:

- The help people understand what a good experience of care looks and feels like.
- To support the CQC in gathering and assessing evidence under the people's experience evidence category

The CQC will be developing tools and techniques that use the I statements to help them gather evidence for their assessments. For example, in focus groups, interviews and case tracking.

We statements express what organisations should be doing to make sure people's actual experiences of care and support lives up to the I statements.

The CQC will use these statements to support in gathering and assessing evidence of people's experiences of care. They continue to explore other ways in which they can be used in the regulation.

You can read more about Making it Real here: https://www.thinklocalactpersonal.org.uk/makingitreal/.

You can read more about how the CQC will be using people's experience in their regulation and inspections here: https://www.cqc.org.uk/about-us/how-we-will-regulate/using-peoples-experience-our-regulation.

The Quality Statements

The CQC are introducing a set of 'quality statements,' pitched at the level of 'good' and linked to the regulations that will help them make their judgments about the quality of care.

It is hoped that this will make things clearer for providers about the expectations on them, while reducing the duplication that currently exists across the KLOEs.

Quality statements are the commitments that providers, commissioners and system leaders should live up to. Expressed as 'We Statements,' they show what is needed to deliver high-quality, person-centred care.

They will replace the current Key Lines of Enquiry (KLOEs) and are the commitments that providers, commissioners and system leaders should live up to.

The Quality Statements will apply to all services which CQC asses and this change is not about overhauling what the CQC look at in their assessments but instead about streamlining much of the duplication that existed with 120 KLOEs, now into 34 quality statements, with the aim to be clearer to understand than the KLOEs, for both providers and inspectors. They have also strengthened some areas, for example around 'learning cultures' under Safe.

The Quality Statements are much more focused on outcomes rather than inputs and "Evidence Categories" have been published describing the types of evidence required to determine compliance with Quality Statements. There are different Evidence Categories for different types of services.

Safe	Caring	Responsive	Effective	Well-Led
Learning culture	Kindness, compassion and dignity.	Person-centred care.	Assessing needs.	Shared direction and culture.
Safe systems, pathways and transitions	Treating people as individuals.	Care provision, integration, and continuity.	Delivering evidence-based care and treatment.	Capable, compassionate and inclusive leaders.
Safeguarding	Independence, choice and control.	Providing information.	How staff, teams and services work together.	Freedom to speak up.
Involving people to manage risks	Responding to people's immediate needs.	Listening to and involving people.	Supporting people to live healthier lives.	Workforce equality, diversity and inclusion.
Safe environments	Workforce wellbeing and enablement.	Equity in access.	Monitoring and improving outcomes.	Governance, management and sustainability.
Safe and effective staffing	Independence, choice and control.	Equity in experiences and outcomes.	Consent to care and treatment.	Partnerships and communities.
Infection prevention and control		Planning for the future.		Learning, improvement and innovation.
Medicines optimisation				Environmental sustainability – sustainable development.

Let's look in more detail:

SAFE	
Learning culture.	We have a proactive and positive culture of safety based on openness and honesty, in which concerns about safety are listened to, safety events are investigated and reported thoroughly, and lessons are learned to continually identify and embed good practices.
Safe systems, pathways and transitions.	We work with people and our partners to establish and maintain safe systems of care, in which safety is managed, monitored and assured. We ensure continuity of care, including when people move between different services.
Safeguarding.	We work with people to understand what being safe means to them as well as with our partners on the best way to achieve this. We concentrate on improving people's lives while protecting their right to live in safety, free from bullying, harassment, abuse, discrimination, avoidable harm and neglect. We make sure we share concerns quickly and appropriately.
Involving people to manage risks.	We work with people to understand and manage risks by thinking holistically so that care meets their needs in a way that is safe and supportive and enables them to do the things that matter to them.
Safe environments.	We detect and control potential risks in the care environment. We make sure that the equipment, facilities and technology support the delivery of safe care.
Safe and effective staffing.	We make sure there are enough qualified, skilled and experienced people, who receive effective support, supervision and development. They work together effectively to provide safe care that meets people's individual needs.
Infection prevention and control.	We assess and manage the risk of infection. We detect and control the risk of it spreading and share any concerns with appropriate agencies promptly.
Medicines optimisation.	We make sure that medicines and treatments are safe and meet people's needs, capacities and preferences by enabling them to be involved in planning, including when changes happen.

EFFECTIVE	
Assessing needs.	We maximise the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.
Delivering evidence-based care and treatment.	We plan and deliver people's care and treatment with them, including what is important and matters to them. We do this in line with legislation and current evidence-based good practice and standards.
How staff, teams and services work together.	We work effectively across teams and services to support people. We make sure they only need to tell their story once by sharing their assessment of needs when they move between different services.
Supporting people to live healthier lives.	We support people to manage their health and wellbeing so they can maximise their independence, choice and control. We support them to live healthier lives and where possible, reduce their future needs for care and support.
Monitoring and improving outcomes.	We routinely monitor people's care and treatment to continuously improve it. We ensure that outcomes are positive and consistent, and that they meet both clinical expectations and the expectations of people themselves.
Consent to care and treatment.	We tell people about their rights around consent and respect these when we deliver person-centred care and treatment.

CARING	
Kindness, compassion and dignity.	We always treat people with kindness, empathy and compassion and we respect their privacy and dignity. We treat colleagues from other organisations with kindness and respect.
Treating people as individuals.	We treat people as individuals and make sure their care, support and treatment meets their needs and preferences. We take account of their strengths, abilities, aspirations, culture and unique backgrounds and protected characteristics.
Independence, choice and control.	We promote people's independence, so they know their rights and have choice and control over their own care, treatment and wellbeing.
Responding to people's immediate needs.	We listen to and understand people's needs, views and wishes. We respond to these in that moment and will act to minimise any discomfort, concern or distress.
Workforce wellbeing and enablement.	We care about and promote the wellbeing of our staff, and we support and enable them to always deliver person centred care.

RESPONSIVE	
Person-centred care.	We make sure people are at the centre of their care and treatment choices and we decide, in partnership with them, how to respond to any relevant changes in their needs.
Care provision, integration, and continuity.	We understand the diverse health and care needs of people and our local communities, so care is joined-up, flexible and supports choice and continuity.
Providing information.	We provide appropriate, accurate and up-to-date information in formats that we tailor to individual needs.
Listening to and involving people.	We make it easy for people to share feedback and ideas or raise complaints about their care, treatment and support. We involve them in decisions about their care and tell them what's changed as a result.
Equity in access.	We make sure that everyone can access the care, support and treatment they need when they need it.
Equity in experiences and outcomes.	We actively seek out and listen to information about people who are most likely to experience inequality in experience or outcomes. We tailor the care, support and treatment in response to this.
Planning for the future.	We support people to plan for important life changes, so they can have enough time to make informed decisions about their future, including at the end of their life.

WELL-LED	
Shared direction and culture.	We have a shared vision, strategy and culture. This is based on transparency, equity, equality and human rights, diversity and inclusion, engagement, and understanding challenges and the needs of people and our communities in order to meet these.
Capable, compassionate and inclusive leaders.	We have inclusive leaders at all levels who understand the context in which we deliver care, treatment and support and embody the culture and values of their workforce and organisation. They have the skills, knowledge, experience and credibility to lead effectively. They do so with integrity, openness and honesty.
Freedom to speak up.	We foster a positive culture where people feel that they can speak up and that their voice will be heard.
Workforce equality, diversity and inclusion.	We value diversity in our workforce. We work towards an inclusive and fair culture by improving equality and equity for people who work for us.
Governance, management and sustainability.	We have clear responsibilities, roles, systems of accountability and good governance. We use these to manage and deliver good quality, sustainable care, treatment and support. We act on the best information about risk, performance and outcomes, and we share this securely with others when appropriate.
Partnerships and communities.	We understand our duty to collaborate and work in partnership, so our services work seamlessly for people. We share information and learning with partners and collaborate for improvement.
Learning, improvement and innovation.	We focus on continuous learning, innovation and improvement across our organisation and the local system. We encourage creative ways of delivering equality of experience, outcome and quality of life for people. We actively contribute to safe, effective practice and research.
Environmental sustainability – sustainable development.	We understand any negative impact of our activities on the environment and we strive to make a positive contribution in reducing it and support people to do the same.

Over the next few pages, we look at each of the new quality statements for Safe, Effective, Caring, Responsive and Well-Led.

Safe and the Quality Statements used to assess care.

Learning culture
We have a proactive and positive culture of safety based on openness and honesty, in which concerns about safety are listened to, safety events are investigated and reported thoroughly, and lessons are learned to continually identify and embed good practices.
More information can be found here: https://www.cqc.org.uk/assessment/quality-statements/safe/learning-culture

Safe systems, pathways and transitions
We work with people and our partners to establish and maintain safe systems of care, in which safety is managed, monitored and assured. We ensure continuity of care, including when people move between different services.
More information can be found here: https://www.cqc.org.uk/assessment/quality-statements/safe/safe-systems-pathways-transitions

Safeguarding
We work with people to understand what being safe means to them as well as with our partners on the best way to achieve this. We concentrate on improving people's lives while protecting their right to live in safety, free from bullying, harassment, abuse, discrimination, avoidable harm and neglect. We make sure we share concerns quickly and appropriately.
More information can be found here: https://www.cqc.org.uk/assessment/quality-statements/safe/safeguarding

Involving people to manage risks
We work with people to understand and manage risks by thinking holistically so that care meets their needs in a way that is safe and supportive and enables them to do the things that matter to them.
More information can be found here: https://www.cqc.org.uk/assessment/quality-statements/safe/involving-people-manage-risk

Safe environments
We detect and control potential risks in the care environment. We make sure that the equipment, facilities and technology support the delivery of safe care.
More information can be found here: https://www.cqc.org.uk/assessment/quality-statements/safe/safe-environments

Safe and effective staffing
We make sure there are enough qualified, skilled and experienced people, who receive effective support, supervision and development. They work together effectively to provide safe care that meets people's individual needs.
More information can be found here: https://www.cqc.org.uk/assessment/quality-statements/safe/safe-effective-staffing

Infection prevention and control
We assess and manage the risk of infection. We detect and control the risk of it spreading and share any concerns with appropriate agencies promptly.
More information can be found here: https://www.cqc.org.uk/assessment/quality-statements/safe/infection-prevention-control

Medicines optimisation
We make sure that medicines and treatments are safe and meet people's needs, capacities and preferences by enabling them to be involved in planning, including when changes happen.
More information can be found here: https://www.cqc.org.uk/assessment/quality-statements/safe/medicines-optimisation

Some suggested evidence could be:

- A record of incidents/significant events, including investigations, actions taken & learning
- Information on the current number of staff by role, their full-time equivalent (FTE), and any qualifications or training provided to them in the last three years.
- Risk Assessments and action plans (e.g. Fire, health & safety, premises)

Further information can be found here: https://www.cqc.org.uk/assessment/quality-statements/safe

Quality statements:
What do we mean by safe? 1/2

Learning culture
We have a proactive and positive culture of safety based on openness and honesty, in which concerns about safety are listened to, safety events are investigated and reported thoroughly, and lessons are learned to continually identify and embed good practices.

Safe systems, pathways and transitions
We work with people and our partners to establish and maintain safe systems of care, in which safety is managed, monitored and assured. We ensure continuity of care, including when people move between different services.

