07/12/2023

Extended briefing for NCF members on CQC's new regulatory model for social care and wider CQC approach – updated December 2023

Context

The CQC started to implement elements of their current approach and the KLOES in 2012 and the full rollout for adult social care services began in 2014. Since then, they have completed a full round of inspections for all registered services using the current methodology (with a few exceptions depending on the date they registered with the CQC). This, along with their new thinking set out in their strategy, has caused them **to take a fundamental look at their current regulatory model,** added to which we have had the pandemic and of course, the CQC now have the duties of oversight for local authorities & Integrated Care Systems.

CQC resources

There are various resources that the CQC have produced to help us all understand their thinking as they make progress on developing their new regulatory model.

CQC Webpages

- New approach to assessment webpage
    - Key questions and quality statements
    - Evidence Categories
    - People's experiences of health and care
    - I statements
    - Assessing quality and performance
- LA webpage
- ICS webpage
- **New Information** Displaying your ratings - Information about the rating posters you need to display

Podcasts

- a podcast sharing the experiences of providers who have been part of research and engagement
- a podcast sharing an update on local authority assessments and why they matter
- a podcast about local authority assessments, featuring a Q&A session with Community Care

Videos and Webinar Recordings

- Video describing when and how CQC is changing
- Video introducing the new provider portal
- Video describing how to submit notifications on the new provider portal
- Video on quality statements and a video on evidence categories
- Webinar on how and when CQC are implementing their new assessment approach and provider portal
- Webinar on quality statements and evidence categories

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"I can't thank NCF enough for the support, guidance and advice they've given me and for their tireless advocacy for our sector. I love the supportive fortnightly virtual members calls and I've really valued all the connections that NCF have made for me."

Claire Rintoul, **CEO, Sheffcare**

NCF Briefing on the New Regulatory Model

This briefing is designed to update you on what we know so far about the new regulatory model as of the start of December 2023.

We have updated:

- Information about the environmental sustainability quality statement (page 11)
- Priority quality statements (page 11)
- Methods the CQC will use to gather evidence (page 23)
- Calculating first scores (page 24)
- Information about the scoring that CQC will publish (page 29)
- Factual accuracy check (page 29)
- Rollout timeline (page 32) and Frequency of assessment (page 33)

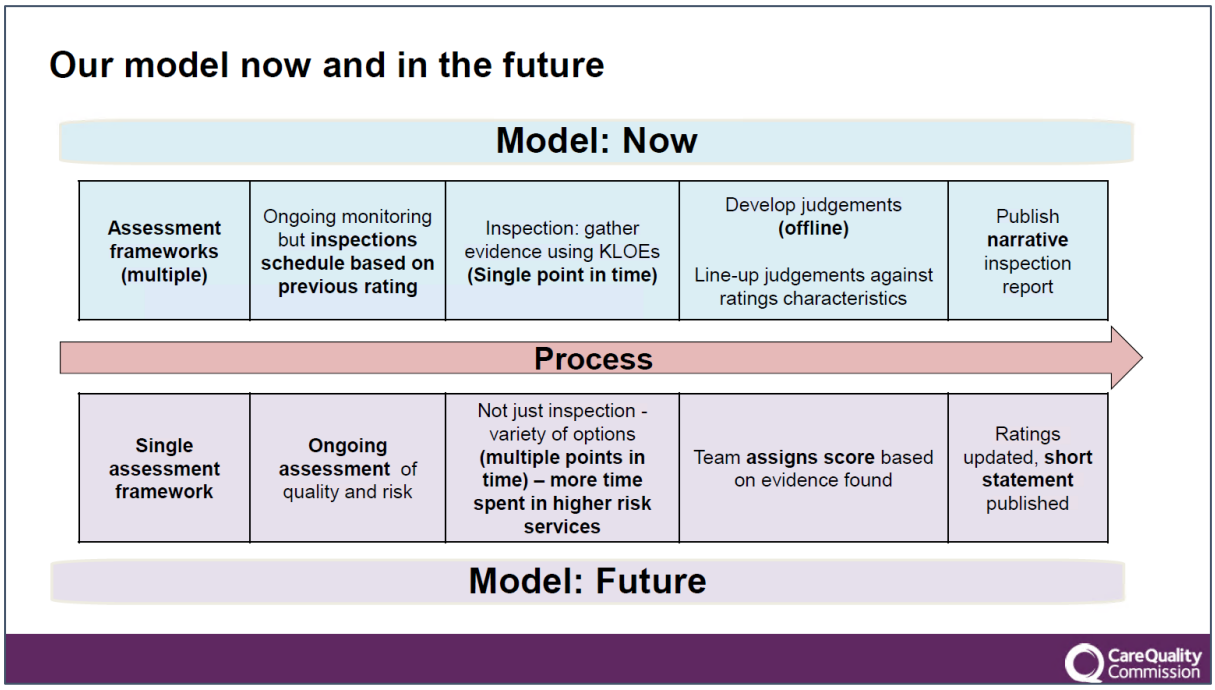
This briefing features information about:

This briefing has been prepared with support from Freya Cassia and Tim Coolican from the regulatory team at Anthony Collins. Members seeking legal advice in relation to the new framework can contact them by email: Freya.Cassia@anthonycollins.com and Tim.Coolican@anthonycollins.com

Where NCF members are subject to assessment under the new framework and want to consider their options to challenge the approach, ACS can offer a free 20-minute consultation to talk about your concerns and options.

Understanding what is changing

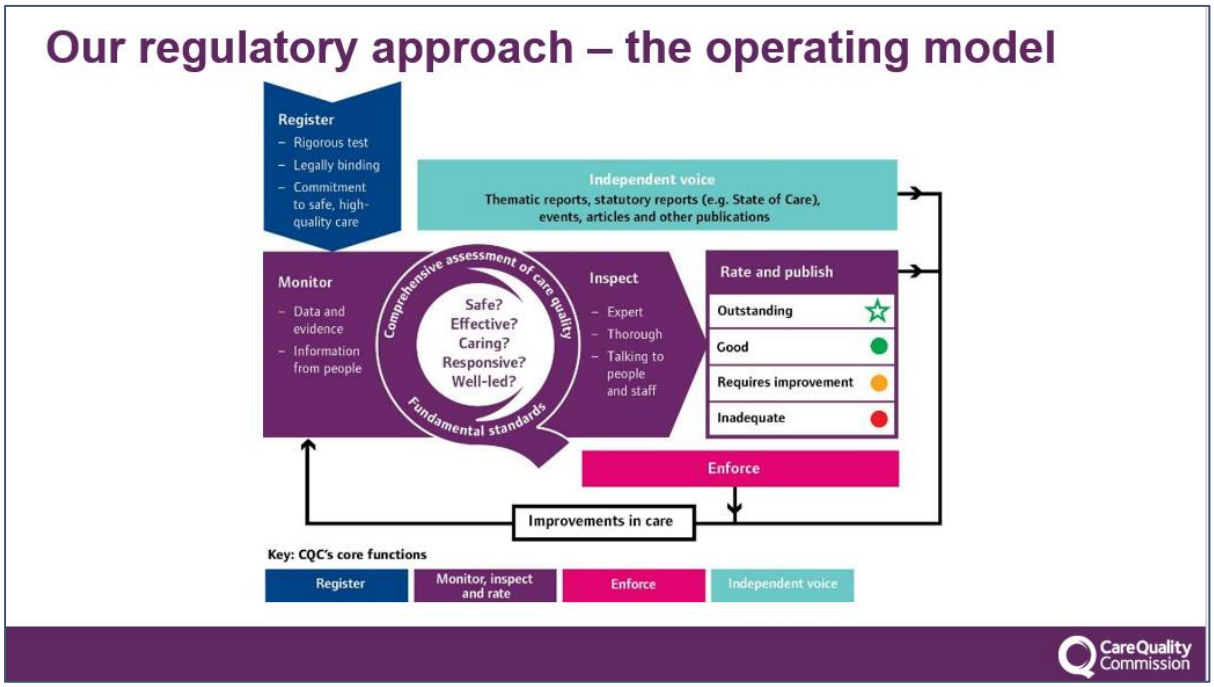
The CQC intends to make these changes to implement their new strategy and take learning from running the current model. They have a number of frameworks for health & for social care, which are detailed & complex, with lots of duplication. They are creating a **single assessment framework** that gives a single set of expectations, a single definition of quality, in plain English, that works for all the different sectors and organisations/systems that they have regulatory oversight of – so care providers, health providers, local authorities, ICS – the CQC are aiming to use the single assessment framework for them all, with some flexing on aspects of detail, **to deliver a simpler, more structured & transparent regulatory model.**



CQC monitoring function

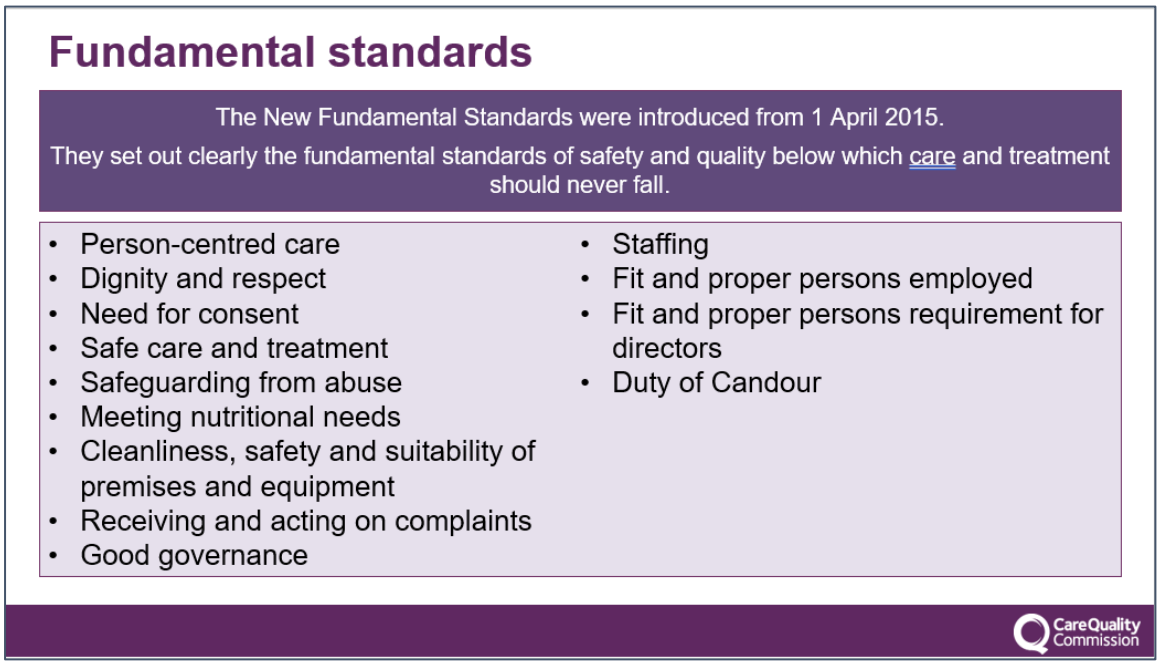
In this future model, they are moving to an ongoing assessment model, the so-called 'smarter more dynamic regulatory approach 'where they can consider new information as it arrives, and then update their judgements & assessments accordingly. In the old model, judgements & assessments were all done via inspection, which is only a single point in time, and they then take that information & insight away, consider what they found, use KLOEs & the 70 pages of ratings characteristics, then reach a judgement to come out with a rating and a narrative based report.

Understanding what is not changing

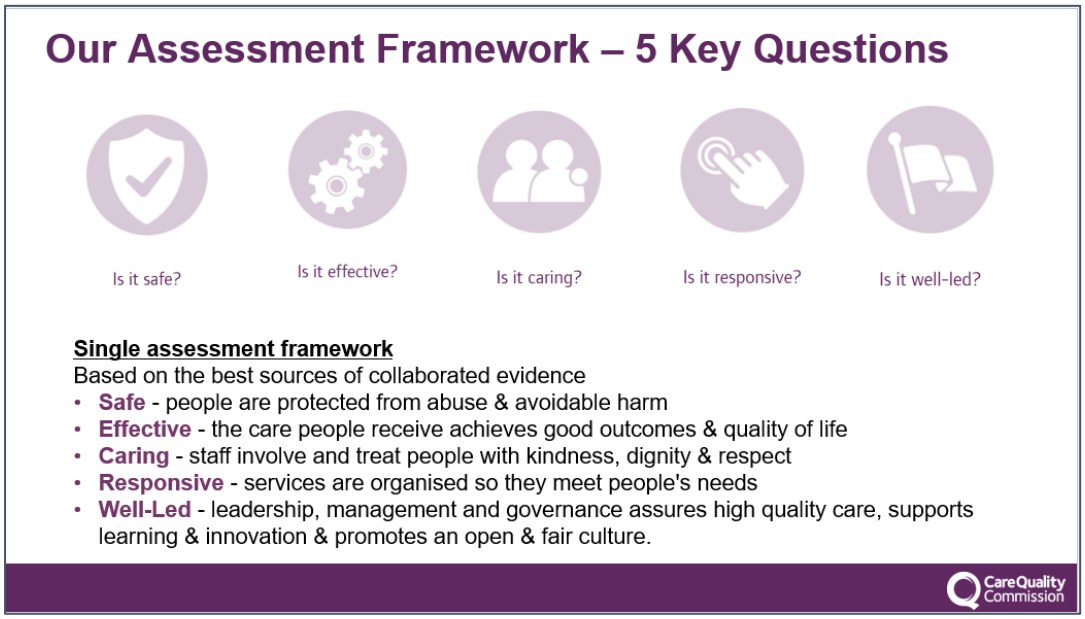


Their **overall regulatory core functions remain unchanged** – these are to register, monitor, inspect and rate, enforce and provide an independent voice.