Safeguarding
We work with people to understand what being safe means to them as well as with our partners on the best way to achieve this. We concentrate on improving people's lives while protecting their right to live in safety, free from bullying, harassment, abuse, discrimination, avoidable harm and neglect. We make sure we share concerns quickly and appropriately.

Involving people to manage risks
We work with people to understand and manage risks by thinking holistically so that care meets their needs in a way that is safe and supportive and enables them to do the things that matter to them.

Source: https://www.cqc.org.uk/assessment/quality-statements

CareQuality Commission

Quality statements:
What do we mean by safe? 2/2

Safe environments
We detect and control potential risks in the care environment. We make sure that the equipment, facilities and technology support the delivery of safe care.

Safe and effective staffing
We make sure there are enough qualified, skilled and experienced people, who receive effective support, supervision and development. They work together effectively to provide safe care that meets people's individual needs.

Infection prevention and control
We assess and manage the risk of infection. We detect and control the risk of it spreading and share any concerns with appropriate agencies promptly.

Medicines optimisation
We make sure that medicines and treatments are safe and meet people's needs, capacities and preferences by enabling them to be involved in planning, including when changes happen.

Source: https://www.cqc.org.uk/assessment/quality-statements

CareQuality Commission

Effective and the Quality Statements used to assess care.

Assessing needs
We maximise the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.
More information can be found here: https://www.cqc.org.uk/assessment/quality-statements/effective/assessing-needs

Delivering evidence-based care and treatment
We plan and deliver people's care and treatment with them, including what is important and matters to them. We do this in line with legislation and current evidence-based good practice and standards.
More information can be found here: https://www.cqc.org.uk/assessment/quality-statements/effective/delivering-evidence-based-care

How staff, teams and services work together
We work effectively across teams and services to support people. We make sure they only need to tell their story once by sharing their assessment of needs when they move between different services.
More information can be found here: https://www.cqc.org.uk/assessment/quality-statements/effective/staff-teams-work-together

Supporting people to live healthier lives
We support people to manage their health and wellbeing so they can maximise their independence, choice and control. We support them to live healthier lives and where possible, reduce their future needs for care and support.
More information can be found here: https://www.cqc.org.uk/assessment/quality-statements/effective/supporting-people-healthier-lives

Monitoring and improving outcomes
We routinely monitor people's care and treatment to continuously improve it. We ensure that outcomes are positive and consistent, and that they meet both clinical expectations and the expectations of people themselves.
More information can be found here: https://www.cqc.org.uk/assessment/quality-statements/effective/monitoring-improving-outcomes

Consent to care and treatment
We tell people about their rights around consent and respect these when we deliver person-centred care and treatment.
More information can be found here: https://www.cqc.org.uk/assessment/quality-statements/effective/consent-care-treatment

Some suggested evidence could be:

- Staff performance management policies and process
- Policies on remote consultations (e.g. video/digital consultation policy)
- Quality Monitoring of treatment and services (e.g. clinical audit cycles from the last 12 months)
- Clinical audits

Further information can be found here: https://www.cqc.org.uk/assessment/quality-statements/effective

Quality statements:
What do we mean by effective? 1/2

Assessing needs
We maximise the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Delivering evidence-based care and treatment
We plan and deliver people's care and treatment with them, including what is important and matters to them. We do this in line with legislation and current evidence-based good practice and standards.

How staff, teams and services work together
We work effectively across teams and services to support people. We make sure they only need to tell their story once by sharing their assessment of needs when they move between different services.

Source: https://www.cqc.org.uk/assessment/quality-statements

CareQuality Commission

Quality statements:
What do we mean by effective? 2/2

Supporting people to live healthier lives
We support people to manage their health and wellbeing so they can maximise their independence, choice and control. We support them to live healthier lives and where possible, reduce their future needs for care and support.

Monitoring and improving outcomes
We routinely monitor people's care and treatment to continuously improve it. We ensure that outcomes are positive and consistent, and that they meet both clinical expectations and the expectations of people themselves.

Consent to care and treatment
We tell people about their rights around consent and respect these when we deliver person-centred care and treatment.

Source: https://www.cqc.org.uk/assessment/quality-statements

CareQuality Commission

Caring and the Quality Statements used to assess care.

Kindness, compassion and dignity
We always treat people with kindness, empathy and compassion and we respect their privacy and dignity. We treat colleagues from other organisations with kindness and respect.
More information can be found here: https://www.cqc.org.uk/assessment/quality-statements/caring/kindness-compassion-dignity

Treating people as individuals
We treat people as individuals and make sure their care, support and treatment meets their needs and preferences. We take account of their strengths, abilities, aspirations, culture and unique backgrounds and protected characteristics.
More information can be found here: https://www.cqc.org.uk/assessment/quality-statements/caring/treating-people-individuals

Independence, choice and control
We promote people's independence, so they know their rights and have choice and control over their own care, treatment and wellbeing.
More information can be found here: https://www.cqc.org.uk/assessment/quality-statements/caring/independence-choice-control

Responding to people's immediate needs
We listen to and understand people's needs, views and wishes. We respond to these in that moment and will act to minimise any discomfort, concern or distress.
More information can be found here: https://www.cqc.org.uk/assessment/quality-statements/caring/responding-immediate-needs

Workforce wellbeing and enablement
We care about and promote the wellbeing of our staff, and we support and enable them to always deliver person centred care.
More information can be found here: https://www.cqc.org.uk/assessment/quality-statements/caring/workforce-wellbeing-enablement

Some suggested evidence could be:

- Complaints & Feedback from the last 12 months (including investigations, actions taken & how you implemented the learning from the event)
- Accessible Standards policies and processes
- Examples of support given to staff members
- Family, friends and stakeholder feedback and reviews.

Further information can be found here: https://www.cqc.org.uk/assessment/quality-statements/caring

Quality statements:
What do we mean by caring?

Kindness, compassion and dignity
We always treat people with kindness, empathy and compassion and we respect their privacy and dignity. We treat colleagues from other organisations with kindness and respect.

Treating people as individuals
We treat people as individuals and make sure their care, support and treatment meets their needs and preferences. We take account of their strengths, abilities, aspirations, culture and unique backgrounds and protected characteristics.

Independence, choice and control
We promote people's independence, so they know their rights and have choice and control over their own care, treatment and wellbeing.

Responding to people's immediate needs
We listen to and understand people's needs, views and wishes. We respond to these in that moment and will act to minimise any discomfort, concern or distress.

Workforce wellbeing and enablement
We care about and promote the wellbeing of our staff, and we support and enable them to always deliver person centred care.

Source: https://www.cqc.org.uk/assessment/quality-statements

CareQuality Commission

Responsive and the Quality Statements used to assess care.

Person-centred care
We make sure people are at the centre of their care and treatment choices and we decide, in partnership with them, how to respond to any relevant changes in their needs.
More information can be found here: https://www.cqc.org.uk/assessment/quality-statements/responsive/person-centred-care

Care provision, integration, and continuity
We understand the diverse health and care needs of people and our local communities, so care is joined-up, flexible and supports choice and continuity.
More information can be found here: https://www.cqc.org.uk/assessment/quality-statements/responsive/care-provision-integration-continuity

Providing information
We provide appropriate, accurate and up-to-date information in formats that we tailor to individual needs.
More information can be found here: https://www.cqc.org.uk/assessment/quality-statements/responsive/providing-information

Listening to and involving people
We make it easy for people to share feedback and ideas or raise complaints about their care, treatment and support. We involve them in decisions about their care and tell them what's changed as a result.
More information can be found here: https://www.cqc.org.uk/assessment/quality-statements/responsive/listening-involving-people

Equity in access
We make sure that everyone can access the care, support and treatment they need when they need it.
More information can be found here: https://www.cqc.org.uk/assessment/quality-statements/responsive/equity-access

Equity in experiences and outcomes
We actively seek out and listen to information about people who are most likely to experience inequality in experience or outcomes. We tailor the care, support and treatment in response to this.
More information can be found here: https://www.cqc.org.uk/assessment/quality-statements/responsive/equity-experiences-outcomes

Planning for the future
We support people to plan for important life changes, so they can have enough time to make informed decisions about their future, including at the end of their life.
More information can be found here: https://www.cqc.org.uk/assessment/quality-statements/responsive/planning-future

Some suggested evidence could be:

- Patient Surveys carried out in the last 12 months (including any findings and actions taken following the results)
- How changes in support needs are met
- Evidence of flexibility to staff, appointments etc.
- Evidence on how choice is made available to the people being supported.

Further information can be found here: https://www.cqc.org.uk/assessment/quality-statements/responsive

Quality statements:
What do we mean by responsive? 1/2

Person-centred care
We make sure people are at the centre of their care and treatment choices and we decide, in partnership with them, how to respond to any relevant changes in their needs.

Care provision, integration, and continuity
We understand the diverse health and care needs of people and our local communities, so care is joined-up, flexible and supports choice and continuity.

Providing information
We provide appropriate, accurate and up-to-date information in formats that we tailor to individual needs.

Listening to and involving people
We make it easy for people to share feedback and ideas or raise complaints about their care, treatment and support. We involve them in decisions about their care and tell them what's changed as a result.

Source: https://www.cqc.org.uk/assessment/quality-statements

CareQuality Commission

Quality statements:
What do we mean by responsive? 2/2

Equity in access
We make sure that everyone can access the care, support and treatment they need when they need it.

Equity in experiences and outcomes
We actively seek out and listen to information about people who are most likely to experience inequality in experience or outcomes. We tailor the care, support and treatment in response to this.

Planning for the future
We support people to plan for important life changes, so they can have enough time to make informed decisions about their future, including at the end of their life.

Source: https://www.cqc.org.uk/assessment/quality-statements

CareQuality Commission

Well-Led and the Quality Statements used to assess care.