The **fundamental standards remain unchanged:**



And the **5 key questions remain unchanged**:

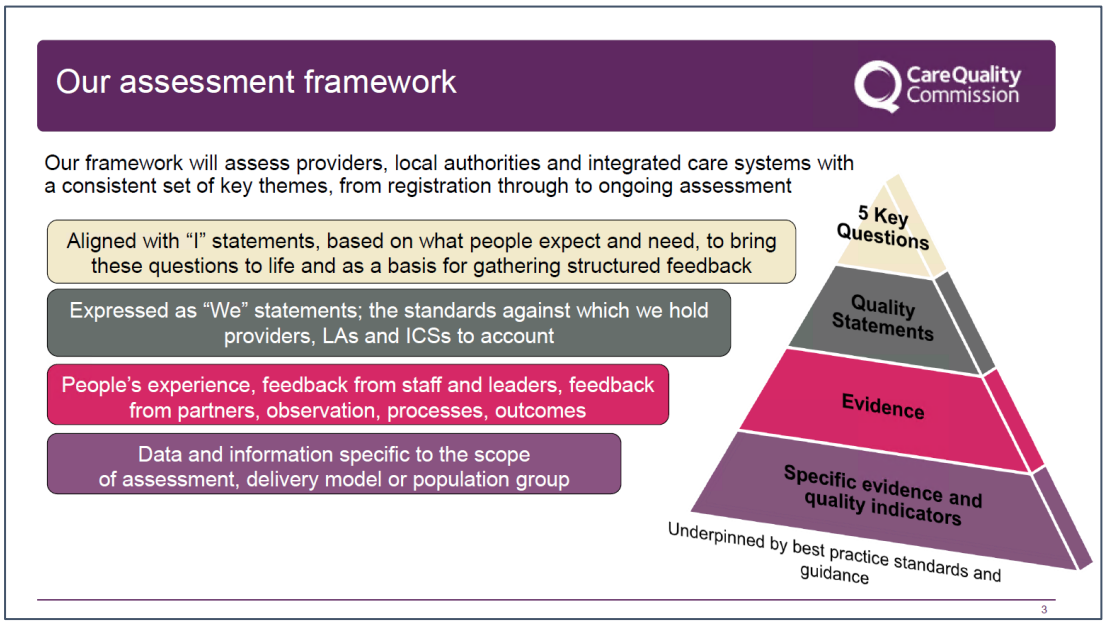


Understanding the new regulatory model

The **single assessment framework** is designed to be clearer, shorter and a better articulation of what good looks like. The idea is to deliver an ongoing assessment of quality & risk that can respond to new information more readily, whether that relates to risk or improvement, as they don't have to feed it through a separate inspection process; instead, the CQC view is that it can enable timely action now to update judgements and assessments.

Inspections are still important, but site visits will not always be the core approach for all service models or LAs or ICSs; it depends on the context, and they are keen to use time on site for key assessment purposes that cannot be achieved another way, such as observing care & staff interaction, using equipment & assessing the overall environment.

Overview of the single assessment framework - One assessment framework to inspect them all!



The CQC have developed a single assessment for health & care providers, LAs & ICS; this is intended to give consistent themes from registration through to ratings. Note that they won't apply the whole framework to LAs & ICS but will use a core subset.

The single assessment retains the 5 Key questions but now brings those to life with **quality statements** based on the **Think Personal Act Local** 'I' statements – these have already been created by people who use services to say what good, person-centred care means to them. The CQC have worked with Think Local Act Personal on this, using the Making It Real statements they developed a few years ago to describe what good person-centred care looks like.

Quality Statements – these are framed as 'We' statements and cover what a provider, commissioner, and system leader need to do to deliver a standard of 'good'; **they are the commitments they must all make, honour and live up to in order to deliver good quality care.**

Each key question has a number of quality statements underneath it and these replace all the KLOES as the standards against which the entity being assessed (service/ LA/ ICS) will be judged & assessed. They form the new standards that CQC will assess against and they are pitched at the level of 'good'.

Evidence categories: In the old model, there are 335 KLOEs & prompts, and on further analysis, the CQC finds that they are all essentially 6 questions, which form the **6 new evidence categories**:

1) Experience of people using care & support
2) Feedback from staff & leaders
3) Feedback from partners
4) Observation
5) Insight from Policies, processes & procedures
6) Insight from structured performance & outcomes metrics

The CQC view is that if they start with the Quality Statements & then gather evidence under the 6 categories, it will provide a more structured, simpler, clearer approach. They say that they have found over the last 10 years of the current methodology, that evidence can be grouped together into six broad categories. In putting these into the assessment framework, they say they can be clearer with providers about the evidence they need to collect and be more transparent about what they have done with it.

****December Update**** CQC have told us that they will be producing a topic map which should have information about the scope of each quality statement, what topic fits in them and how they are structuring the quality statement. This information has not yet been released, but once it is, we will send it out to NCF members.

New scoring system: this uses a 4-point scale, where 1= inadequate and 4 = outstanding & will consider if the evidence provided meets the criteria of 'good' or not. It will apply at the level of the 6 evidence categories and will then feed up into the scores for the 5 key questions which will then drive the overall rating.

An overall rating will be the combination of scores at evidence category, quality statement and then key question level. The CQC teams will then review the evidence they have against each required evidence category and give a score of between 1 and 4 based on the strength of what they find. They will take an average of these scores to give us a score for that quality statement. (see page 26 for a worked example.)

Reporting: The CQC are keen to be more timely in how speedily they publish reports & they believe that the single assessment framework and the scoring approach & moving away from a single point in time judgement to more iterative judgements over time will be a beneficial approach in achieving this. We look at the quality statements, evidence categories & scoring in more detail below.

NCF Observations

Balancing different sources of evidence: The new single assessment is welcome in its focus on the experience of people using care and support and feedback from staff/leaders/key partners. However, as we know, there is a human tendency to put a lot more effort into complaining as opposed to complimenting, so it is essential that a) providers have an opportunity to respond to concerns raised prior to any monitoring judgement, b) there is a balance in the algorithm/weighting to ensure a degree of triangulation of the experiential evidence and c) that the commissioning environment evidence and impact is properly considered as well as perception – oversight of LAs and ICSs should certainly help here.

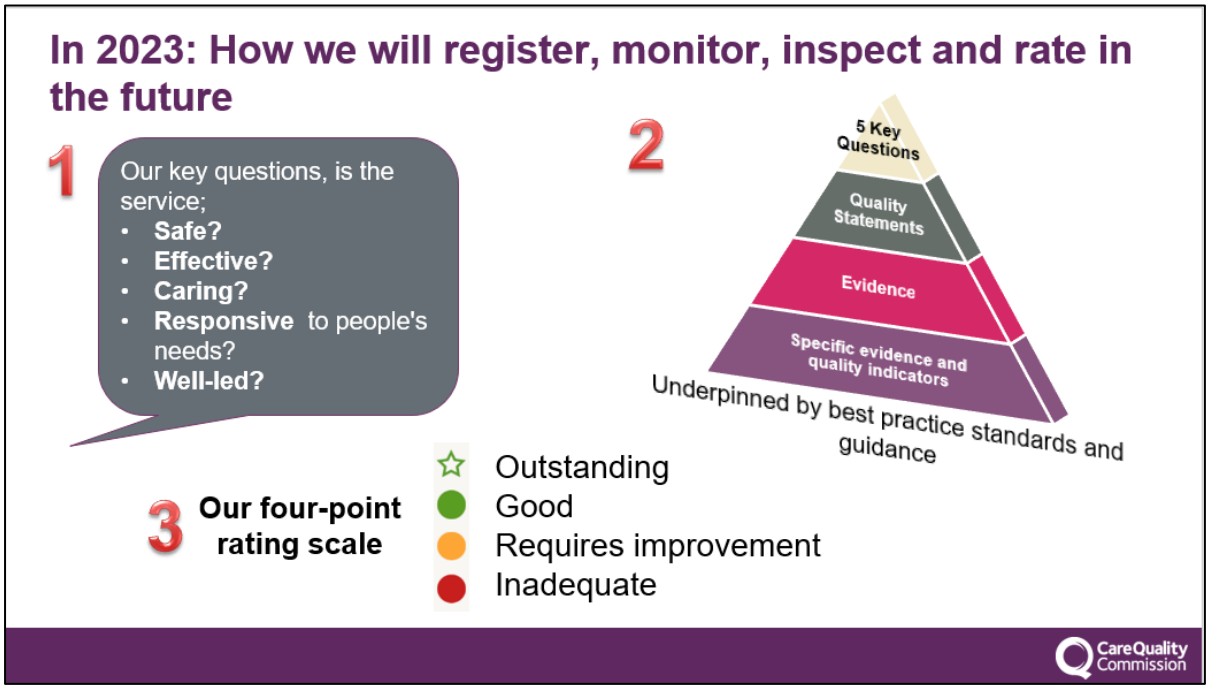
Evidence categories and scoring: this has the welcome potential to improve the consistency of the assessment and rating process, since all inspectors/ CQC colleagues should be following the same structured process in assessing and scoring evidence. However, at present, we do not have enough information to be confident that there are clear, transparent, and widely understood parameters for each scoring judgement, so there is a strong risk of different views amongst inspectors of what constitutes, for example, a score of 1 vs a score of 2 and providers are in the dark as to what the paraments for each score actually looks like. **Much more detail is needed on the scoring parameters and, without transparency & clarity, this feels likely to be an area of significant challenge from providers**.

Rating limiters – The CQC have published guidance in relation to rating limiters which may mean that some evidence categories can more easily pull down a rating. Essentially, if a 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'. There is a similar rule for key question scores which are in the 'Outstanding' range, where if there is a score of 1 or more for one or more quality statement scores, the rating is limited to 'Good'. This means that even if a provider receives scores of 3 and 4 for most evidence categories, poor feedback, e.g., from staff or people being supported, might well limit the rating.

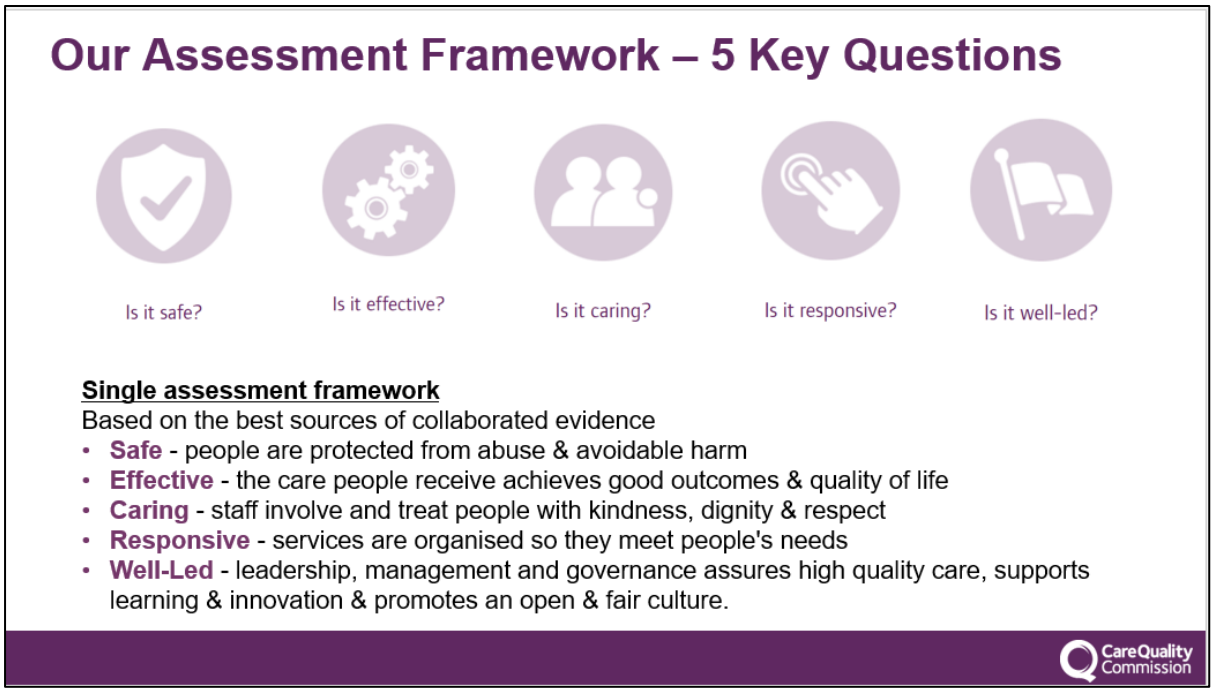
Timings also matter - when combined with the 'always on, dynamic monitoring' and a phased approach to evidence gathering, there is the potential for the new approach to be very unfair if ratings may be amended based on a small slice of evidence. The timetable for updating evidence categories and then scoring them and amending ratings is crucial here – if it is all done at once, then the overall process will provide a valid, real-time view of the quality of the service being delivered. However, if it is done in phases – such as viewing performance metrics every six months, seeking feedback from people using the service every 12 months, talking to staff every 2 years, seeking updated processes and policies every 2 years and visiting to do observations on site every 3 years, then making an assessment via scoring of only some of those evidence categories at a point in time

when only some of the information is available will not be providing a holistic or credible view of the overall quality of service and will not provide a valid overall rating.

Getting into the detail of the single assessment framework



The 5 key questions remain unchanged



Quality statements

There are 34 quality statements in total.

Each of the 5 key questions has a number of quality statements that must be demonstrated - they are on the CQC website – see here – but we have grouped them onto slides to make it easier to see them in one place.

Remember – these 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.

Key question Safe has 8 quality statements designed to demonstrate this: Safety is a priority for everyone, and leaders embed a culture of openness and collaboration. People are always safe and protected from bullying, harassment, avoidable harm, neglect, abuse and discrimination. Their liberty is protected where this is in their best interests and in line with legislation.

Key question Effective has 6 quality statements designed to demonstrate this: People and communities have the best possible outcomes because their needs are assessed. Their care, support and treatment reflect these needs and any protected equality characteristics. Services work in harmony, with people at the centre of their care. Leaders instil a culture of improvement, where understanding current outcomes and exploring best practice is part of everyday work.

Key question Caring has 5 quality statements designed to demonstrate this: People are always treated with kindness, empathy and compassion. They understand that they matter and that their experience of how they are treated and supported matters. Their privacy and dignity is respected. Every effort is made to take their wishes into account and respect their choices, to achieve the best possible outcomes for them. This includes supporting people to live as independently as possible.

Note the quality statement no 5 about staff wellbeing for the key question Caring: 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.

This is a new area of focus and has very limited evidence categories so needs careful thought & preparation. The evidence categories for this quality statement are 1) feedback from staff and leaders and 2) processes. The types of processes they will look at are stated to be *mechanisms to monitor, improve and promote staff safety and wellbeing, staff management policies and staff sickness, vacancy and turnover rates.*

Since the score for this quality statement rests so heavily on staff feedback, providers will need to consider how they can obtain feedback from staff that notes the positive aspects of the service especially as staff can often be more vocal about things that they are unhappy about than things that work well. Providers will also need to consider how well they are likely to score in relation to the types of process-related evidence and what they can do to improve this.

In a service facing challenges around staffing, retention and recruitment it appears that this is a quality statement where there is a risk of a low score, which could then act as a rating limiter for Caring.

Key question Responsive has 7 quality statements designed to demonstrate this: There is an inclusive and positive culture of continuous learning and improvement. This is based on meeting the

needs of people who use services and wider communities, and all leaders and staff share this. Leaders proactively support staff and collaborate with partners to deliver care that is safe, integrated, person-centred and sustainable, and to reduce inequalities.

Key question Well Led has 8 quality statements designed to demonstrate this: There is an inclusive and positive culture of continuous learning and improvement. This is based on meeting the needs of people who use services and wider communities, and all leaders and staff share this. Leaders proactively support staff and collaborate with partners to deliver care that is safe, integrated, person-centred and sustainable, and to reduce inequalities.

Note the quality statement no 8 about Environmental sustainability: 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. **This is definitely a new area of focus and we have asked for more detail about what it actually means/ is looking for.**

****December Update **** CQC have now provided an update about how they will assess the environmental sustainability quality statement. This statement will not be assessed during the first year of the single assessment framework for social care services. Unlike the other quality statements, CQC have also said that they will not create a transitional score for environmental sustainability – it will only be scored when an assessment has taken place.

CQC are hoping to release more information about the focus of the environmental sustainability quality statement before the end of the year.

****December Update**** **Priority Statements**

The CQC have more recently updated their approach to indicate how they will calculate the first scores for services with an existing rating or findings about compliance. This involves the approach of identifying 'priority quality statements'.

By this, they seem to mean that when they carry out their first assessment of the service using the new single assessment framework, 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 the service.

In a recent meeting with the CQC, we were told that there will be very few priority quality statements (between 5 – 7). These statements will be determined based on risk and will be the statements that must be looked at for every service.

At the same meeting, it was suggested that for care homes, supported living, home care and shared lives, there would initially be 5 core priority quality statements:

1. Safeguarding
2. Involving people to manage risks
3. Safe and effective staffing
4. Independence choice and control
5. Equity in experience and outcome

At the moment we have no officially published information about how going forward 'national priorities' will be either a) determined or b) communicated to providers.

More information about priority quality statements is available in the **Calculating the First Scores** section on page 24.

Key Questions and Related Regulations

Key Question: Safe

Safety is a priority for everyone, and leaders embed a culture of openness and collaboration. People are always safe and protected from bullying, harassment, avoidable harm, neglect, abuse and discrimination. Their liberty is protected where this is in their best interests and in line with legislation.

Quality Statements

1. **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.
2. **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.
3. **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.
4. **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.
5. **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.
6. **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.
7. **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.
8. **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.

Related Regulations: Safe

X – Regulated Activities Regulations 2014

X – Can also consider from Regulated Activities Regulations 2014

	Quality Statements: Safe							
CQC Related Regulations	Learning Culture	Safe Systems Pathways and Transitions	Safeguarding	Involving people to manage risks	Safe environments	Safe and effective staffing	Infection prevention and control	Medicine optimisation
Reg 9: Person-centred care		X	X	X				X
Reg 10: Dignity and Respect			X	X				
Reg 11: Need for consent			X	X				X
Reg 12: Safe care and treatment	X	X	X	X	X	X	X	X
Reg 13: Safeguarding service users from abuse and improper treatment			X					
Reg 14: Meeting nutritional and hydration needs								
Reg 15: Premises and equipment					X		X	
Reg 16: Receiving and acting on complaints	X							
Reg 17: Good governance	X	X	X		X		X	
Reg 18: Staffing						X		
Reg 19: Fit and proper persons employed						X		
Reg 20: Duty of candour	X		X					

Key Question: Effective

People and communities have the best possible outcomes because their needs are assessed. Their care, support and treatment reflects these needs and any protected equality characteristics. Services work in harmony, with people at the centre of their care. Leaders instil a culture of improvement, where understanding current outcomes and exploring best practice is part of everyday work.

Quality Statements

1. **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.
2. **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.
3. **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.
4. **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.
5. **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.
6. **Consent to care and treatment** - We tell people about their rights around consent and respect these when we deliver person-centred care and treatment.

Related Regulations: Effective

X – Regulated Activities Regulations 2014

X – Can also consider from Regulated Activities Regulations 2014

	Quality Statements: Effective					
CQC Related Regulations	Assessing needs	Delivering evidence-based care and treatment	How staff, teams and services work together	Supporting people to live healthier lives	Monitoring and improving outcomes	Consent to care and treatment
Reg 9: Person-centred care	X	X	X	X	X	X
Reg 10: Dignity and Respect	X	X		X		X
Reg 11: Need for consent	X	X		X		X
Reg 12: Safe care and treatment	X	X	X	X	X	
Reg 13: Safeguarding service users from abuse and improper treatment						
Reg 14: Meeting nutritional and hydration needs		X				
Reg 15: Premises and equipment						
Reg 16: Receiving and acting on complaints						
Reg 17: Good governance	X	X	X		X	
Reg 18: Staffing						
Reg 19: Fit and proper persons employed						
Reg 20: Duty of candour						

Key Question: Caring

People are always treated with kindness, empathy and compassion. They understand that they matter and that their experience of how they are treated and supported matters. Their privacy and dignity is respected. Every effort is made to take their wishes into account and respect their choices, to achieve the best possible outcomes for them. This includes supporting people to live as independently as possible.

Quality Statements

1. **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.
2. **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.
3. **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.
4. **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.
5. **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.

Related Regulations: Caring

X – Regulated Activities Regulations 2014

X – Can also consider from Regulated Activities Regulations 2014

	Quality Statements: Caring				
CQC Related Regulations	Kindness, compassion and dignity	Treating people as individuals	Independence, choice and control	Responding to people's immediate needs	Workforce wellbeing and enablement
Reg 9: Person-centred care	X	X	X	X	X
Reg 10: Dignity and Respect	X	X	X	X	
Reg 11: Need for consent				X	
Reg 12: Safe care and treatment	X		X	X	X
Reg 13: Safeguarding service users from abuse and improper treatment					
Reg 14: Meeting nutritional and hydration needs		X			
Reg 15: Premises and equipment		X			
Reg 16: Receiving and acting on complaints				X	
Reg 17: Good governance					X
Reg 18: Staffing					X
Reg 19: Fit and proper persons employed					
Reg 20: Duty of candour					

Key Question: Responsive

People and communities are always at the centre of how care is planned and delivered. Their health and care needs of people and communities are understood and they are actively involved in planning care that meets these needs. Care, support and treatment is easily accessible, including physical access. People can access care in ways that meet their personal circumstances and protected equality characteristics.

Quality Statements

1. **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.
2. **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.
3. **Providing information** - We provide appropriate, accurate and up-to-date information in formats that we tailor to individual needs.
4. **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.
5. **Equity in access** - We make sure that everyone can access the care, support and treatment they need when they need it.
6. **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.
7. **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.

Related Regulations: Responsive

X – Regulated Activities Regulations 2014

X – Can also consider from Regulated Activities Regulations 2014

	Quality Statements: Responsive						
CQC Related Regulations	Person-centred care	Care provision, integration, and continuity	Providing information	Listening to and involving people	Equity in access	Equity in experiences and outcomes	Planning for the future
Reg 9: Person-centred care	X	X	X	X	X	X	X
Reg 10: Dignity and Respect	X	X		X	X	X	X
Reg 11: Need for consent	X						X
Reg 12: Safe care and treatment	X	X			X	X	
Reg 13: Safeguarding service users from abuse and improper treatment					X		
Reg 14: Meeting nutritional and hydration needs	X						
Reg 15: Premises and equipment							
Reg 16: Receiving and acting on complaints				X			
Reg 17: Good governance		X	X	X	X	X	
Reg 18: Staffing						`	
Reg 19: Fit and proper persons employed							
Reg 20: Duty of candour							

Key Question: Well-led

There is an inclusive and positive culture of continuous learning and improvement. This is based on meeting the needs of people who use services and wider communities, and all leaders and staff share this. Leaders proactively support staff and collaborate with partners to deliver care that is safe, integrated, person-centred and sustainable, and to reduce inequalities.

Quality Statements

1. **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.
2. **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.
3. **Freedom to speak up** - We foster a positive culture where people feel that they can speak up and that their voice will be heard.
4. **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.
5. **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.
6. **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.
7. **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
8. **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.

Related Regulations: Well-led

X – Regulated Activities Regulations 2014

X – Can also consider from Regulated Activities Regulations 2014

	Quality Statements: Well-Led							
CQC Related Regulations	Shared direction and culture	Capable, compassionate and inclusive leaders	Freedom to speak up	Workforce equality, diversity and inclusion	Governance, management and sustainability	Partnerships and communities	Learning, improvement and innovation	Environmental sustainability – sustainable development
Reg 6: Requirement where the service provider is a body other than a partnership		X						
Reg 7: Requirements relating to registered managers		X						
Reg 9: Person-centred care	X		X			X		
Reg 10: Dignity and Respect	X		X					
Reg 11: Need for consent								
Reg 12: Safe care and treatment	X		X		X	X		
Reg 13: Safeguarding service users from abuse and improper treatment			X					
Reg 14: Meeting nutritional and hydration needs								
Reg 15: Premises and equipment								
Reg 16: Receiving and acting on complaints			X				X	
Reg 17: Good governance	X		X	X	X	X	X	X
Reg 18: Staffing		X		X				
Reg 19: Fit and proper persons employed		X						
Reg 20: Duty of candour								

Evidence categories

CQC have always asked for different types of evidence to help them make judgements in terms of the 5 key questions, the fundamental standards, compliance with the regulations and the overall rating of the service. With this new approach, the CQC has segmented the evidence they are seeking into 6 categories. Scoring against the evidence in each category will then be done by the CQC – more detail on scoring later on.

The CQC say that, in many ways, providers will already be familiar with the data and evidence that will be gathered and used. But, **by introducing the six categories and setting out the evidence the CQC always need to collect and review to make a decision, alongside a way of scoring evidence, they feel it will create a more structured and consistent framework for assessing quality**.

CQC have grouped the different types of evidence into 6 categories

1) Experience of people using care & support
2) Feedback from staff & leaders
3) Feedback from partners
4) Observation
5) Processes
6) Outcomes

The CQC have listed the key evidence categories by sector groups: see here and shown below: https://www.cqc.org.uk/assessment/evidence-categories/evidence-categories-sector-groups

Evidence categories

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

They say: '*We'll prioritise collecting evidence in these categories as part of our assessments. These lists are a guide, not a checklist. We will collect evidence in all the key evidence categories for a particular quality statement:*

- *for our first assessments under the new approach*
- *following new registrations.*

We may look at other categories as well if evidence suggests that we need to.'

Note also that they say this: ***It is only the first assessment of our new approach, and for services newly registering with us, that we'll look at every key evidence category. For future assessments we may review evidence just in particular categories.*** *[See page 8 for our concerns about this approach]*

More detail is shown below about each of the 6 evidence categories. Each category sets out the type of evidence they will use to understand:

- Quality of care being delivered
- Performance against each quality statement

The CQC have set out the types of evidence they will use during their assessment.
The number of categories considered, and the source of evidence depends on:

- 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.