Shared direction and culture
We have a shared vision, strategy and culture. This is based on transparency, equity, equality and human rights, diversity and inclusion, engagement, and understanding challenges and the needs of people and our communities in order to meet these.
More information can be found here: https://www.cqc.org.uk/assessment/quality-statements/well-led/shared-direction-culture

Capable, compassionate and inclusive leaders
We have inclusive leaders at all levels who understand the context in which we deliver care, treatment and support and embody the culture and values of their workforce and organisation. They have the skills, knowledge, experience and credibility to lead effectively. They do so with integrity, openness and honesty.
More information can be found here: https://www.cqc.org.uk/assessment/quality-statements/well-led/capable-compassionate-inclusive-leaders

Freedom to speak up
We foster a positive culture where people feel that they can speak up and that their voice will be heard.
More information can be found here: https://www.cqc.org.uk/assessment/quality-statements/well-led/freedom-speak-up

Workforce equality, diversity and inclusion
We value diversity in our workforce. We work towards an inclusive and fair culture by improving equality and equity for people who work for us.
More information can be found here: https://www.cqc.org.uk/assessment/quality-statements/well-led/workforce-equality-diversity-inclusion

Governance, management and sustainability
We have clear responsibilities, roles, systems of accountability and good governance. We use these to manage and deliver good quality, sustainable care, treatment and support. We act on the best information about risk, performance and outcomes, and we share this securely with others when appropriate.
More information can be found here: https://www.cqc.org.uk/assessment/quality-statements/well-led/governance-management-sustainability

Partnerships and communities
We understand our duty to collaborate and work in partnership, so our services work seamlessly for people. We share information and learning with partners and collaborate for improvement.
More information can be found here: https://www.cqc.org.uk/assessment/quality-statements/well-led/partnerships-communities

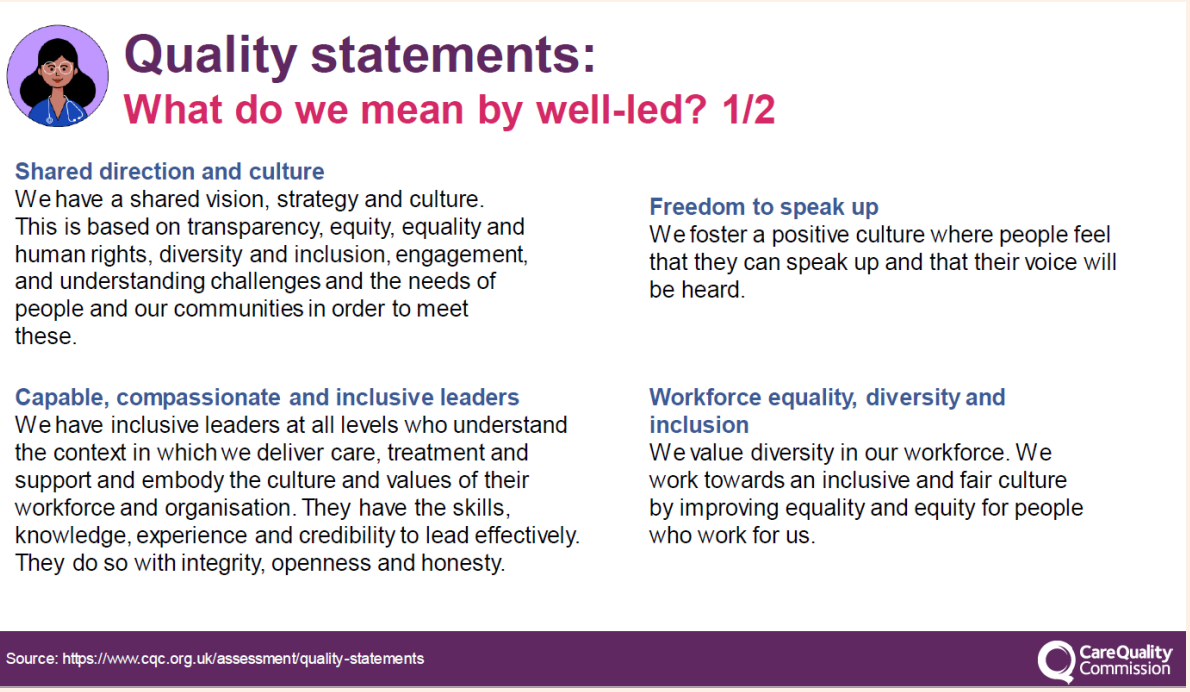
Learning, improvement and innovation
We focus on continuous learning, innovation and improvement across our organisation and the local system. We encourage creative ways of delivering equality of experience, outcome and quality of life for people. We actively contribute to safe, effective practice and research.
More information can be found here: https://www.cqc.org.uk/assessment/quality-statements/well-led/learning-improvement-innovation

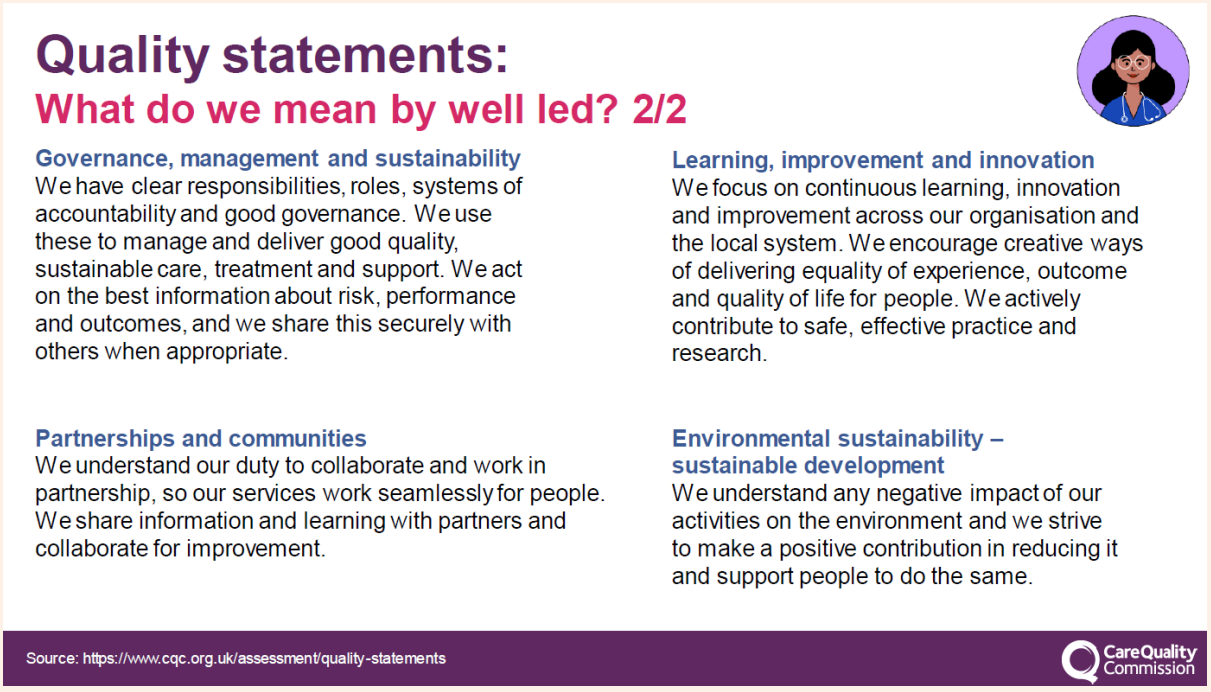
Environmental sustainability – sustainable development
We understand any negative impact of our activities on the environment and we strive to make a positive contribution in reducing it and support people to do the same.
More information can be found here: https://www.cqc.org.uk/assessment/quality-statements/well-led/environmental-sustainability

Some suggested evidence could be:

- Practice Statement, Visions and Values
- Business Continuity Plans
- DSP Toolkit compliance, and that the practice is registered as a data controller.
- Meeting Minutes from practice meetings, clinical/information governance meetings, PCN related meetings and others.

Further information can be found here: https://www.cqc.org.uk/assessment/quality-statements/well-led





Evidence categories

The regulator wants to be more consistent and transparent in their approach and how they make judgments on quality. To address this, they have developed a way to categorise and score evidence as part of their assessments.

The CQC have listed the key evidence categories by sector groups and have confirmed that they will prioritise collecting evidence in these categories as part of their assessments. These lists are a guide and not a checklist.

It is only the first assessment of their new approach, and for services newly registering with the CQC, that they'll look at every key evidence category, however they have stated if evidence suggests that they need to then they will. For future assessments they may review evidence just in particular categories.

The evidence 'categories' aim to bring more structure to their process for assessing quality and they have grouped the different types of evidence.

Each category sets out the types of evidence they use to understand:

- The quality of care being delivered.
- The performance against each quality statement.

In order to make clear what they will look at in their assessments, they have set out the key evidence categories that they will focus on when assessing a particular quality statement.

The number of evidence categories that they need to consider and the sources of evidence they will collect varies according to:

- The type or model of service
- The level of assessment (service, provider, local authority or integrated care system)
- Whether the assessment is for an existing service or at registration.

The six categories are:

1. People's experiences of Health and Care Services - https://www.cqc.org.uk/assessment/evidence-categories/peoples-experience
2. Feedback from staff and leaders - https://www.cqc.org.uk/assessment/evidence-categories/feedback-staff-and-leaders
3. Feedback from partners - https://www.cqc.org.uk/assessment/evidence-categories/feedback-partners
4. Observation - https://www.cqc.org.uk/assessment/evidence-categories/observation
5. Processes - https://www.cqc.org.uk/assessment/evidence-categories/processes
6. Outcomes - https://www.cqc.org.uk/assessment/evidence-categories/outcomes

To enable the regulator to be clearer with providers and the public about how they use the information they have about care in a service or local area, they will set out which of those evidence categories they will focus on and prioritise for each service type and at each level – including at registration.

People's experiences of Health and Care Services

This is all types of evidence from people who have experience relating to a specific health or care service, or a pathway across services. It also includes evidence from families, carers and advocates for people who use services.

CQC define people's experiences as: "a person's needs, expectations, lived experience and satisfaction with their care, support and treatment. This includes access to and transfers between services".

Evidence from people's experience of care includes:

- phone calls, emails and through feedback provided to the CQC from the public/relatives etc

- interviews with people and local organisations who represent them or act on their behalf
- survey results.
- feedback from the public and people who use services obtained by:
    - community and voluntary groups
    - health and care providers
    - local authorities
- groups representing:
    - people who are more likely to have a poorer experience of care and poorer outcomes
    - people with protected equality characteristics
    - unpaid carers

Feedback from staff and leaders

This is evidence from people who work in a service, local authority or integrated care system, and groups of staff involved in providing care to people.

It also includes evidence from those in leadership positions.

This includes, for example:

- results from staff surveys and feedback from staff to their employer
- individual interviews or focus groups with staff
- interviews with leaders
- feedback from people working in a service sent through the CQC Give feedback on care service
- whistleblowing

Feedback from partners

This is evidence from people representing organisations that interact with the service or organisation that is being assessed. CQC may gather evidence through interviews and engagement events, but organisations include, for example:

1. commissioners
2. other local providers
3. professional regulators
4. accreditation bodies
5. royal colleges
6. multi-agency bodies.

Observation

CQC have stated observing care and the care environment will remain an important way to assess quality.

Most observation will be carried out on the premises by CQC inspectors and Specialist Professional Advisors (SpAs).

External bodies may also carry out observations of care and provide evidence, for example, Local Healthwatch. Where the evidence from organisations such as Healthwatch is specifically about observation of the care environment, we will include it in this category, and not in the people's experiences category.

All observation is carried out on site.

Processes

Processes are any series of steps, arrangements or activities that are carried out to enable a provider or organisation to deliver its objectives.

CQC assessments focus on how effective policies and procedures are. To do this, we will look at information and data sources that measure the outcomes from processes.

For example, they may consider processes to:

4. measure and respond to information from audits.
5. look at learning from incidents or notifications.
6. review people's care and clinical records.

Outcomes

Outcomes are focused on the impact of care processes on individuals. They cover how care has affected people's physical, functional or psychological status.

CQC consider outcomes measures in context of the service and the specifics of the measure.
Some examples of outcome measures are:

7. mortality rates
8. emergency admissions and re-admission rates to hospital
9. infection control rates
10. vaccination and prescribing data.

CQC will source the information from:

9. patient level data sets
10. national clinical audits
11. initiatives such as the patient reported outcome measures (PROMs) programme.