1) **Experience of people using care & support**

People's experience 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.

We 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".

Find out about the importance of people's experience in our assessments

https://www.cqc.org.uk/assessment/evidence-categories

CareQuality Commission

1. People's Experience of Health and Care Services

"A person's needs, expectations, lived experience, and satisfaction with their care, support, and treatment, including access to and transfers between services."

Sources of Evidence from People's Experience:

- Phone calls, emails, and "Give Feedback on Care" forms received by CQC.
- Interviews with individuals and local organizations representing them.
- Survey results.
- Feedback from the public and service users obtained by various groups:
  - Community and voluntary groups.
  - Health and care providers
  - Local Authorities.

Groups representing:

- Individuals likely to have a poorer experience of care and outcomes.
- People with protected equality characteristics.
- Unpaid carers.

2) **Feedback from staff & leaders**

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 our Give feedback on care service
- whistleblowing

https://www.cqc.org.uk/assessment/evidence-categories

CareQuality Commission

3) **Feedback from partners**

Feedback from partners

This is evidence from people representing organisations that interact with the service or organisation that is being assessed.

We may gather evidence through interviews and engagement events.

The organisations include, for example:

- commissioners
- other local providers
- professional regulators
- accreditation bodies
- royal colleges
- multi-agency bodies.

https://www.cqc.org.uk/assessment/evidence-categories

CareQuality Commission

4) **Observation**

Observation

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.

We will not use the observation category for local authority assessments. It does not apply to a local authority context.

All observation is carried out on site.

https://www.cqc.org.uk/assessment/evidence-categories

CareQuality Commission

5) **Processes**

Processes

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

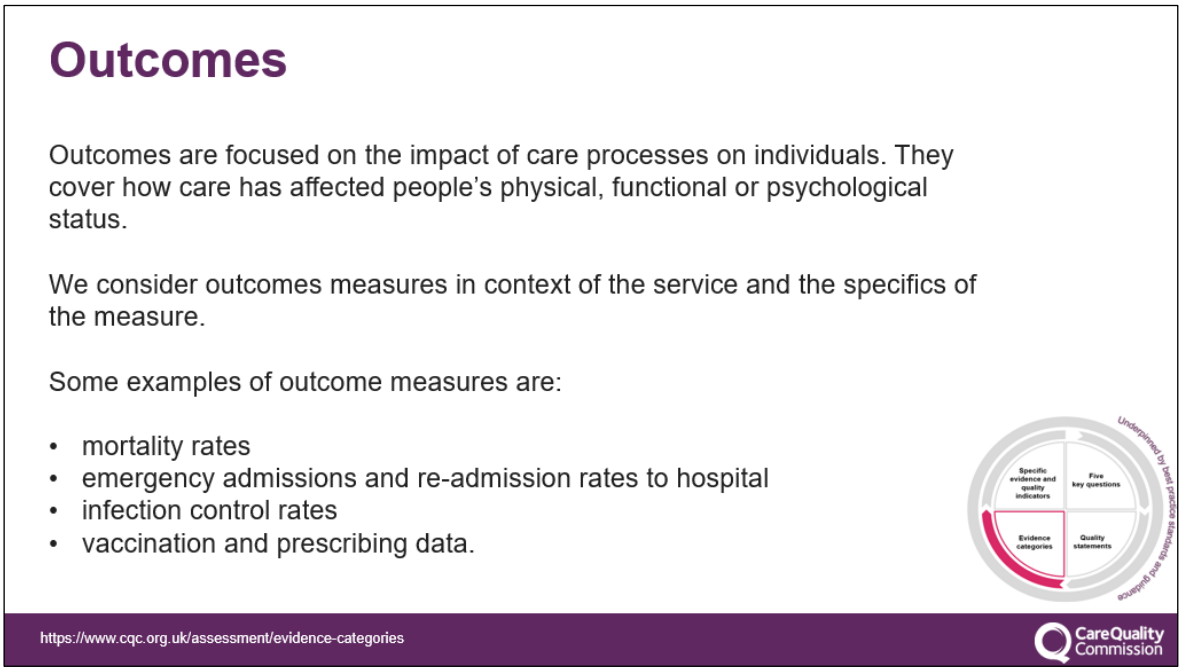
Our assessments focus on how effective policies and procedures are. To do this, we will look at information and data sources that measure the outcomes from processes. For example, we may consider processes to:

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

https://www.cqc.org.uk/assessment/evidence-categories

CareQuality Commission

6) **Outcomes**



The Outcomes category is interesting as no social care outcome measures are listed – when we questioned this, the response was as follows:

'The structure of our evidence categories draws on the Donabedian model where 'outcomes' have quite a specific meaning. In terms of the CQC evidence category then, Outcomes are the impact of care on people, and cover how care has affected people's physical, functional or psychological status.

Outcomes measures are not available for all types of services or care pathways; where they are available, they need to be considered carefully given the context of the service and the specifics of the measure. Examples of outcome measures include mortality rates, re-admission rates, emergency admission rates, and patient reported outcome measures following hip surgery. They are sourced from patient level data sets and national clinical audits, or initiatives such as the Patient Reported Outcome Measures programme.

If Outcome measures were available for ASC at the current time and in a way that meant they could be consistently applied in our assessments, we would look to use them. This is not where the sector is at. However, in ASC, it is fair to say that the 'outcomes' we want to assess are covered under our People's Experience evidence category. In other words, what is the sum total/impact of the provider's processes, how its staff are supported, how the service is run on etc. what people actually experience.

Our interpretation of this is that the lack of any formally accepted outcome measures for social care means that the CQC are not referencing any specific outcome measures in relation to this evidence category.

NCF observations

There are a few observations to make on this point; firstly, this seems to provide an ideal opportunity for the social care sector to co-produce a set of formally accepted outcome measures with the regulator & some academic partners, rather than having one imposed. For example, the

University of Kent has done some excellent work on Quality of Life measures that we could consider adopting. Secondly, it makes it even more important to capture your own outcome measures/ evidence across the other evidence categories, obviously via the 3 feedback categories (lived experience, families/ friends, staff, partners) as well as in your processes and in any observation evidence. Thirdly, it might suggest, rather disappointingly, that the single assessment framework may have been more focused on regulating health, rather than social care.

Our observations about evidence and data: collating, assessing and managing all the information that could constitute evidence for any of the evidence categories is more important than ever in this new approach. Providers have long experience of doing and a focus on being proactive in gathering, recording, monitoring and understanding their own data is key.

Maintaining good working relationships with your key multi-agency partners is also a consideration as they are increasingly likely to be one of the sources of evidence that the CQC are seeking, and of course, overall the CQC's new strategy does take a risk-based approach. Risk-based regimes tend to focus on perceived negatives, even when there is little evidence to back up such concerns: for example, we have already seen that where the CQC receives feedback that an individual has had a poor experience of care, they will tend to always identify that as a concern going forward, even when other evidence sources do not indicate any issues. This means that it is particularly important to act if local authorities are raising concerns and work collaboratively with the local authority to demonstrate that the concern has been addressed.

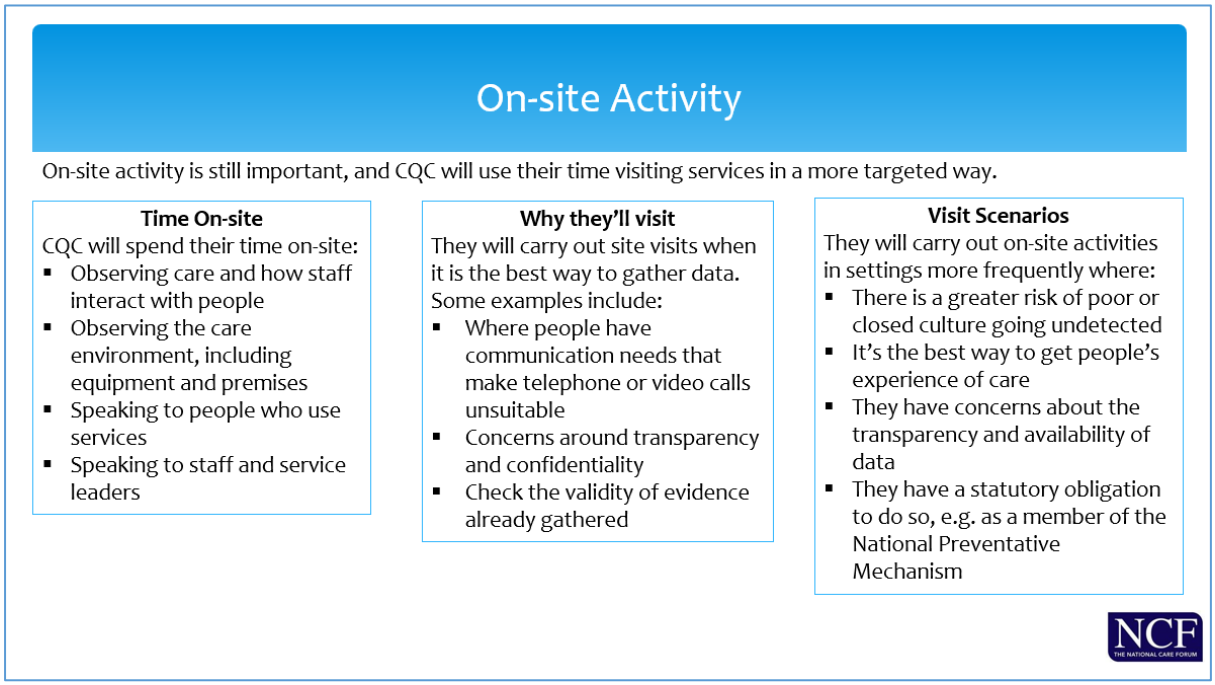
Providers will want to be clear about how their current data and evidence can be segmented to support the different evidence categories and this will help you to see if there are any gaps.

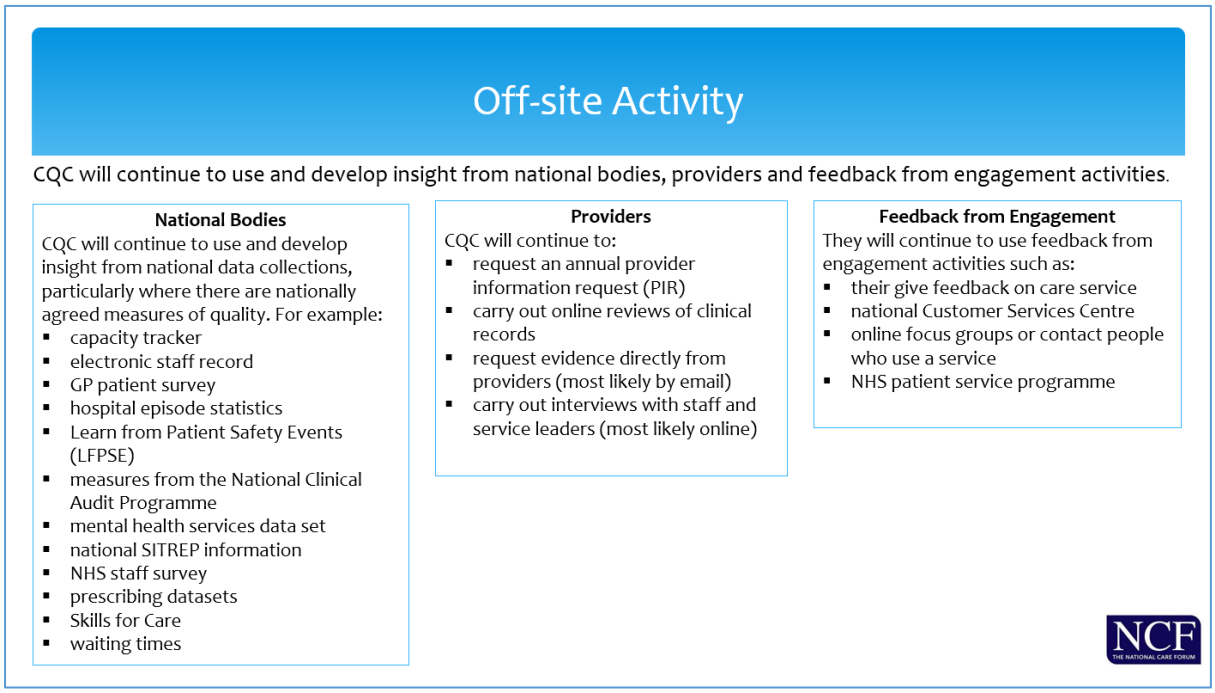
Digital systems and technology may help with the process of information gathering, analysis and evidence generation, but of course, this brings issues of extracting and sharing data, access to systems and being fully aware of the picture your data is presenting.

Have a look at Appendix 1 which has more detail on each evidence category for Care Homes & Supported Living and Appendix 2 which has more detail on each evidence category for Home Care & Shared Lives.

****December Update** Methods to gather evidence**

CQC have provided an update on the methods that they will use to gather this evidence. They say that they will use the best methods to collect evidence depending on the type of evidence for a quality statement. The evidence may be gathered through both on-site and off-site methods.