Evidence categories can be found here for each service type:

- Ambulance services
- Care homes and supported living services
- Community health services and hospices
- Homecare and shared lives services
- Independent doctors
- Independent healthcare single services
- Mental health services
- NHS acute hospital services
- Primary health services

Evidence Gathering

The CQC will make much more use of information, including people's experiences of services. They will gather evidence to support their judgements in a variety of ways and at different times – not just through inspections. This means inspections will support this activity, rather than being their primary way to collect evidence.

The CQC confirmed on their website on 15th November that they will use the best method to collect evidence depending on the type of key evidence for a quality statement. They will continue to build on their existing methods for collecting evidence. Although they will be assessing the evidence using a different framework, most of the information they consider will be similar to what they have been looking at in the past.

The evidence they use in their assessments of quality may be gathered through both on-site and off-site methods. On-site activity remains really important and they expect to use their time visiting services in a more targeted way.

On-site activity:

- observing care and how staff interact with people.
- observing the care environment, including equipment and premises
- speaking to people using the service
- speaking to staff and service leaders.

They will carry out site visits when it's the best way to gather the evidence they need. For example, they'll do this:

- where people have communication needs that make telephone or video conversations challenging, or not suitable.
- where there are concerns around transparency and confidentiality, for example to make sure someone isn't overheard or being influenced by others.
- to check the validity of evidence we have already gathered in a setting.

They may carry out a site visit to collect evidence without giving notice beforehand. They would do this, for example in response to a specific concern.

They will carry out on-site activity more frequently in settings where:

- there is a greater risk of a poor or closed culture going undetected in a service.
- it is the best way to gather people's experience of care.
- they have concerns about transparency and the availability of evidence.
- They have a statutory obligation to do so, for example as a member of the National Preventative Mechanism they must visits places of detention regularly to prevent torture and other ill-treatment.

They will continue to use and develop insight from national data collections, particularly where there are nationally agreed measures of quality. For example:

- capacity tracker for adult social care services
- electronic staff records.
- GP patient surveys
- hospital episode statistics
- Learn from Patient Safety Events (LFPSE)
- measures from the National Clinical Audit Programme
- mental health services data set
- national SITREP information

- NHS staff survey
- prescribing datasets
- Skills for Care
- waiting times

They have a programme to manage the external data sources they use. Updates to the data sources depend on the schedules set by the bodies responsible for them.

The CQC will continue to:

- request an annual provider information request (PIR) from adult social care services, using the existing collection method.
- carry out online reviews of clinical records.
- request evidence directly from providers to support an assessment, most likely by email.

Where they request evidence, they will use information that a provider has available. Apart from the PIR for adult social care services, they will not specify a particular format for the information. They know services are at different levels of digital maturity so will adapt their collection methods while they develop, in line with the plan for digital health and social care.

For now, providers do not need to submit evidence to the CQC proactively. They will ask you for anything they need. In addition to specific requests for evidence from providers, they will continue to carry out interviews with staff and workers in services, and with service leaders. They may do this online.

The CQC will determine when they need to request evidence directly from providers based on the timetable for assessments.

They will continue to use the feedback they receive from people and their representatives about their experiences. This could be:

- from their 'give feedback on care' service.
- when people contact them through our National Customer Services Centre

They will also continue to:

- run online focus groups or contact people with experience of using a service.
- commission the NHS Patient Survey Programme to understand people's experiences of care.

They will also work with other people and organisations to help collect evidence, for example local Healthwatch groups and our Experts by Experience.

The timetable for collecting these sources of evidence depends on the specific source. For some sources, such as Give feedback on care, this is ongoing. Other evidence sources will be updated less frequently – such as through patient surveys (which are annual or biennial).

They will bring together all relevant evidence for a specific evidence category. They will then make a judgement based on the requirements of the quality statement and the new scoring scale. As they do this, they will consider:

1. if the evidence collected covers the scope of the service sufficiently
2. the quality and validity of the evidence.

To inform how they collect and use evidence, their teams will engage the expertise of their:

- Experts by Experience

- specialist advisors
- executive reviewers (colleagues who support on inspections of the well-led key question for NHS trusts).

Assessment teams can get quick access to specialists to support them to:

- understand which evidence to collect.
- corroborate and analyse evidence.
- interview key staff.

This will help ensure that their judgements maintain credibility.

The evidence they collect and how they collect it depends on a combination of factors:

1. the type of service
2. the quality statement and relevant evidence category
3. the information we already hold about a service.

There isn't a full list of evidence that fits every service. They may need to follow up specific risks or circumstances that would need particular evidence. They do not want providers to prepare specific documents.

The Inspection Process

The CQC will not be undertaking comprehensive inspections anymore and the new approach will be updating reflective scores against the key questions. The new regulatory model states that the CQC will carry out a rolling assessment of quality and risk.

This means that inspections will not be the only way that CQC assess your service.

They will become a part of a broader style of ongoing assessment that will include:

- Different ways of understanding and assessing the experiences of people.
- Hearing from staff and leaders.
- Direct monitoring activities.
- Evidence you submit to CQC.
- Surveys and focus groups.

Moving away from single inspections and an approach of continuous monitoring will mean a more dynamic approach that is built on shared information which will be presented on a new dashboard. This approach will give more consistency in quality and outcome/ratings.

Each area of the new style of assessment methodology could lead to a change in your rating. The current ambition of the CQC is to update the information they hold on a service across all of the required quality statements and evidence categories within 2 years.

Concerns have been raised from providers about the lack of consistency with outcomes of inspections and the regulator is confident that their systems and the technology will record and capture evidence to ensure consistency. They have said there will be greater visibility on outcomes being made and that all CQC colleagues from across the country will be able to see how people have interpreted the data and come to an outcome.

The CQC will ensure people who use services will form part of each inspection and through these voices it will drive consistency.

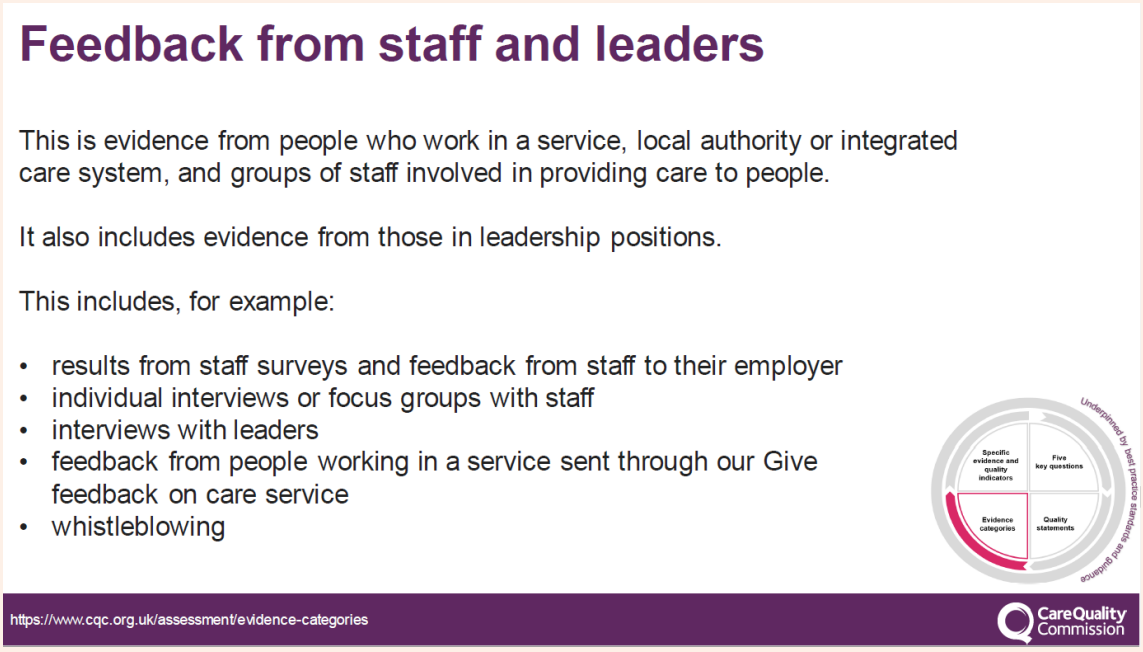
How will they gather evidence?

The CQC will collect evidence on site, off site or a combination of the two. This will include data that other organisations have already collected as well as information that they can collect themselves. Examples of some evidence that they can collect entirely off site can include:

- Data on outcomes of care
- Anonymised information from people's records
- Feedback and complaints to a service provider
- Feedback to CQC from people and their representatives about their experiences

The CQC will also work with other people and organisations to help collect evidence, for example local Healthwatch groups, local authority commissioners and through their Experts by Experience who will help the regulator reach out to people, families and carers and engage with communities whose voices are seldom heard.

This means the regulator may not always need to physically visit to gather this evidence and update the ratings.



Collecting evidence on site

The CQC will carry out site visits (inspections) when it's the best way to gather the evidence they need. For example, they will do this:

- When a service is registering with the CQC for the first time.
- So they can talk to people about their experience of care in some types of service.
- Where people have communication needs that make telephone or video conversations challenging.
- Where there are concerns around transparency and confidentiality.
- To check the validity of evidence they have already gathered in a setting.
- They can observe the care environment and how staff interact with people.

Whilst on site they will:

- Observe care.
- Observe the care environment, including equipment and premises.
- Speak to people using the service and the staff.

Their teams will also use the expertise of their Experts by Experience, specialist advisors and executive reviewers to inform their assessment activity. Executive reviewers are CQC colleagues who support on inspections of the well-led key question for NHS trusts. This ensures that their judgements maintain credibility.

Assessment teams can get quick access to specialists to support them in:

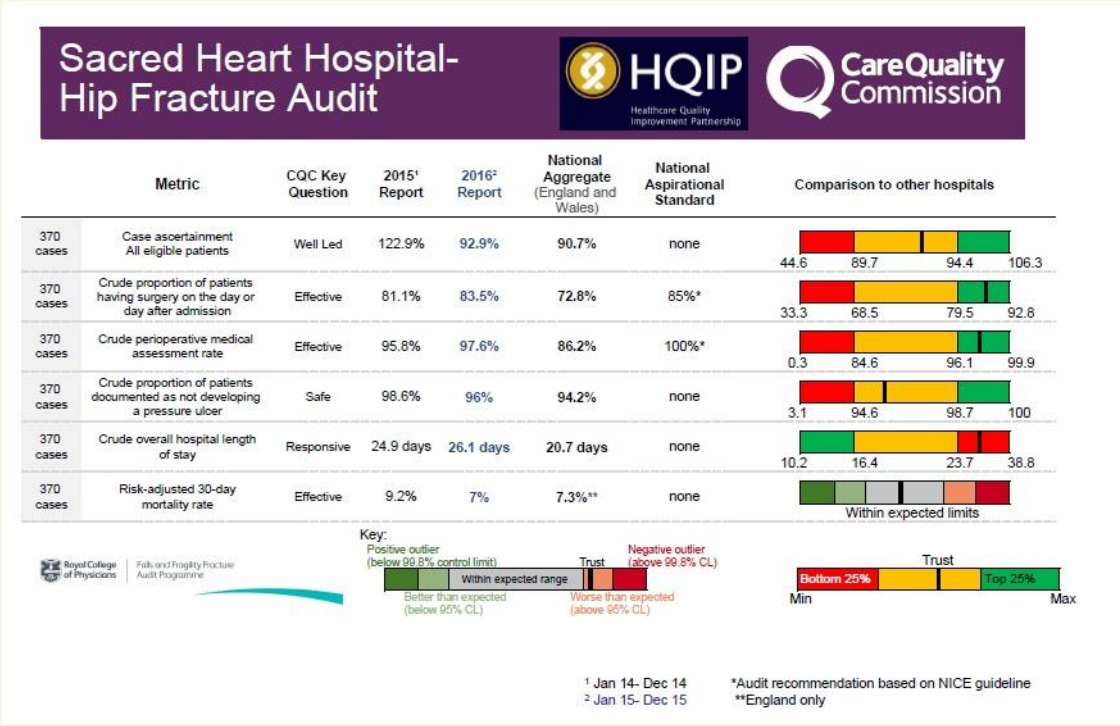
- Understanding which evidence to collect
- Corroborating and analysing evidence
- Interviewing key staff.

They will carry out site visits more frequently where:

- There is a greater risk of a poor or closed culture going undetected in a service.
- It is the best way to gather people's experience of care.
- They have concerns about transparency and the availability of evidence.
- They have a statutory obligation to do so. For example, as a member of the National Preventative Mechanism they must visit places of detention regularly to prevent torture and other ill-treatment.

At the moment, following an inspection a PDF inspection report is generated. Going forward there will be an accessible approach using other information on what they find. Reports will be shorter and the dashboard will have benchmarking information so providers know where to improve.

An example of how the benchmarking could look:



You can read an example of how they will reach a rating from this GP scenario on the CQC website: https://www.cqc.org.uk/assessment/quality-performance/reach-rating-example-gp-practice

Levels of Ratings

The CQC consider information about the quality of care provided when they look at the 5 key questions. They provide ratings at different levels for different types of service. They use professional judgement and a set of principles to help them to determine the final ratings.

The levels they rate are:

- Level 1: A rating for every key question at service level. For example a rating for how safe a care home is or how effective the surgery service at a hospital is.
- Level 2: An aggregated overall rating for the service. For example the rating for a care home or the surgery service at a hospital.
- Level 3: An aggregated rating for each key question at location level. For example the rating for how safe a hospital is.
- Level 4: An aggregated overall rating for the location. For example the rating for a hospital.
- Level 5: An overall rating for an NHS trust. This is based on the trust-level assessment of the well-led quality statements and moderation.

The levels CQC will rate each type of service.

They will rate services at the following levels:

- Adult social care services: levels 1 and 2
- GP services: levels 1 and 2
- Independent doctors and clinics: levels 1 and 2
- Independent health single specialty services: levels 1 and 2
- Independent health hospital (offering more than 1 service): levels 1, 2, 3 and 4
- Online primary care: levels 1 and 2
- Urgent care: levels 1 and 2
- Non-acute NHS trusts: levels 1, 2 and 5
- Acute NHS trusts: levels 1, 2, 3, 4 and 5.

How the CQC will aggregate ratings

When the provider of a service changes, the CQC will continue to show the previous ratings on their website. They will use these ratings to plan a proportionate, risk-based approach to planning the first assessment after a registration change. The first assessment will make new judgements and produce new ratings. Ratings from the previous provider are not used to produce a new aggregated rating.

Using professional judgement

If the CQC identify concerns in an assessment, we will use their professional judgement to decide whether to depart from applying our ratings principles. This will particularly be where we need to aggregate ratings that range from inadequate to outstanding.

When they do this, they will consider:

- The extent of the concerns
- The impact of the concerns on people who use services
- The risk to quality and safety of services, taking into account the type of setting
- Our confidence in the provider to address the concerns

- Whether the provider has already taken action.

If concerns have a very limited impact on people, it may reduce the impact on the aggregation of ratings.

Where a rating is not consistent with the principles, the CWC will record the rationale clearly in the report.

They will review the decision using their quality control and consistency processes.

Adult social care

CQC will rate these services at 2 levels.

- Level 1: we use our rating methodology and professional judgement to produce ratings for each of the five key questions.
- Level 2: we aggregate these separate ratings up to an overall service rating using the ratings principles.

CQC will decide overall service ratings using the following principles:

1. The five key questions are all equally important. They weight them equally when aggregating.
2. For an overall rating of outstanding, a service will normally need to have both:
    a. At least 2 key questions rated as outstanding.
    b. The other key questions rated as good.
3. The overall rating will normally be good if there are both:
    a. no key questions rated as inadequate.
    b. no more than 1 key question rated as requires improvement.
4. The overall rating will normally be requires improvement if 2 or more key questions are rated as requires improvement.
5. The overall rating will normally be inadequate if 2 or more key questions are rated as inadequate.

The New Scoring System

The 4 ratings CQC use to describe the quality of care; outstanding, good, requires improvement or inadequate will remain in place.

Different quality statements are likely to be assessed on an ongoing basis as CQC move away from inspecting and making judgements at a single point in time. When they assess evidence, they will assign scores to the key evidence categories for each quality statement that they are assessing. Ratings will be based on building up scores from quality statements to an overall rating.

The evidence consists of an analysis of information that CQC already holds, alongside their onsite/off-site assessment activity. The evidence findings will determine the score for each quality statement.

Using scoring as part of their assessments will help outcomes be clearer and more consistent about how they have reached a judgement on:

- The quality of care in a service
- How well a local authority is delivering its duties under the Care Act
- The performance of an integrated care system.

For example, for a rating of good, the score will tell if this is either:

- In the upper threshold, nearing outstanding.
- In the lower threshold, nearer to requires improvement.

Similarly, for a rating of requires improvement, the score would tell if it was either:

- In the upper threshold, nearing good.
- In the lower threshold, nearer to inadequate.

Their quality statements clearly describe the standards of care that people should expect.

To make things clearer and more consistent, they will set out the types of evidence they will focus on in each evidence category when they are assessing a quality statement.

To assess a particular quality statement, they will take into account the evidence they have in each of the key evidence categories. This will vary depending on the type of service or organisation. For example, the evidence they will collect for GP practices will be different to what they will have available in an assessment of a home care service.

They will collect different evidence when they assess local authorities and integrated care systems.

Evidence could be information that they either:

- Already have, for example from statutory notifications
- Actively look for, for example from an on-site inspection.

Depending on what they find, they will give a score for each evidence category that is part of the assessment of the quality statement. All evidence categories and quality statements are weighted equally. There are 27 written statements, each scored between 1 to 4 (4 is outstanding)

Scores for evidence categories relate to the quality of care in a service or performance of a local authority or integrated care system:

1. 4 = Evidence shows an exceptional standard
2. 3 = Evidence shows a good standard
3. 2 = Evidence shows some shortfalls
4. 1 = Evidence shows significant shortfalls

As they are moving away from assessing at a single point in time, in future they will likely assess different areas of the framework on an ongoing basis. This means they can update scores for different evidence categories at different times.

While the quality statements clearly describe the standards of care people should expect, and providers need to 'live up to,' evidence in each required evidence category will be used to assess a particular quality statement.

This means that scores for different quality statements will be updated at different times leading to a more current and up-to-date view of quality. This may lead to changes in your rating.

To make their judgement CQC will:

- Review evidence types within the required evidence categories for each quality statement.
- Apply a score to each of these evidence categories.
- Combine these required evidence category scores to give a score for the related quality statement.
- Combine the quality statement scores to give a total score for the relevant key question.
- This score generates a rating for each key question.
- Aggregate the key question ratings to give the overall rating.

They will follow these initial 3 stages for all assessments:

- Review evidence within the evidence categories they are assessing for each quality statement.
- Apply a score to each of these evidence categories.
- Combine these evidence category scores to give a score for the related quality statement.

After these stages, they build up scores from quality statements to an overall rating. This depends on the type of assessment.

For service providers

The quality statement scores are combined to give a total score for the relevant key question. This score generates a rating for each key question (safe, effective, caring, responsive, and well-led).
They then aggregate the scores for key questions to give a rating for their view of quality at an overall service level.
They will initially only publish the ratings for providers, but they intend to publish the scores in future.

For local authorities

The quality statement scores are combined to give an overall score and a rating.
Ratings will be indicative for the pilot assessments until they move to ongoing assessment.

For integrated care systems

The quality statement scores are combined to give a theme score.
Theme scores are then combined to give a score for each of the 3 themes and an overall score and rating.

General

By using the following rules, they can make sure any areas of poor quality are not hidden.

If the key question score is within the:

- Good range, but there is a score of 1 for one or more quality statement scores, the rating is limited to requires improvement.
- Outstanding range, but there is a score of 1 or 2 for one or more quality statement scores, the rating is limited to good.

They do not have rules or limiters for different combinations of evidence category scores. But they can apply their professional judgement if the quality statement score produced does not reflect quality for that topic.

Their judgements will go through a quality assurance processes.

They will need to collect evidence for all the quality statements for services that have not previously been inspected or rated before they can publish scores and ratings.

CQC say the new scoring system will better support consistency and transparency in their judgements. Rather than the 'once and done' style of current inspections, future assessments will often be much shorter and much more frequent covering different aspects of the quality and safety of your service.

The new scoring system will allow providers and the public to see how CQC reached their judgment, as well as reviewing if the quality of care is moving up or down within a rating. It will also show if a service is getting close to a different rating. For example, for a provider with a 'good' rating, the score will be able to show if it's closer to 'outstanding' or closer to 'needs improvement.'

To work out the scoring, the CQC will calculate the percentage by dividing the total score of all the Evidence Categories in the key area and multiplying it by the maximum possible score (4).

Calculating, scoring and rating

Example: combining evidence category scores to give a quality statement score

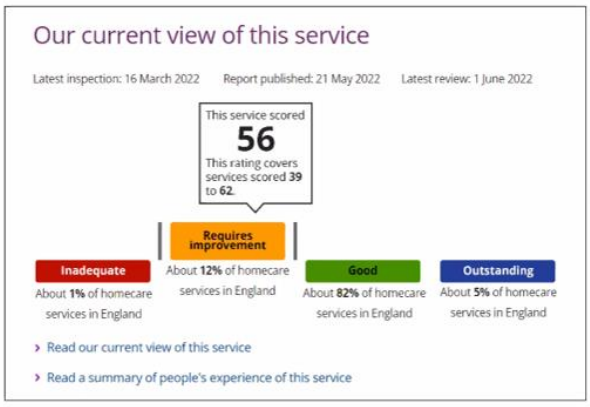
We calculate this as a percentage so that we have more detailed information at evidence category and quality statement level and can share this.

To calculate the percentage, we divide the total (in this case 11) by the maximum possible score.
This maximum score is the number of required evidence categories multiplied by the highest score for each category, which is 4.
In this case, the maximum score is 16. Here, it gives a percentage score for the quality statement of 69% (this is 11 divided by 16).