New scoring system for the evidence categories

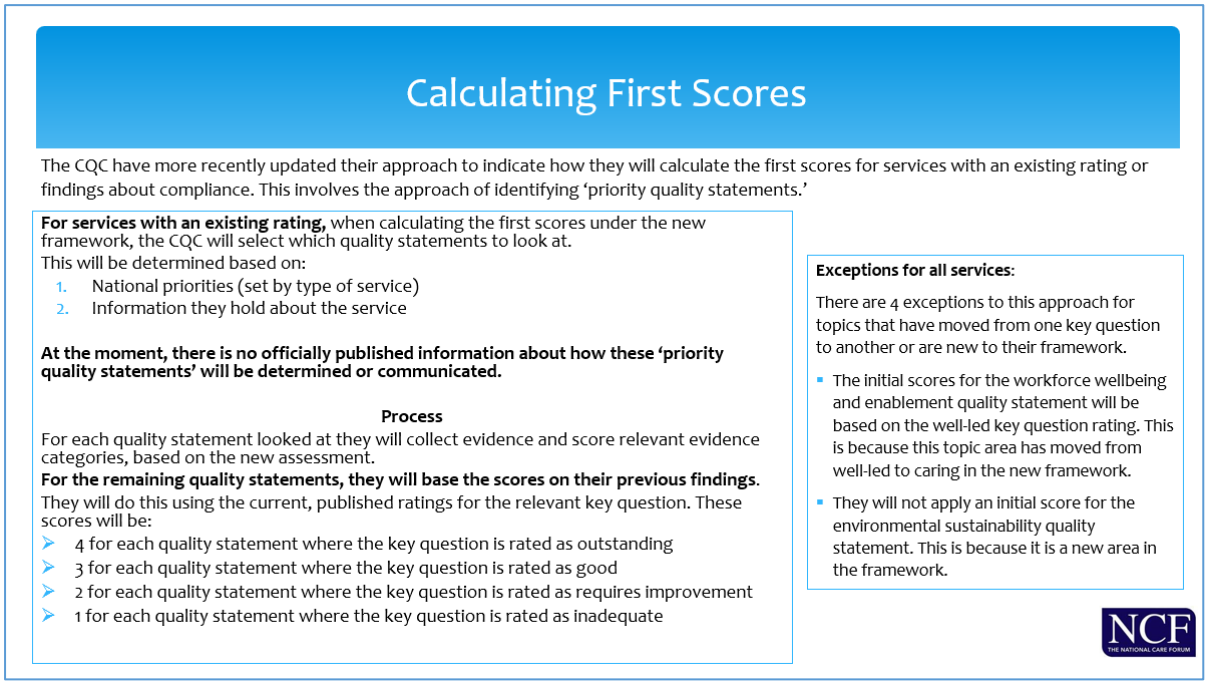
The CQC plans to use scoring in assessments with the intention to be clear and consistent when judging:

- ✓ Quality of care in a service
- ✓ How well Local Authorities follow the Care Act
- ✓ The performance of an integrated care system

The CQC will give a score to each applicable evidence category, based on the evidence that is presented to them/ received or observed - evidence can come from existing sources or on-site inspections. **All categories carry equal weight** - this is worth noting, given previous statements about the primary importance of the feedback from people with lived experience.

CQC initially said that for the first assessments under the new approach, the CQC will review evidence under all the evidence categories. The CQC will then assign scores for each evidence category – see the Score column in the table below. However, going forward they have indicated that they may only look at some evidence categories in isolation (for example people's experience) and will adjust the scoring for that evidence category, which may in turn require adjustment of the rating for the quality statement and overall rating for the key question in turn.

****December Update**** **Calculating first scores**



NCF observation: We have raised concerns with the CQC about this approach as it seems to mean that in the new single assessment world, a subset of quality statements' scores will be based on new evidence gathered for the service – the subset being the 'priority quality statements' - while the remainder of the quality statements' scores will be based on scores from previous findings, which could well be based on evidence that is years out of date. To us, this seems neither fair to the provider nor helpful to either the provider, any potential commissioner or potential customer.

The CQC's response was as follows:

The approach we're taking is intended to balance the importance of giving as many providers as possible an updated view of quality in our initial rollout with reviewing the most relevant areas of quality. If we receive additional information we can expand the number of quality statements we review, and the age of ratings/evidence may be something that triggers this. It has never been our intention to deliver a programme of comprehensive assessments across all providers in the way we did when the five key questions were introduced.

We will also be clear on what quality statements we have assessed when we publish new reports and ratings. Our new approach will enable us to be more agile, assess providers more regularly and give them more frequently updated ratings.

Scoring options: The scoring options are a 4-point scale as follows:

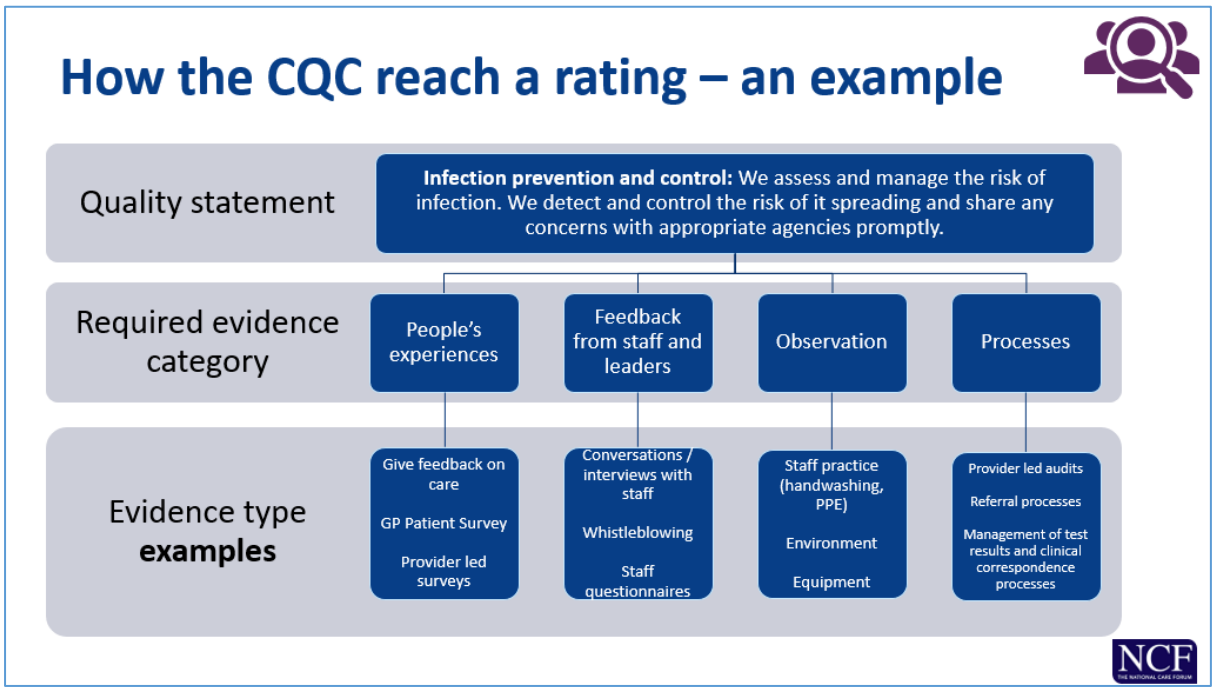
4 = Exceptional standard.

3 = Good standard.

2 = Some shortfalls.

1 = Significant shortfalls.

The scoring of each of the up to 6 evidence categories will then feed up to the scoring for each quality statement.



For each quality statement, the CQC teams will review the evidence they have against each required evidence category and give a score of between 1 and 4 based on the strength of what they find. The scores awarded to all of the relevant evidence categories are added up and then calculated to create a percentage for that quality statement.

The percentage is then translated back into a score using the metric below:

Percentage band	Score	Rating
25-38%	1	Inadequate
39-62%	2	Requires improvement
63-87%	3	Good
87% <	4	Outstanding

The reason for the extra step is to make the process easier to understand (in theory) and make it easier for the CQC to combine the scores for the different quality statements to produce a rating for that key question.

To get a rating for the key question, the CQC add up the scores for each quality statement and divide that figure by the maximum possible score to get a percentage.

The percentage is then converted into a rating using the thresholds in the box above. For example, a percentage score of 58% would result in a rating of 'Requires Improvement'.

Example

Below is an example of how the CQC will assess a quality statement.

The example quality statement is 'learning culture' which sits under the Safe key question: *"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."*

For learning and culture, the CQC will look at the following evidence categories:

- People's experiences
- Feedback from staff and leaders
- Feedback from partners
- Processes

They will review various types of evidence under each category and assign a score to the overall category – see the example on the slide below.

How the CQC reach a rating – example

Evidence category	Score
People's experiences	1
Feedback from staff and leaders	3
Feedback from partners	2
Processes	2
Total score÷ maximum score	**8÷16=50%**
Total quality statement score	**2**

25-38% = 1
39-62% = 2
63-87% = 3
>87% = 4

The scores are added up to get a total, in this case, 8. The score is then divided by the maximum possible score to get a percentage. The maximum possible score is 16 because the CQC are reviewing 4 evidence categories and the highest score for each one is 4 (4 x 4 = 16).

This gives a percentage score of 50%. Using the metric in the grey box on the slide, the CQC will convert the percentage into a score. 50% results in a score of 2.

The CQC will then combine all the quality statement scores to get a rating for the key question. The score (2) for learning culture will therefore be added up with all the other scores for the quality statements under Safe and divided by the maximum possible score to get a percentage again.

How the CQC reach a rating – example

Quality statement	Score
Learning culture	2
Medicines optimisation	2
Safe systems, pathways and transitions	1
Infection prevention and control	2
Safeguarding	1
Involving people to manage risks	2
Safe environments	1
Safe and effective staffing	2
Total score ÷ maximum score	**13÷32=41%**
Key question rating	**Requires improvement**

25-38% = Inadequate
39-62% = Requires improvement
63-87% = Good
>87% = Outstanding

There are 8 quality statements under Safe which means that the maximum possible score is 32. In the example, the total score is 13. 13 ÷ 32 = 41%.

That is then translated into a rating, using the percentage bands outlined by the CQC (see the grey box on the slide), to give an overall rating for that key question. 41% sits in the 'Requires Improvement' band, which means that the rating for the key question (Safe) is 'Requires Improvement'.

The CQC will then aggregate the scores for the key questions to give a rating for their view of quality at an overall service level – **but the CQC have not given any further detail on the metric they will use to aggregate the scores.**

Rating limiters

The CQC have also included 'rating limiters' – they say that by using the following rules, they can make sure any areas of poor quality are not hidden.

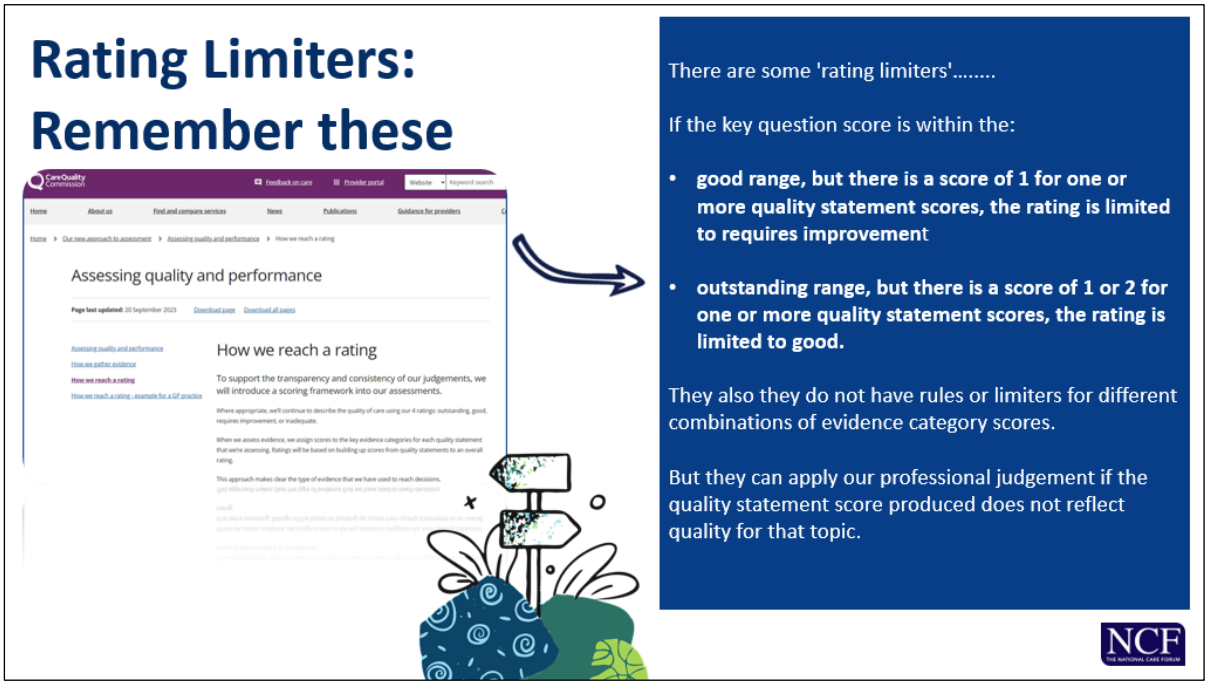
If the key question score is within the 'good' range, but there is a score of 1 for one or more quality statement scores, the rating is limited to 'requires improvement'.

If the key question score is within the 'outstanding' range, but there is a score of 1 or 2 for one or more quality statement scores, the rating is limited to 'good'.

We do not have rules or limiters for different combinations of evidence category scores.

Note also they say this: **But we can apply our professional judgement if the quality statement score produced does not reflect quality for that topic.** Our judgements go through quality assurance processes.

NCF observation: this is a broad sweeping statement that potentially undermines all the evidence-scoring approach above – we will ask for more clarity on what this actually means.



Overall ratings: the CQC calculates scores for overall ratings based on assessment type.

- For service providers, CQC combines scores for key questions to rate overall quality.
- For local authorities, CQC creates an overall score and rating.
- For integrated care systems, CQC calculates theme scores and an overall score and rating.

Thinking about the scoring then, if a service is rated as 'good,' the score indicates if it's:

- Close to being 'outstanding' (high score).
- Closer to 'requires improvement' (low score).

Similarly, for a 'requires improvement' rating, the score tells us if it's:

- Nearing 'good' (high score).
- Closer to 'inadequate' (low score).

****December Update**** In November, the CQC said that they will initially publish only a provider's rating. They also indicated that they intended to publish the scores in the future, though they had not yet confirmed the level of scoring detail they would publish, i.e., whether that would be scores for each quality statement and/or the individual evidence category scores.

Now, the CQC are saying that in the report of their findings, they will publish:

Overall service information – which will include:

- An overall rating for the service
- Summary of the current view of the service written by the assessment team
- Summary of people's experience of the service written by the assessment team (where relevant)

Key question information. For each key question assessed, they will publish:

- A rating
- A score (out of 100)
- A summary of their findings

Quality statement information. For each quality question assessed, they will publish:

- A score (from 1 to 4)
- Statements explaining what the score means
- Summary of key findings for each evidence category they looked at

Looking ahead: the CQC say: *As we are moving away from assessing at a single point in time, in future we will likely assess different areas of the framework on an ongoing basis. This means we can update scores for different evidence categories at different times. Any changes in evidence category scores can then update the existing quality statement score.* **[**See page 8 for our concerns about this approach]

****December Update** Factual Accuracy Check**

CQC have also provided an update on the factual accuracy check process. Once the quality of the draft assessment report has been checked, the CQC will send the report to the appropriate registered person for review.

The process allows the registered person to tell them:

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

The draft report includes judgements, scores, and ratings where appropriate. While the report may not reference all the evidence used, it should include the best evidence to support the CQC's judgements.

Factual Accuracy Check Process

The appropriate registered person receives an email to review the draft report online. (Note: if there are more than 1 registered person, each person will receive the email)

If they wish to comment:

- Enter comment against the relevant section of the report
- Upload evidence to support comments

They will receive a date by which to review and submit comments. This will be at least 10 working days from when you receive the email. This will not be extended unless exceptional circumstances.

There are only certain types of information that can be corrected:

What you can correct

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 our assessment. You can also send us information about action you have taken since the assessment that addresses the concerns we raised with you, or which is included in the draft report. The assessor will consider any further information you send us 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 process should not be used to challenge:

- An assessment rating solely because you disagree with it
- How CQC carried out the assessment
- Enforcement activity they propose

You can ask for information before you submit your comments, but it must be short, specific, and clear as to why you need to raise the point. This should be submitted directly to your assessor if you are in contact with them or you can email enquiries@cqc.org.uk, quoting your assessment reference number (starts with AP) and marking it for the attention of the assessment team.

CQC will not release full notes from an inspection but 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 our statement is not clear from the draft report)".*

CQC will not identify someone who has reported concerns to them.

Factual Accuracy Check - How CQC will respond

After considering the points and information, CQC will decide whether to amend the draft report.

They will:

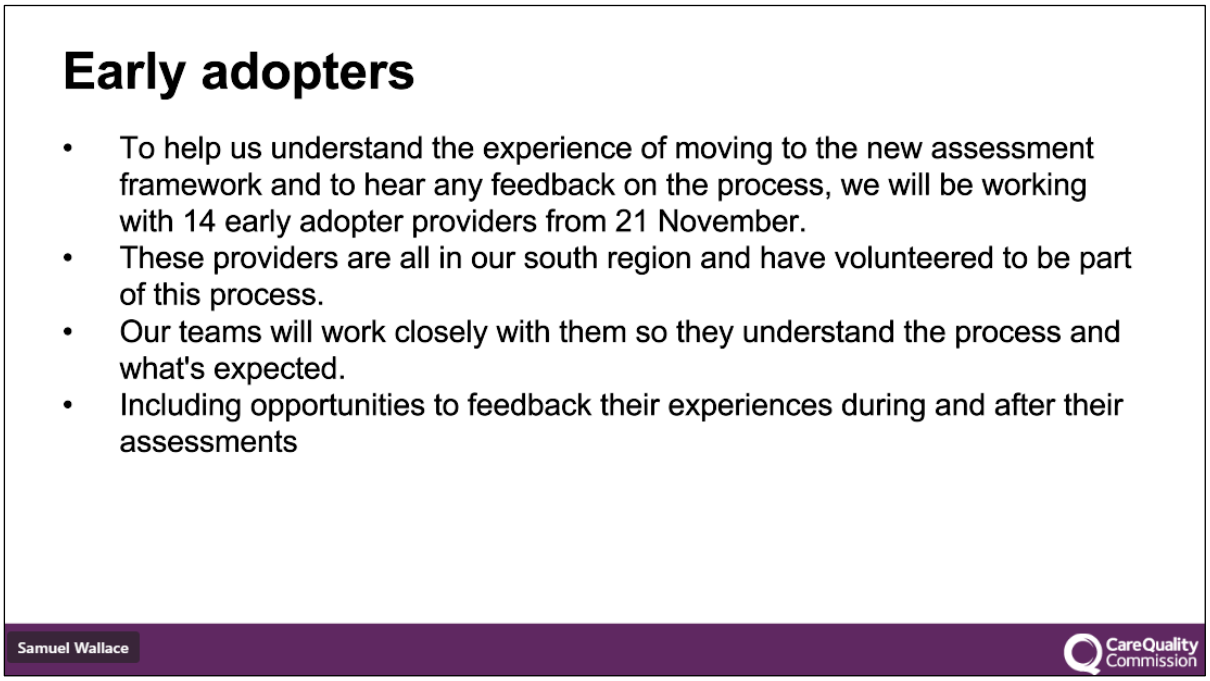
- Email a link to the final report before it is published
- Respond to any comments submitted about factual accuracy

All responses will be reviewed by another member of CQC who is independent of the assessment.

Draft ratings may change if they determine that the evidence on which they are based on is inaccurate or incomplete.

Roll out plans

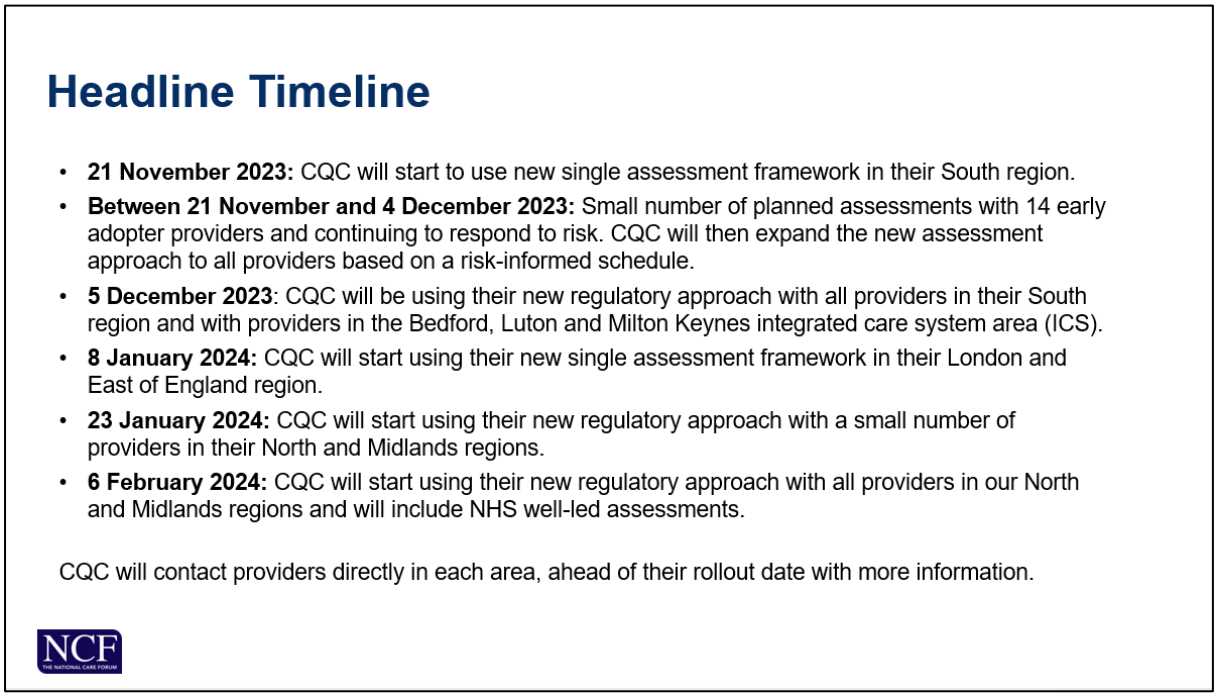
The CQC have recently announced that they plan to start working with 14 early adopters from 21 November 2023. These will be across all the areas they regulate & will be in the south region (i.e., services registered in these counties: Berkshire, Buckinghamshire, Cornwall, Devon, Dorset, Gloucestershire, Hampshire, Kent, Oxfordshire, Somerset, Surrey, Sussex and Wiltshire). Note: these are not pilots, they are the real thing in terms of assessment under the new single assessment framework.



The CQC are planning further rollout across other regions from December 2023 to February 2024.

****December Update****

CQC have provided a more detailed timeline for the rollout of the new single assessment framework.



Once the rollout reaches a region, the CQC will use their new framework to assess services. These assessments will either be planned or responsive (where they have received concerning information).

****December Update**** **Frequency of Assessment**

CQC have provided more information about when we should find out more about the frequency of assessment. They say that they will regularly review how the framework is working and the timelines involved until the end of June 2024. They will also learn from the feedback from providers. They will then decide on the frequency of the new assessments for each sector using:

- what they have learned from the first 6 months
- their view of regulatory risk
- issues affecting health and care systems

CQC will have a risk-informed approach and will decide the order of the planned assessments of providers based on the level of risk.

By the start of July 2024, CQC are hoping to be able to publish a more detailed schedule for planned assessments including a date by when all providers' ratings will have been updated. This will signal the end of their transition period.

NCF observation

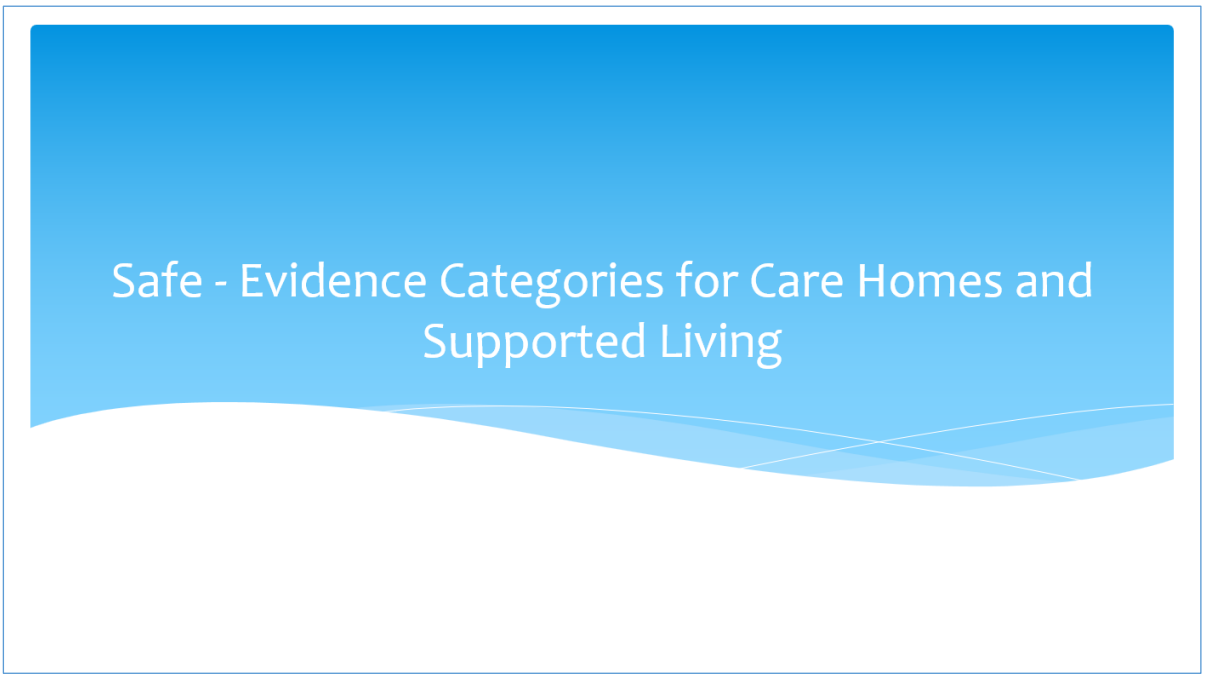
We have repeatedly fed back to the CQC that NCF members and the wider sector are finding it tough to get ready for the new inspection framework. They feel unprepared mainly because they don't have enough information. This lack of information includes important details like what evidence they need to show, how they will be scored, how often inspections will happen, and so on.