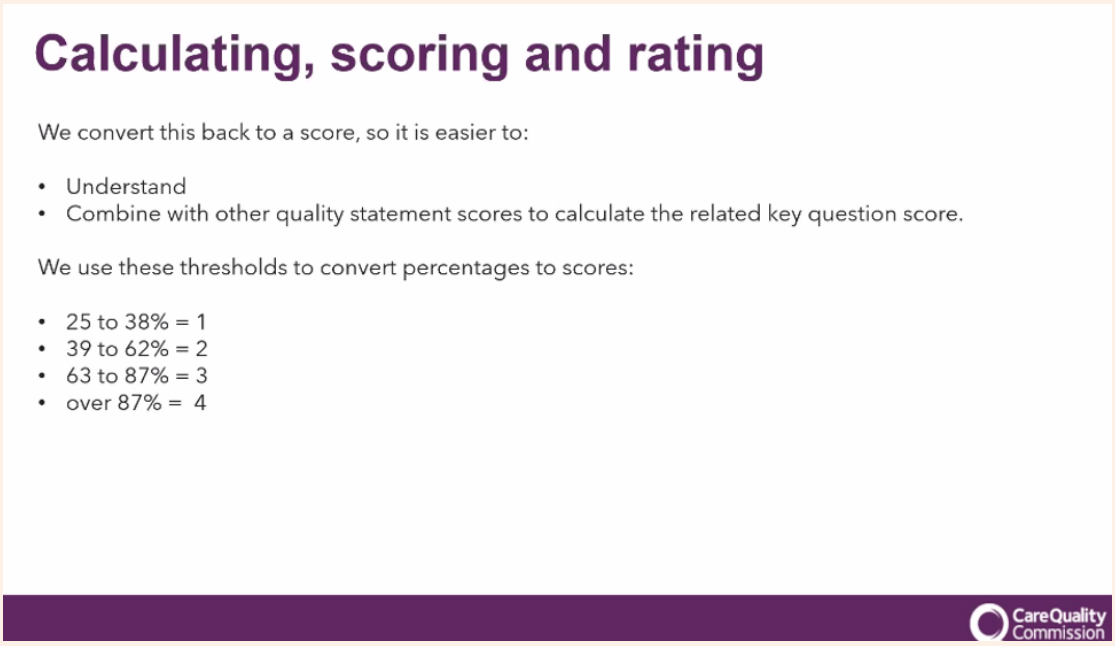
Evidence category	Score	Existing or updated score
People's experiences	3	updated
Feedback from staff and leaders	2	updated
Observation	3	updated
Processes	3	existing
Total score for the combined evidence categories	**11**	

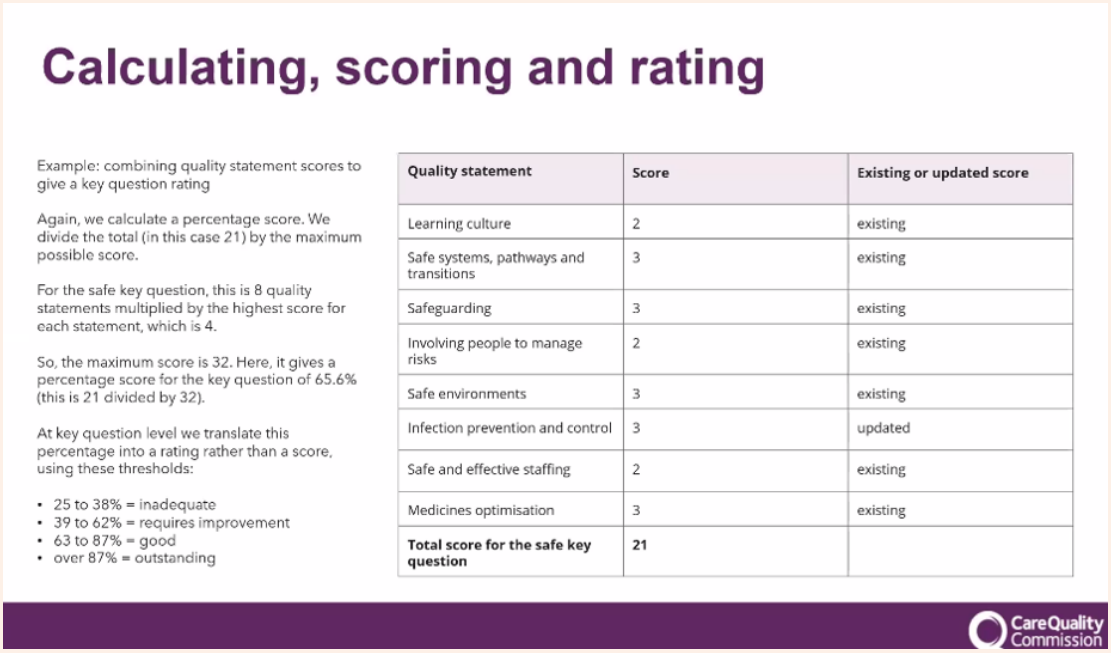
CareQuality Commission

Overview page: rating position



CareQuality Commission





Here are a couple of examples of how the scoring system may work:

Quality Statement (Safe)	Score and Percentage
Learning culture	3
Safe systems, pathways and transitions	2
Safeguarding	3
Involving people to manage risks	1
Safe environments	3
Safe and effective staffing	3
Infection prevention and control	3
Medicines optimisation	3
Total combined score for SAFE	21
Maximum possible score for the combined Evidence Category	32 (8 statements x 4 points)
Percentage score for Quality Statements	66% (21 divided by 32)
Overall score for Quality Statement SAFE	3 (Good)

Quality Statement (Effective)	Score and Percentage
Assessing needs.	3
Delivering evidence-based care and treatment.	3
How staff, teams and services work together.	4
Supporting people to live healthier lives.	3
Monitoring and improving outcomes.	3
Consent to care and treatment.	3
Assessing needs.	3
Delivering evidence-based care and treatment.	3
Total combined score for EFFECTIVE	25
Maximum possible score for the combined Evidence Category	32 (8 statements x 4 points)
Percentage score for Quality Statements	78% (25 divided by 32)
Overall score for Quality Statement SAFE	3 (Good)

25% - 38%	1 = Evidence shows significant shortfalls	Inadequate
39% - 62%	2 = Evidence shows some shortfalls	Requires Improvement
63% - 87%	3 = Evidence shows a good standard	Good
87%+	4 = Evidence shows an exceptional standard	Outstanding

The CQC has recognised that providers have to wait a long time to find out their inspection results, so have aimed to streamline and speed up their reporting processes to improve turnaround times. You can read more about the scoring process here: https://www.cqc.org.uk/assessment/quality-performance/reach-rating

How they will calculate the first scores

Their new single assessment framework uses scores to help them decide the ratings for a service. When they start to assess services using this new approach, they will need to apply scores for each quality statement.

Services with an existing rating or findings about compliance

When they carry out their first assessment of a service, they will select which quality statements to look at. The selection of quality statements will be determined by national priorities, set by type of service, as well as a consideration of the information they hold about your service.

For each of the quality statements they look at, they will collect evidence and score all the relevant evidence categories. This means the scores for those quality statements will be entirely based on their new assessment.

For the remaining quality statements, they will base the scores on their previous findings. They will do this using the current, published ratings for the relevant key question. These scores will be:

- 4 for each quality statement where the key question is rated as outstanding.
- 3 for each quality statement where the key question is rated as good.
- 2 for each quality statement where the key question is rated as requires improvement.
- 1 for each quality statement where the key question is rated as inadequate.

There are 4 exceptions to this approach for topics that have moved from one key question to another or are new to our framework.

For all services:

- The initial scores for the workforce wellbeing and enablement quality statement will be based on the well-led key question rating. This is because this topic area has moved from well-led to caring in their new framework.
- They will not apply an initial score for the environmental sustainability quality statement. This is because it is a new area in their framework.

For services previously inspected using the adult social care framework only:

- The initial scores for the care provision, integration and continuity quality statement will be based on the well-led key question rating.
- The initial scores for the providing information quality statement will be based on the effective key question rating. This is because this topic area has moved from effective to responsive in their new framework.

Services that have not yet been inspected

If your service has not been inspected when it moves under the new approach, they will not apply initial scores as there are no previous findings to base these on.

For these services, they will normally collect evidence for all the quality statements within the first year.

Factual Accuracy Checks

When the CQC have checked the quality of the draft assessment report, they will send it to you to review. They will make it clear whether this is about the new type of assessment or old. If you are inspected under the old assessment, you'll need to follow the factual accuracy check guidance for our existing assessment process instead.

The CQC will ask you to check the factual accuracy and completeness of the information they have used to reach their judgements and ratings, where applicable.

The factual accuracy checking process allows you to tell the CQC:

- where information is factually incorrect
- where their evidence in the report may be incomplete

The factual accuracy process gives assessment teams and providers the opportunity to ensure they consider all relevant information that will form the basis of their judgements.

Assessment teams base their judgements, scores and ratings on all the available evidence, using their professional judgement and their scoring model. The assessment report does not need to reference all the evidence but it should include the best evidence to support our judgements.

The CQC will email the appropriate registered person a link so you can review the draft report online. . If your organisation has more than one registered person, for example a nominated individual and a registered manager, each registered person will receive the email.

You will be able to enter comments about factual accuracy against each section.

You can read the draft report online. You can also print or download it.

If you wish to raise one or more points about factual accuracy, you can:

- enter a comment against the relevant section of the report.
- upload evidence to support comments you make against our evidence categories, if needed

Providers are responsible for making sure that the responsible person has checked the factual accuracy of the draft report and that any factual accuracy comments have been approved and submitted.

When you view the draft report online, the CQC gives a date by which you will need to review it and submit any comments about factual accuracy. This date is at least 10 working days from when you receive our email.

They will not extend this period unless there are exceptional circumstances. If you are unable to respond before the deadline, you must tell them why immediately in writing. They will use their discretion to determine whether there are exceptional circumstances.

There are certain types of correction you can make:

- Typographical or numerical errors or, for example, incorrect job titles.
- Information that has contributed to a judgement, but which you believe is factually inaccurate. You will need to provide supporting evidence. This must relate to the position at the time of the assessment.
- Additional information, or information that was omitted, which you think we should consider. For example, you may have further examples of exemplary practice that demonstrate real benefits for people using your service, which may support a rating of outstanding rather than good. Again, this must be relevant to the time of the assessment.

The draft report is based on evidence we collected during their assessment. You can also send them information about action you have taken since the assessment that addresses the concerns they raised with you, or which is included in the draft report. The assessor will consider any further information you send and determine whether the report should be amended.

Unless there are exceptional circumstances, this new information will not form part of CQC's decision around final judgements or ratings (where appropriate).

The factual accuracy checking process should not be used to challenge:

- an assessment rating or score solely because you disagree with it.
- how they carried out an assessment
- enforcement activity that they propose (see how to make a representation about proposed enforcement activity)

If you need to ask them for information before you can submit factual accuracy comments, your request should be short, specific and should clearly justify why you need the information to raise a point of factual inaccuracy. You should send your request directly to your assessor if you're already in contact with them. Otherwise email enquiries@cqc.org.uk, quoting your assessment reference number (starts with AP) and marking it for the attention of the assessment team.

The CQC will not release the inspector's full notes from an inspection. They will consider requests for extracts of notes about a specific issue where this is reasonably necessary to enable you to understand the basis for a statement in the draft report that you believe is factually inaccurate (that is, if the basis of their statement is not clear from the draft report).

To protect the confidentiality of people reporting concerns to the CQC, they will not identify someone who has shared this information with them.

Requesting information from CQC describes the types of information you can ask the CQC for.

After the CQC have considered your points and any supporting information, they'll decide whether to amend the draft report.

They will email you a link to the final version of the report before it is published and also respond to any comments you've submitted about factual accuracy.

If they have evidence that supports a point in the draft report, they are entitled to rely on this. If you dispute the point, but you have not provided any evidence in support, they may ask you to provide it.

All factual accuracy responses will be reviewed by another member of CQC's staff who is independent of the original assessment.

Example of possible outcomes from a factual accuracy check

During an inspection, the inspector asks to see a copy of a safety policy. A senior member of staff tells them there isn't one. The inspector includes this information in the draft report and it is considered as part of the rating/judgement. CQC also considers the information when deciding whether to take enforcement action against the provider.

Scenario 1:

As part of the factual accuracy check, the provider sends this policy to CQC, stating that it did exist at the time of the inspection and that they do not know why the senior member of staff told the inspector that they didn't have one. The inspector is satisfied that the document was available at the time of inspection so includes this information in the final report and it is considered as part of the rating/judgement. CQC also considers the information when deciding whether to take enforcement action against the provider.

Scenario 2:

As a result of the factual accuracy check, the provider tells us that they have now implemented a policy. The inspector includes this information in the final report, but does not consider it as part of the rating/judgement. CQC also considers the information when deciding whether to take enforcement action against the provider.

If there are no factual inaccuracies in the report, you can confirm you've reviewed it. The CQC will then be able to publish the final version.

Displaying your Ratings

If your service is one of the first to have a report and rating published under our new single assessment framework, there will not be a PDF poster generated on your profile page. These will be added early in 2024.

Instead, the CQC will provide a template for you to use to display your ratings at your premises. As before, you can choose to create your own posters so long as they include the necessary information and are as visible and clear as our posters.

You can promote your most recent ratings when you contact people who use your services, for example on letters or emails. If you are rated as good or outstanding, you can use the CQC official promotional graphics to promote this to people using your service and the wider community.

As well as displaying ratings posters, think whether people who use your service will fully understand your ratings. You can display additional information alongside a poster, but not instead of it.

You can tell people how to find out about improvements or what you have changed since we published your ratings. Use the space the CQC provide on the posters or put extra information next to the poster, but make sure it does not detract from it.

You can decide not to use CQC posters and create your own. They must be just as visible and clear as our posters.

If you create your own poster, inspectors will compare it with the ones CQC produce to decide whether your ratings display meets the regulation.

Gone will be the days where you search for a service on the CQC website and download the PDF report, and instead the CQC will display the information, and have stated this makes the information more accessible on tablets, phones, computers etc.

The CQC will publish the following:

- Overall rating for the service.
- Summary of current review of the service by the assessment team
- Summary of people's experiences of the service by the assessment team
- Key Question
    - Ratings
    - Score
    - Summary of findings.
- Quality Statement
    - Score
    - Explanation of what the score means.
- Summary of key findings for evidence category

Throughout 2024, CQC will deliver some improvements to the way they display the information. These will include:

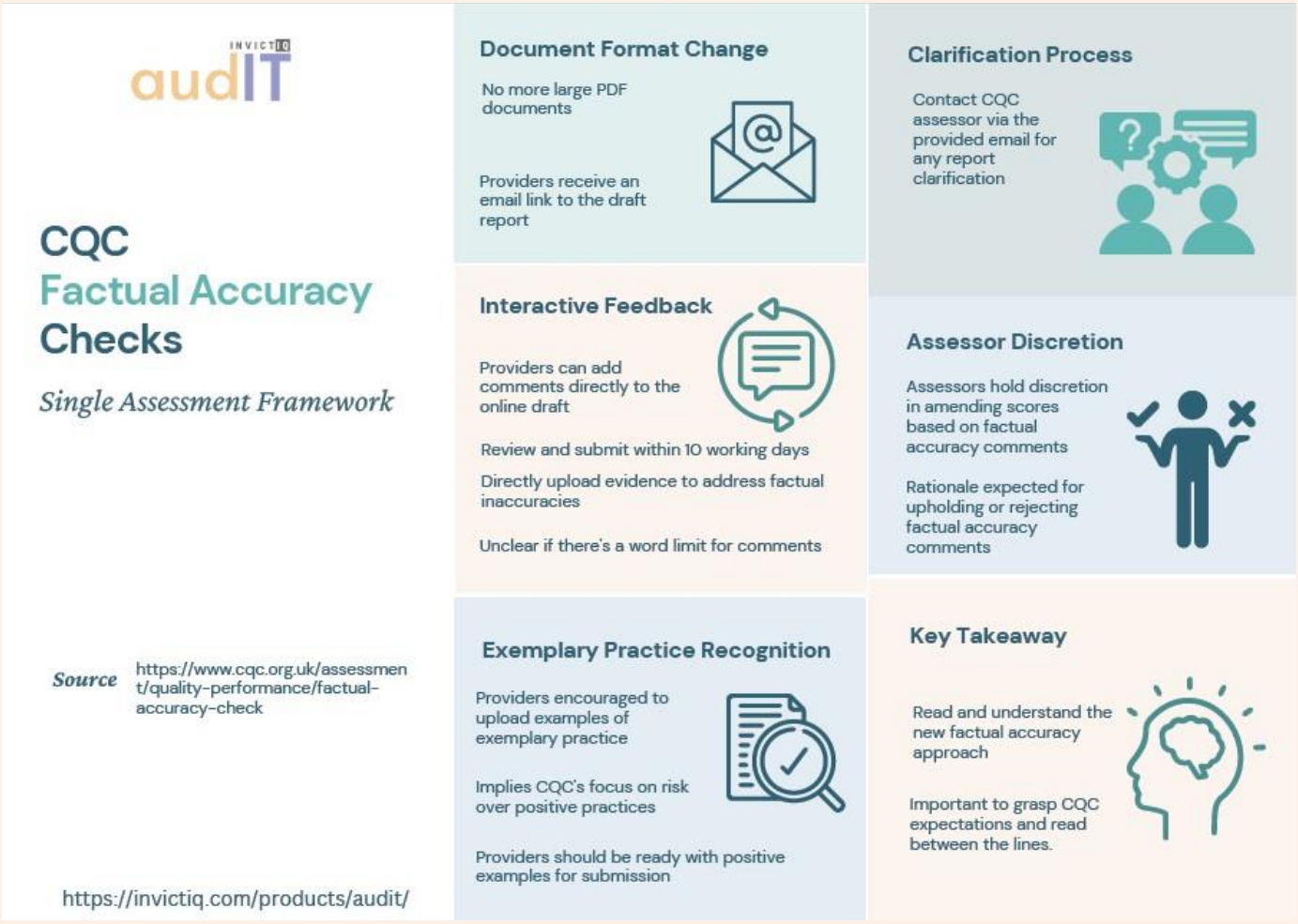
- New visualisations of the scoring information to make it clear where a service sits on the rating scale and in comparison to equivalent services nationally and locally.
- Separate profiles for services at the same location but where CQC do not aggregate ratings to an overall level. For example, where a care home and a homecare agency or a GP practice and an out-of-hours GP service are provided from the same location.

They will also improve the way you can refine search results using ratings and scores.

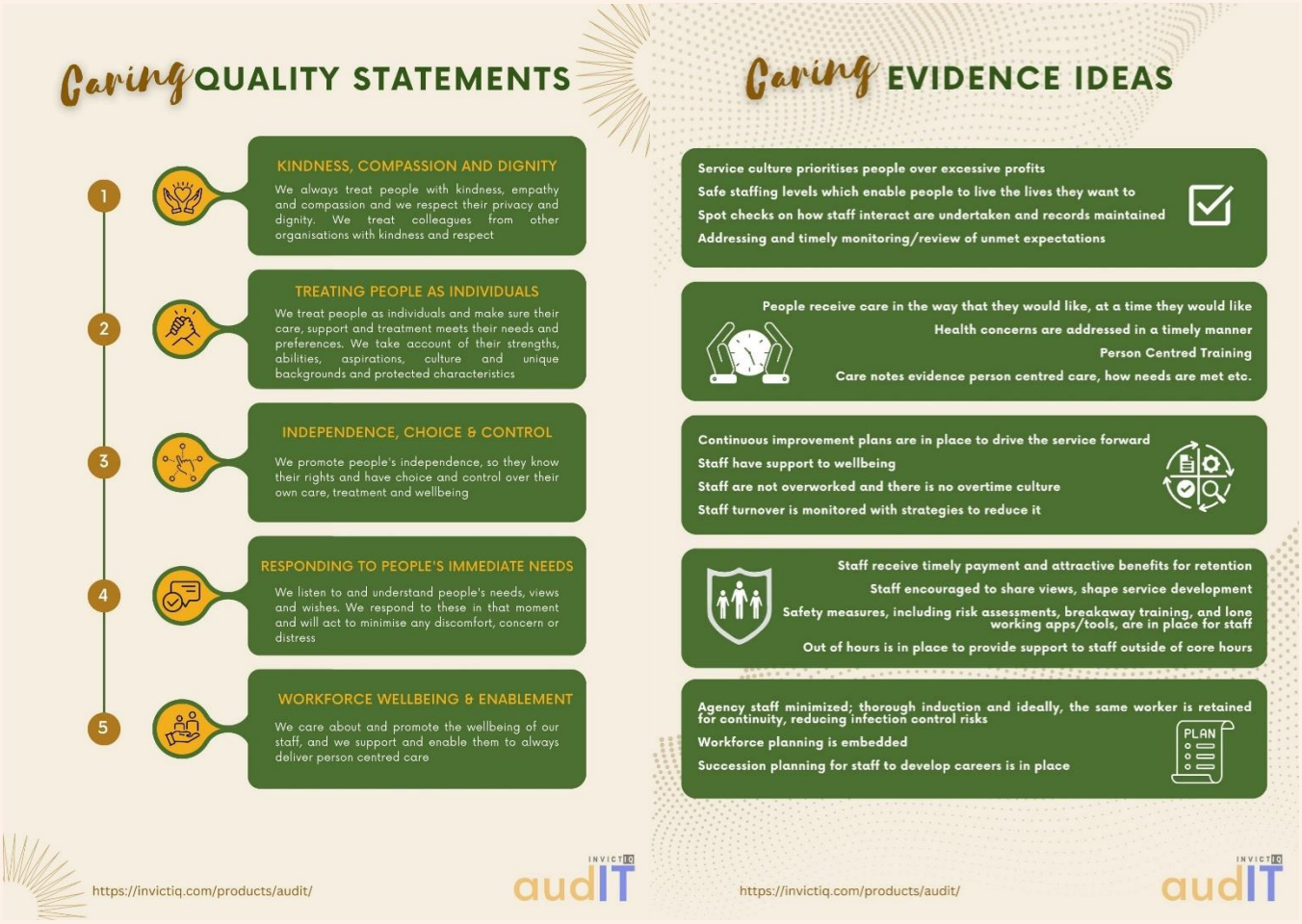
What we are still waiting to know

- The frequency of evidence collection, and therefore score reviews.
- Importance of evidence collaboration / checking people's experience of care is accurate (perception vs reality)
- What is the data validation and quality assurance process.
- What is the lifespan of a data set.
- Whether there will be a limited number of words or not for factual accuracy checks
- Will there be an increased burden to care providers (PIR/checking data)
- When will scores be publicly available.
- When the new system will hold Local Authority's to account when the person is receiving care and support and having a good experience because of the efforts of the provider and yet the provider is not having a good experience because of action/inactions by a Local Authority/CCG.