They need clear information about what exactly is expected of them – details about how they'll be inspected, what they need to show, and how they'll be scored. They will have to go through a new systematic segmentation of evidence against new quality statements, which will take time.

They want practical help – something like a handbook or toolkit that puts all the necessary information in one place (as it's quite difficult to find things on the website as it's all over the place). This way, they can easily understand what's expected of them without getting lost in confusing details.

Liz Jones, Policy Director: Email: liz.jones@nationalcareforum.org.uk

Appendix 1 – Care Homes & Supported Living detail for each evidence category



Safe - Evidence Categories for Care Homes and Supported Living

For all **Safe** quality statements for care homes and supported living, the following evidence categories will be looked at:

People's experience

- feedback from people collected by CQC, the provider, local community groups and other stakeholders
- give feedback on care

Feedback from staff and leaders

- feedback from staff collected by CQC and the provider
- feedback from leaders
- whistleblowing

Safe - Evidence Categories for Care Homes and Supported Living (1)

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.

Evidence Categories

Alongside people's experience and feedback from staff and leaders. The following evidence categories will be looked at:

Feedback from partners
- commissioners and other system partners (supported living services)
- health and care professionals working with the service (supported living services)

Processes
- duty of candour records
- evidence of learning and improvement
- incident, near misses and events records

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.

Evidence Categories

Alongside people's experience and feedback from staff and leaders. The following evidence categories will be looked at:

Observation
- staff practice (including how they deliver care, staff culture and behaviours)

Processes
- DoLS and Court of Protection (POA) records
- Mental Capacity Act records and training
- people's care records or clinical records
- safeguarding policy, records and training

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.

Evidence Categories

Alongside people's experience and feedback from staff and leaders. The following evidence categories will be looked at:

Feedback from partners
- commissioners and other system partners
- health and care professionals working in or with the service

Processes
- multidisciplinary team meeting records
- people's care records or clinical records
- records of referral, transfer or transition of care

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.

Evidence Categories

Alongside people's experience and feedback from staff and leaders. The following evidence categories will be looked at:

Observation
- equipment
- staff practice (including how they deliver care, staff culture and behaviours)
- the care environment

Processes
- DoLS and Court of Protection (POA) records
- people's care records or clinical records
- records of restrictive practice

Safe - Evidence Categories for Care Homes and Supported Living (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

Evidence Categories

Alongside people's experience and feedback from staff and leaders. The following evidence categories will be looked at:

Observation
- equipment
- staff practice (including how they deliver care, staff culture and behaviours)
- the care environment

Processes
- business continuity plans
- equipment maintenance and calibration records (care homes only)
- risk assessments

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.

Evidence Categories

Alongside people's experience and feedback from staff and leaders. The following evidence categories will be looked at:

Observation
- equipment
- staff practice (including how they deliver care, staff culture and behaviours)
- the care environment

Processes
- infection prevention and control policy, audit and action plans

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.

Evidence Categories

Alongside people's experience and feedback from staff and leaders. The following evidence categories will be looked at:

Observation
- staff practice (including how they deliver care, staff culture and behaviours)

Processes
- recruitment records
- staff vacancy and turnover rate
- staff records, including appraisal, training, development and competency
- training in communication with people with a learning disability and autistic people

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.

Evidence Categories

Alongside people's experience and feedback from staff and leaders. The following evidence categories will be looked at:

Observation
- equipment
- staff practice (including how they deliver care, staff culture and behaviours)
- the care environment

Processes
- administration of and dispensing medicines, including 'when required' (PRN) medication
- medicines audits, action plans and reviews
- people's care records or clinical records
- STOMP and STAMP records

Effective - Evidence Categories for Care Homes and Supported Living

Effective - Evidence Categories for Care Homes and Supported Living (1)

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.

Evidence Categories

People's experience

- feedback from people collected by CQC, the provider, local community groups and other stakeholders
- give feedback on care

Processes

- assessments and records of meeting needs under the Equality Act 2010
- assessments and/or best interest decisions under the MCA
- clinical tools to assess pain and monitor risk
- people's care records or clinical records

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.

Evidence Categories

People's experience

- feedback from people collected by CQC, the provider, local community groups and other stakeholders
- give feedback on care

Feedback from staff and leaders

- feedback from staff collected by CQC and the provider
- feedback from leaders
- whistleblowing

Processes

- food and fluid charts
- people's care records or clinical records
- quality improvement activity

Effective - Evidence Categories for Care Homes and Supported Living (2)

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.

Evidence Categories

People's experience

- feedback from people collected by CQC, the provider, local community groups and other stakeholders
- give feedback on care

Feedback from staff and leaders

- feedback from staff collected by CQC and the provider
- feedback from leaders
- whistleblowing

Feedback from partners

- commissioners and other system partners
- health and care professionals working with the service

Processes

- multidisciplinary team meeting records
- people's care records or clinical records

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.

Evidence Categories

People's experience

- feedback from people collected by CQC, the provider, local community groups and other stakeholders
- give feedback on care

Feedback from staff and leaders

- feedback from staff collected by CQC and the provider
- feedback from leaders
- whistleblowing

Feedback from partners

- commissioners and other system partners (supported living services)
- health and care professionals working with the service (supported living services)

Processes

- activities list
- annual health check or screening records
- care, education and treatment reviews (CETRs)
- hospital passport, people's care records or clinical records

Effective - Evidence Categories for Care Homes and Supported Living (3)

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.

Evidence Categories

People's experience

- feedback from people collected by CQC, the provider, local community groups and other stakeholders
- give feedback on care

Feedback from staff and leaders

- feedback from staff collected by CQC and the provider
- feedback from leaders
- whistleblowing

Processes

- people's care records or clinical records
- provider led audits and action plans

Consent to care and treatment

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

Evidence Categories

People's experience

- feedback from people collected by CQC, the provider, local community groups and other stakeholders
- give feedback on care

Feedback from staff and leaders

- feedback from staff collected by CQC and the provider
- feedback from leaders
- whistleblowing

Processes

- best interest meetings, evidence of power of attorney
- capacity assessments
- consent policy
- people's care records/clinical records

Caring - Evidence Categories for Care Homes and Supported Living

Caring - Evidence Categories for Care Homes and Supported Living

For all **Caring** quality statements for care homes and supported living, the following evidence categories will be looked at:

People's experience

- feedback from people collected by CQC, the provider, local community groups and other stakeholders
- give feedback on care

Feedback from staff and leaders

- feedback from staff collected by CQC and the provider
- feedback from leaders
- whistleblowing

Caring - Evidence Categories for Care Homes and Supported Living (1)

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.

Evidence Categories

Alongside people's experience and feedback from staff and leaders. The following evidence categories will be looked at:

Feedback from partners

- commissioners and other system partners
- health and care professionals working in or with the service

Observation

- equipment
- staff practice (including how they deliver care, staff culture and behaviours)
- equipment

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.

Evidence Categories

Alongside people's experience and feedback from staff and leaders. The following evidence categories will be looked at:

Feedback from partners

- commissioners and other system partners (supported living services)
- health and care professionals working in or with the service (supported living services)

Observation

- equipment
- staff practice (including how they deliver care, staff culture and behaviours)
- equipment

Processes

- people's care records or clinical records

Caring - Evidence Categories for Care Homes and Supported Living (2)

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.

Evidence Categories

Alongside people's experience and feedback from staff and leaders. The following evidence categories will be looked at:

Observation

- equipment
- staff practice (including how they deliver care, staff culture and behaviours)
- equipment

Processes

- people's care records or clinical records

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.

Evidence Categories

Alongside people's experience and feedback from staff and leaders. The following evidence categories will be looked at:

Observation

- equipment
- staff practice (including how they deliver care, staff culture and behaviours)
- the care environment

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.

Evidence Categories

Alongside people's experience and feedback from staff and leaders. The following evidence categories will be looked at:

Processes

- mechanisms to monitor, improve and promote staff safety and wellbeing
- staff management policies
- staff sickness, vacancy and turnover rates

Responsive - Evidence Categories for Care Homes and Supported Living

Responsive - Evidence Categories for Care Homes and Supported Living

For all **Responsive** quality statements for care homes and supported living, the following evidence categories will be looked at:

People's experience

- feedback from people collected by CQC, the provider, local community groups and other stakeholders
- give feedback on care

Feedback from staff and leaders

- feedback from staff collected by CQC and the provider
- feedback from leaders
- whistleblowing

Responsive - Evidence Categories for Care Homes and Supported Living (1)

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.

Evidence Categories

Alongside people's experience and feedback from staff and leaders. The following evidence categories will be looked at:

Observation

- staff practice (including how they deliver care, staff culture and behaviours)
- the care environment

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.

Evidence Categories

Alongside people's experience and feedback from staff and leaders. The following evidence categories will be looked at:

Feedback from partners

- commissioners and other system partners
- health and care professionals working in or with the service

Processes

- arrangements to ensure continuity of care
- people's care records or clinical records

Providing information

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

Evidence Categories

Alongside people's experience and feedback from staff and leaders. The following evidence categories will be looked at:

Processes

- arrangements to:
  - explain fees
  - ensure continuity of care (supported living services only)
  - identify people's communication preferences
- information sharing with people using services and those close to them
- meeting the Accessible Information Standard

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.

Evidence Categories

Alongside people's experience and feedback from staff and leaders. The following evidence categories will be looked at:

Processes

- advocacy and support service records
- collecting people's feedback, taking action and sharing learning
- complaints records and outcomes
- improvement plans and audits

Responsive - Evidence Categories for Care Homes and Supported Living (2)

Equity in access

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

Evidence Categories

Alongside people's experience and feedback from staff and leaders. The following evidence categories will be looked at:

Feedback from partners (care homes only)

- commissioners and other system partners
- health and care professionals working in or with the service

Processes

- people's care records or clinical records
- provider led audits of processes
- records and risk assessments about accessible facilities and premises

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.

Evidence Categories

Alongside people's experience and feedback from staff and leaders. The following evidence categories will be looked at:

Processes

- people's care records or clinical records
- improvement plans and audits

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.

Evidence Categories

Alongside people's experience and feedback from staff and leaders. The following evidence categories will be looked at:

Processes

- DNACPR and ReSPECT decisions
- end of life care planning
- people's care records or clinical records

Well-Led - Evidence Categories for Care Homes and Supported Living

Well-Led - Evidence Categories for Care Homes and Supported Living

For all **Well-Led** quality statements for care homes and supported living, the following evidence categories will be looked at:

Feedback from staff and leaders

- feedback from staff collected by CQC and the provider
- feedback from leaders
- whistleblowing

Well-Led - Evidence Categories for Care Homes and Supported Living (1)

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.

Evidence Categories

Alongside feedback from staff and leaders. The following evidence categories will be looked at:

Processes

- business plans
- equality, diversity, and inclusion policy
- monitoring service objectives
- vision, aims and strategy

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.

Evidence Categories

Alongside feedback from staff and leaders. The following evidence categories will be looked at:

Processes

- equality, diversity and inclusion policies and training
- flexible working arrangements
- reasonable adjustments and assistive technology for staff
- records of incidents towards staff
- workforce or EDI strategy and associated objectives and action plans

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.

Evidence Categories

Alongside feedback from staff and leaders. The following evidence categories will be looked at:

Processes

- evidence of compliance with schedule 3 and Fit and Proper Person Requirements
- leadership development and training
- recruitment and induction records
- registered manager status and changes

Freedom to speak up

We foster a positive culture where people feel that they can speak up and that their voice will be heard.

Evidence Categories

Alongside feedback from staff and leaders. The following evidence categories will be looked at:

Processes

- mechanisms for seeking and responding to staff feedback
- whistleblowing records

Well-Led - Evidence Categories for Care Homes and Supported Living (2)

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.

Evidence Categories

Alongside feedback from staff and leaders. The following evidence categories will be looked at:

Processes

- business continuity plans and risk register
- governance arrangements and organisation structure (roles and responsibilities)
- information security, data protection and GDPR arrangements
- quality management, systems and reporting
- workforce planning

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

Evidence Categories

Alongside feedback from staff and leaders. The following evidence categories will be looked at:

Processes

- evidence of embedding learning and making improvements
- evidence of engagement in innovation initiatives

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.

Evidence Categories

Alongside feedback from staff and leaders. The following evidence categories will be looked at:

People's experience

- feedback from people collected by CQC, the provider, local community groups and other stakeholders
- give feedback on care

Feedback from partners

- commissioners and other system partners
- health and care professionals working in or with the service

Processes

- examples of sharing learning and best practice
- records of collaboration
- Trusted Assessors/Discharge to Assess schemes

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.