Factual Accuracy Checks courtesy of InvictIQ



Quality Statement – Caring courtesy of InvictIQ



Quality Statement – Effective courtesy of InvictIQ

Effective QUALITY STATEMENTS

Assessing needs
We maximise the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them

Delivering evidence-based care and treatment
We plan and deliver people's care and treatment with them, including what is important and matters to them. We do this in line with legislation and current evidence-based good practice and standards

How staff, teams and services work together
We work effectively across teams and services to support people. We make sure they only need to tell their story once by sharing their assessment of needs when they move between different services

Supporting people to live healthier lives
We support people to manage their health and wellbeing so they can maximise their independence, choice and control. We support them to live healthier lives and where possible, reduce their future needs for care and support

Monitoring and improving outcomes
We routinely monitor people's care and treatment to continuously improve it. We ensure that outcomes are positive and consistent, and that they meet both clinical expectations and the expectations of people themselves

Consent to care and treatment
We tell people about their rights around consent and respect these when we deliver person-centred care and treatment

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Effective EVIDENCE IDEAS

Care plan reviews and updates as needs change, which document the involvement of the person and their support network

Information is provided in an accessible format

Assessment records are detailed, including transition periods where applicable.

Pain assessments in place

BMI / Waterlow Scoring in place

Clinical records in place (speech and language, occupational therapist, physiotherapist etc)

Mental Capacity and Deprivation of Liberty is in place where applicable. Where needed best interest meetings and records are in place

People are encouraged to remain independent through enabling risk assessments.

Risk assessments are reviewed as needs change or on a regular basis

Weight monitoring is in place

Menus offer a balanced diet

Care plans and care delivery ensure people are supported to live healthy lives, access the community and remain in control of the things they do

Staff meeting minutes

Supervision records

Staff survey, with you said, we did outcomes

Surveys of those who use your care services, with you said, we did outcomes

Family / next of kin surveys, with you said, we did outcomes

Professionals who visit/are involved surveys, with you said, we did outcomes

Multidisciplinary team meeting records

Records of referrals to other services and professionals

GP/Dentist/Chiropodist etc visits are documented, with outcomes met.

Consent to care in place for each person and regularly reviewed.

Dieticians involved where needed.

Diet records maintained (food intake, fluid intake)

Bowel charts / urine charts in place as required.Improvement plans in place, fed from audits undertaken in the service to evidence continuous improvements and learning.

Evidence of knowledge sharing and collaboration with other services, including shared care records for people transferring in or out of the service

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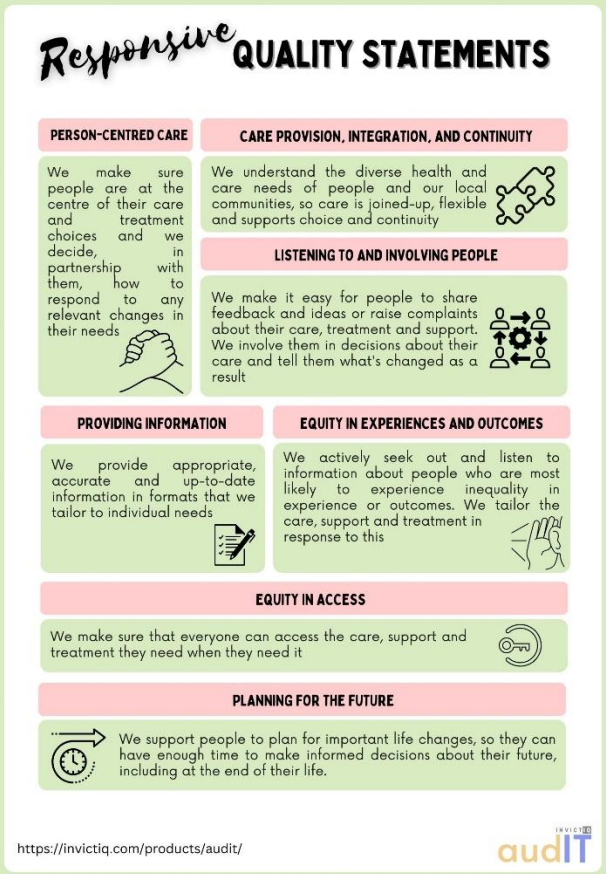
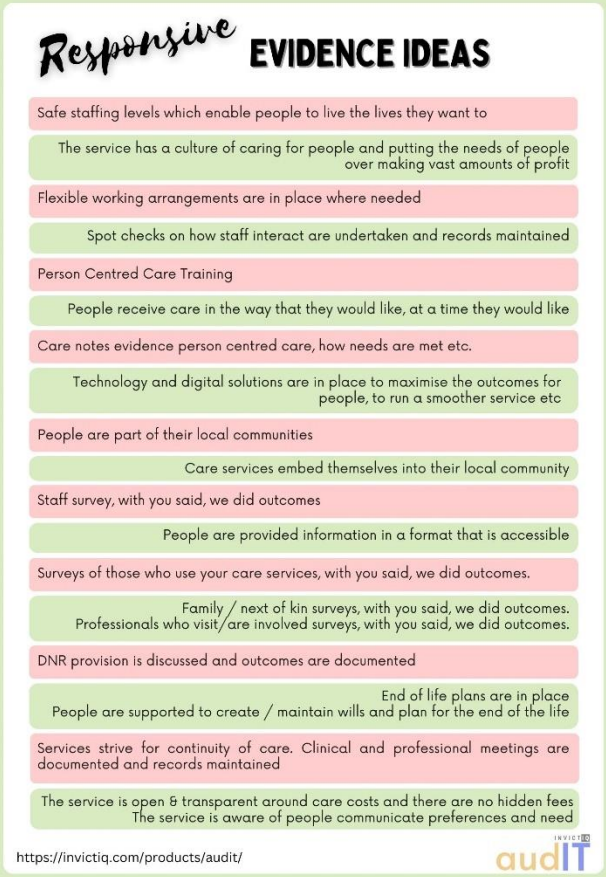
Quality Statement – Responsive courtesy of InvictIQ





Quality Statement – Safe courtesy of InvictIQ

Quality Statement – Well-Led courtesy of InvictIQ

Well-Led EVIDENCE IDEAS

- The organisation has business plans in place for the future which is shared with staff for the shared vision
- Equality, Diversity and Inclusion policies in place
- Staff are aware of the mission, vision and values
- Values are embedded into the organisation
- Mission, Vision and Values are reviewed periodically so that it is adapting to the world around us, strives for improvement and incorporates the vision that the staff team and people who use the service want

- Providers have effective recruitment and selection procedures
- Workforce planning is embedded
- Succession planning for staff to develop careers is in place
- The service ensures reasonable steps are made to make adjustments to enable people to carry out their role, in line with requirements to make reasonable adjustments for employees under the Equality Act 2010
- Staff have CPD and encouraged to develop their skills and careers within health and social care
- There is a culture of continuous feedback and development

- Staff and people who use care services are encouraged to voice their opinions and feedback in different ways (surveys, suggestions boxes, reviews)
- Clear policies and procedures which are reviewed and updated as needed
- Good HR practices are in place
- The service is committed to sustainable practices, with staff and those using the care service being part of this. Initiatives are in place such as battery recycling, car sharing, window seals checked for draughts etc

- For services supporting people in their own homes, conversations around sustainability are documented and people informed about how they can contribute to a sustainable lifestyle
- Rota management tools are in place to reduce mileage and car emissions.
- Trusted assessor model in place
- Services are part of their local Integrated Care Systems.

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Well-Led EVIDENCE IDEAS

- Discharge to assess schemes in place where applicable to aid hospital discharges/flow from the NHS
- Staff are encouraged to share forward thinking ideas of how the service can adapt for the future
- There is clear partnership working with other local services, health colleagues, community services etc. Shared care records are in place where needed
- Directors/CEO have oversight of the service
- Flexible working arrangements are in place where needed

- There is clear partnership working with other local services, health colleagues, community services etc. Shared care records are in place where needed
- CQC notifications are submitted in a timely manner and records maintained
- Managers are supported and upskilled, in areas other than the requirements set by the regulator. Managers are encouraged and supported to maintain good well-being and work/life balance
- Spot checks are done on all staff, regardless of role/level within the organisation
- Technology and digital solutions are in place to maximise the outcomes for people, to run a smoother service etc.

- Business continuity plans (including Winter Planning, Flood planning, Cyber Attacks)
- Risk registers are in place
- GDPR training and mechanisms to safeguard data are in place

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Stay up to date and getting ready.

1. Keep checking the CQC website – they won't necessarily make it obvious what has been updated, but it is being updated on a regular basis. Changes are date stamped on their website though.

2. Share information with your team to support their understanding of the changes as they emerge. Try to reduce and remove the fear factor of the regulator.

3. Speak to other social care managers and leaders and share knowledge.

4. Look out for the CQC webinars and other events being hosted by care organisations aimed to upskill, educate and raise awareness of the changes.

5. Undertake a mock inspection, this should be done by someone else in your organisation or a third party. Please do not pay for an expensive 'new single assessment mock inspection' as no one truly knows what this is going to look like yet. A mock inspection will ensure you are fully compliant with the current CQC's regulation, help you determine how efficiently your service is and identify where improvements can be made. It can help gain valuable insight and a clear action plan.

6. Follow The Caring View on LinkedIn, Twitter and Facebook – this free resource is great for upskilling you in all things social care. Find out more at www.thecaringview.co.uk.

7. Review your organisations internal processes to ensure these are aligned with the Quality Statements and the specific Evidence Categories relevant to your service.

8. Be proactive in capturing, monitoring and recording your own data and make sure it is organised, analytical and factual. The CQC love to see where you have made a positive impact, so make sure you capture that too.

9. Once you have collected your evidence in each Key Question, rate it yourself and see what score you would give your own service.

10. Maintain good working relationships with your multi-agency partners as they will become sources of evidence used by the CQC to inform their inspection of your service.

11. Utilise the CQC resources available:
    a. Provider Bulletin - https://www.cqc.org.uk/news/newsletters-alerts/email-newsletters-cqc or google 'CQC Bulletin.'
    b. Twitter (X) - @CQCProf
    c. YouTube – https://www.youtube.com/user/cqcdigitalcomms.
    d. Facebook – https://www.facebook.com/CareQualityCommission.
    e. Their digital platform which often has early insights into ideas and upcoming features and gives you the chance to give your feedback and ideas – https://cqc.citizenlab.co/en-GB/
    f. CQC Podcast – Search 'CQC Connect' in your favourite podcast app.
    g. CQC Blog - https://carequalitycomm.medium.com/ or google search 'Medium CQC.'
    h. CQC Publications - https://www.cqc.org.uk/publications.

Of course, you can find me at:

1. Twitter - @_mark_topps
2. LinkedIn - https://www.linkedin.com/in/marktopps/ and be sure to follow my bi-weekly newsletter which contains lots more guides and information for those working in social care. Just search The Care Mentor into your LinkedIn search bar.

Sources of information used to create this guide: W&P Assessment and Training Centre, The Access Group, Log My Care, InvictIQ, Think Local Act Personal, CQC, Virtual Administration, Homecare Association and reviewing many summary posts on manager FB forums, Twitter and LinkedIn.