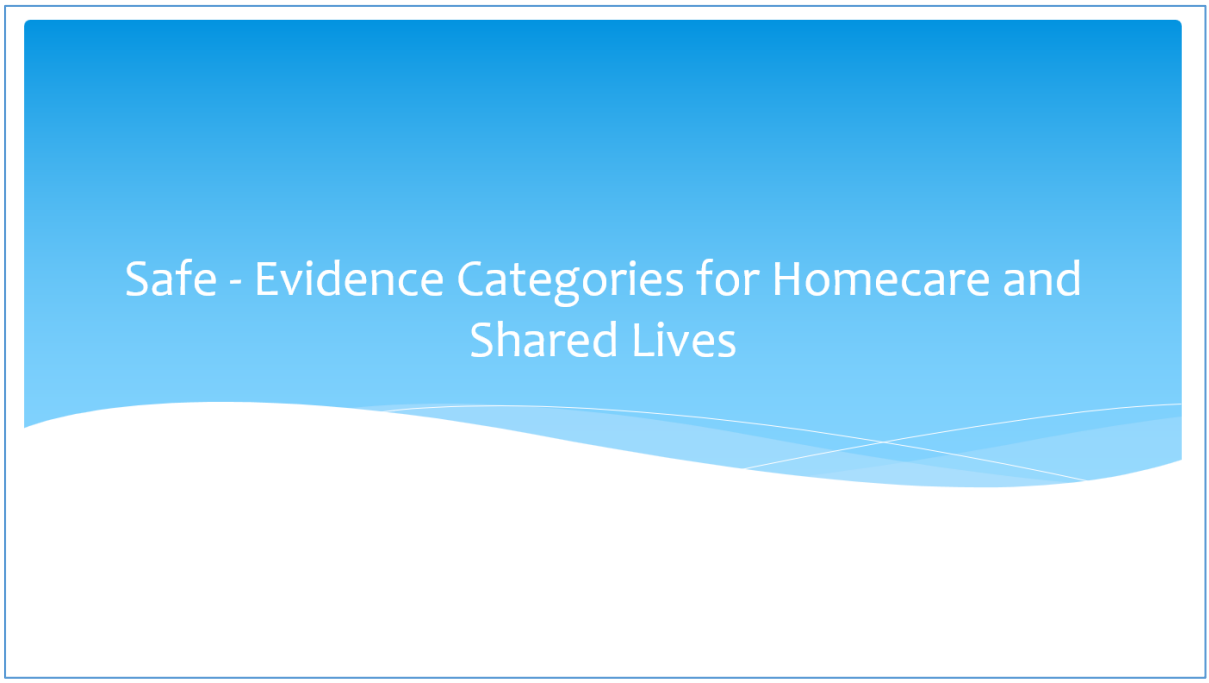
Evidence Categories

Alongside feedback from staff and leaders. The following evidence categories will be looked at:

Processes

- green and carbon reduction plans and policies
- processes for recycling
- staff training in environmental sustainability

Appendix 2 – Home Care & Shared Lives detail for each evidence category



Safe - Evidence Categories for Homecare and Shared Lives

For all **Safe** quality statements for homecare and shared lives, the following evidence categories will be looked at:

People's experience

- feedback from people collected by CQC, the provider, local community groups and other stakeholders
- give feedback on care

Feedback from staff and leaders

- feedback from staff collected by CQC and the provider
- feedback from leaders
- whistleblowing

Safe - Evidence Categories for Homecare and Shared Lives (1)

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.

Evidence Categories

Alongside people's experience and feedback from staff and leaders, the following evidence categories will be looked at:

Processes

- duty of candour records
- evidence of learning and improvement
- incident, near misses and events records

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.

Evidence Categories

Alongside people's experience and feedback from staff and leaders, the following evidence categories will be looked at:

Processes

- DoLS and Court of Protection (POA) records
- Mental Capacity Act records and training
- people's care records or clinical records
- safeguarding policy, records and training

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.

Evidence Categories

Alongside people's experience and feedback from staff and leaders, the following evidence categories will be looked at:

Feedback from partners

- commissioners and other system partners
- health and care professionals working in or with the service

Processes

- people's care records or clinical records
- records of referral, transfer or transition of care

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.

Evidence Categories

Alongside people's experience and feedback from staff and leaders, the following evidence categories will be looked at:

Processes

- arrangements to
  - respond to emergencies
  - identify people in need of urgent medical treatment
- DoLS and Court of Protection (POA) records
- people's care records or clinical records
- records of restrictive practice

Safe - Evidence Categories for Homecare and Shared Lives (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

Evidence Categories

Alongside people's experience and feedback from staff and leaders, the following evidence categories will be looked at:

Processes

- business continuity plans (including in response to extreme weather events)
- environmental risk assessment
- equipment maintenance and calibration records
- health and safety risk assessments
- infection prevention and control audit and action plans

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.

Evidence Categories

Alongside people's experience and feedback from staff and leaders, the following evidence categories will be looked at:

Processes

- infection prevention and control policy
- minimising the risk of infection at the services (shared lives only)

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.

Evidence Categories

Alongside people's experience and feedback from staff and leaders, the following evidence categories will be looked at:

Processes

- appraisal and supervision records
- recruitment records
- staff vacancy and turnover rate
- staffing and staff skill mix records
- training in communication with people with a learning disability and autistic people
- training, development and competency records

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.

Evidence Categories

Alongside people's experience and feedback from staff and leaders, the following evidence categories will be looked at:

Observation

- equipment
- staff practice (including how they deliver care, staff culture and behaviours)
- the care environment

Processes

- administering and dispensing medicines
- medicines audits and action plans
- medicines reviews
- PRN protocols
- people's care records or clinical records

Effective - Evidence Categories for Homecare and Shared Lives

Effective - Evidence Categories for Homecare and Shared Lives

For all **Effective** quality statements for homecare and shared lives, the following evidence categories will be looked at:

People's experience

- feedback from people collected by CQC, the provider, local community groups and other stakeholders
- give feedback on care

Feedback from staff and leaders

- feedback from staff collected by CQC and the provider
- feedback from leaders
- whistleblowing

Effective - Evidence Categories for Homecare and Shared Lives (1)

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.

Evidence Categories

Alongside people's experience and feedback from staff and leaders, the following evidence categories will be looked at:

Processes

- assessments and records of meeting needs under the Equality Act 2010
- assessments and/or best interest decisions under the MCA
- clinical tools to assess pain and monitor risk
- people's care records or clinical records

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.

Evidence Categories

Alongside people's experience and feedback from staff and leaders, the following evidence categories will be looked at:

Feedback from partners

- commissioners and other system partners
- health and care professionals working with the service

Processes

- information sharing and transfer of records across or between services
- multidisciplinary team meeting records
- people's care records or clinical records

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.

Evidence Categories

Alongside people's experience and feedback from staff and leaders, the following evidence categories will be looked at:

Processes

- people's care records or clinical records
- quality improvement activity

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.

Evidence Categories

Alongside people's experience and feedback from staff and leaders, the following evidence categories will be looked at:

Feedback from partners

- commissioners and other system partners (shared lives services)
- health and care professionals working with the service (shared lives services)

Processes

- people's care records or clinical records

Effective - Evidence Categories for Homecare and Shared Lives (2)

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.

Evidence Categories

Alongside people's experience and feedback from staff and leaders, the following evidence categories will be looked at:

Processes

- people's care records or clinical records
- provider led audits and action plans

Consent to care and treatment

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

Evidence Categories

Alongside people's experience and feedback from staff and leaders, the following evidence categories will be looked at:

Processes

- best interest meetings, evidence of power of attorney
- capacity assessments
- consent policy
- people's care records/clinical records

Caring - Evidence Categories for Homecare and Shared Lives

Caring - Evidence Categories for Homecare and Shared Lives

For all **Caring** quality statements for Homecare and Shared Lives, the following evidence categories will be looked at:

Feedback from staff and leaders

- feedback from staff collected by CQC and the provider
- feedback from leaders
- whistleblowing

Caring - Evidence Categories for Homecare and Shared Lives (1)

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.

Evidence Categories

Alongside feedback from staff and leaders, the following evidence categories will be looked at:

People's experience

- feedback from people collected by CQC, the provider, local community groups and other stakeholders
- give feedback on care

Feedback from partners

- commissioners and other system partners
- health and care professionals working in or with the service

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.

Evidence Categories

Alongside feedback from staff and leaders, the following evidence categories will be looked at:

People's experience

- feedback from people collected by CQC, the provider, local community groups and other stakeholders
- give feedback on care

Feedback from partners

- commissioners and other system partners (shared lives services)
- health and care professionals working in or with the service (shared lives services)

Processes

- people's care records or clinical records

Caring - Evidence Categories for Homecare and Shared Lives (2)

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.

Evidence Categories

Alongside feedback from staff and leaders, the following evidence categories will be looked at:

People's experience

- feedback from people collected by CQC, the provider, local community groups and other stakeholders
- give feedback on care

Processes

- people's care records or clinical records

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.

Evidence Categories

Alongside feedback from staff and leaders, the following evidence categories will be looked at:

People's experience

- feedback from people collected by CQC, the provider, local community groups and other stakeholders
- give feedback on care

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.

Evidence Categories

Alongside feedback from staff and leaders, the following evidence categories will be looked at:

Processes

- mechanisms to monitor, improve and promote staff safety and wellbeing
- staff management policies
- staff sickness, vacancy and turnover rates

Responsive - Evidence Categories for Homecare and Shared Lives

Responsive - Evidence Categories for Homecare and Shared Lives

For all **Responsive** quality statements for homecare and shared lives, the following evidence categories will be looked at:

People's experience

- feedback from people collected by CQC, the provider, local community groups and other stakeholders
- give feedback on care

Feedback from staff and leaders

- feedback from staff collected by CQC and the provider
- feedback from leaders
- whistleblowing

Responsive - Evidence Categories for Homecare and Shared Lives (1)

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.

Evidence Categories

People's experience and feedback from staff and leaders.

Providing information

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

Evidence Categories

Alongside people's experience and feedback from staff and leaders. The following evidence categories will be looked at:

Processes

- arrangements to:
  - explain fees
  - identify people's communication preferences
- information sharing with people using services and those close to them
- meeting the Accessible Information Standard

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.

Evidence Categories

Alongside people's experience and feedback from staff and leaders. The following evidence categories will be looked at:

Feedback from partners

- commissioners and other system partners
- health and care professionals working in or with the service

Processes

- people's care records or clinical records
- arrangements to ensure continuity of care

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.

Evidence Categories

Alongside people's experience and feedback from staff and leaders. The following evidence categories will be looked at:

Processes

- advocacy and support service records
- collecting people's feedback, taking action and sharing learning
- complaints records and outcomes
- improvement plans and audits

Responsive - Evidence Categories for Homecare and Shared Lives (2)

Equity in access

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

Evidence Categories

Alongside people's experience and feedback from staff and leaders. The following evidence categories will be looked at:

Processes

- people's care records or clinical records
- provider led audits of processes

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.

Evidence Categories

Alongside people's experience and feedback from staff and leaders. The following evidence categories will be looked at:

Processes

- DNACPR and ReSPECT decisions
- end of life care planning
- people's care records or clinical records

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.

Evidence Categories

Alongside people's experience and feedback from staff and leaders. The following evidence categories will be looked at:

Processes

- people's care records or clinical records
- improvement plans and audits

Well-Led - Evidence Categories for Homecare and Shared Lives

Well-Led - Evidence Categories for Homecare and Shared Lives

For all **Well-Led** quality statements for homecare and shared lives, the following evidence categories will be looked at:

Feedback from staff and leaders

- feedback from staff collected by CQC and the provider
- feedback from leaders
- whistleblowing

Well-Led - Evidence Categories for Homecare and Shared Lives (1)

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.

Evidence Categories

Alongside feedback from staff and leaders. The following evidence categories will be looked at:

Processes

- business plans
- equality, diversity, and inclusion policy
- monitoring service objectives
- vision, aims and strategy

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.

Evidence Categories

Alongside feedback from staff and leaders. The following evidence categories will be looked at:

Processes

- evidence of compliance with schedule 3 and Fit and Proper Person Requirements
- leadership development and training
- recruitment and induction records

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.

Evidence Categories

Alongside feedback from staff and leaders. The following evidence categories will be looked at:

Processes

- equality, diversity and inclusion policies and training
- flexible working arrangements, reasonable adjustments and assistive technology for staff
- records of incidents towards staff
- workforce or EDI strategy and associated objectives and action plans

Freedom to speak up

We foster a positive culture where people feel that they can speak up and that their voice will be heard.

Evidence Categories

Alongside feedback from staff and leaders. The following evidence categories will be looked at:

Processes

- mechanisms for seeking and responding to staff feedback
- whistleblowing records

Well-Led - Evidence Categories for Homecare and Shared Lives (2)

Governance and assurance

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.

Evidence Categories

Alongside feedback from staff and leaders, the following evidence categories will be looked at:

Processes

- business continuity plans and risk register
- governance arrangements and organisation structure (roles and responsibilities)
- information security, data protection and GDPR arrangements
- quality management, systems and reporting
- workforce planning

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.

Evidence Categories

Alongside feedback from staff and leaders, the following evidence categories will be looked at:

People's experience

- feedback from people collected by CQC, the provider, local community groups and other stakeholders
- give feedback on care

Feedback from partners

- commissioners and other system partners
- health and care professionals working in or with the service

Processes

- examples of sharing learning and best practice
- records of collaboration
- Trusted Assessors/Discharge to Assess schemes

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

Evidence Categories

Alongside feedback from staff and leaders, the following evidence categories will be looked at:

Processes

- evidence of embedding learning and making improvements
- evidence of engagement in innovation initiatives

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.

Evidence Categories

Alongside feedback from staff and leaders, the following evidence categories will be looked at:

Processes

- green and carbon reduction plans and policies
- processes for recycling
- staff training in environmental sustainability