HEALTHCARE COUNSEL

CQC SINGLE ASSESSMENT FRAMEWORK

Summary of the New Regulatory Regime (2nd Edition)

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Introduction

This document contains a summary of the CQC's new regulatory regime, current to July 2023, together with information regarding the single assessment framework, which is to be formally introduced across all service types at all levels. It is intended to be used as a reference tool.

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Information contained within this document is taken from the CQC website and the CQC YouTube Channel.

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CQC's New Strategy – the Single Assessment Framework

1. Published in May 2021, CQC's new strategy sets out the regulator's ambitions under four themes: people and communities, smarter regulation, safety through learning, and accelerating improvement. Through each theme run two core ambitions: assessing local systems and tackling inequalities in health and care. There are 12 outcomes within the new strategy.

2. For regulation, CQC is moving from multiple assessment frameworks to a single assessment framework (SAF) for all service types at all levels. The four ratings and five key questions remain, however KLOEs, prompts, and ratings characteristics are replaced with 34 Quality Statements. If a service provider hits these Quality Statements they will be delivering a "good" level of care.

3. There are six new categories of evidence: people's experience of health and care services, feedback from staff and leaders, feedback from partners, observation, processes, and outcomes.

Summary of Changes

From	To
Multiple assessment frameworks	Single assessment framework
Ongoing monitoring with inspections scheduled according to previous rating	Ongoing assessment of quality and risk
Evidence gathered at single point in time (during on-site inspection)	Evidence gathered at multiple points in time, to give a much more up to date view e.g. inspections, feedback from service users, intelligence gathered from local authorities and health partners, and information shared by service providers themselves
Judgements and ratings decisions made using ratings characteristics	Teams assign scores to evidence. Each evidence category scored from 1 to 4
Longer narrative inspection reports	Ratings updated at any time, shorter narratives published for the benefit of the public

4. A major change is the introduction of the online service provider portal which should eventually allow the easy exchange of information with CQC and will be used to review draft judgements. The Factual Accuracy Check will become the Provider Review Process and will also be conducted through the portal. This new process is still under review and its final form will be decided with the assistance of feedback from service providers.

5. Providers will be able to proactively submit evidence with the aim of introducing an ongoing conversation about service performance. A flow of information will enable CQC to reassess service providers much more frequently than it does now. CQC would also like to introduce a benchmarking tool so that providers can see how they rate against other businesses. Improvements like this will be rolled out in collaboration with service providers.

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Key Question	Quality Statement	Regulation
Is it safe?	Learning Culture	12: safe care and treatment
		16: receiving and acting on complaints
		17: good governance
		20: duty of candour
	Safe systems, pathways and transitions	12: safe care and treatment
		17: good governance
		(9: person-centred care)
	Safeguarding	11: need for consent
		12: safe care and treatment
		13: safeguarding service users from abuse and improper treatment
		(9: person-centred care)
		(17: good governance)
		(20: duty of candour)
	Involving people to manage risks	9: person-centred care
		11: need for consent
		12: safe care and treatment
		(10: dignity and respect)
	Safe environments	12: safe care and treatment
		15: premises and equipment
		17: good governance
	Safe and effective staffing	12: safe care and treatment
		18: staffing
		19: fit and proper persons employed
	Infection prevention and control	12: safe care and treatment
		15: premises and equipment
		(17: good governance)
	Medicines optimisation	9: person-centred care
		12: safe care and treatment
		(11: need for consent)

Quality statements directly relate to the Regulations listed. Regulations the CQC would also consider in its judgements are shown (in parentheses).

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Key Question	Quality Statement	Regulation
Is it effective?	Assessing needs	9: person-centred care
		12: safe care and treatment
		(11: need for consent)
		(17: good governance)
	Delivering evidence-based care and treatment	9: person-centred care
		12: safe care and treatment
		14: meeting nutritional and hydration needs
		17: good governance
		(11: need for consent)
	How staff, teams and services work together	9: person-centred care
		12: safe care and treatment
		(17: good governance)
	Supporting people to live healthier lives	9: person-centred care
		12: safe care and treatment
		(10: dignity and respect)
	Monitoring and improving outcomes	17: good governance
		(9: person-centred care)
	Consent to care and treatment	11: need for consent

Quality statements directly relate to the Regulations listed. Regulations the CQC would also consider in its judgements are shown (in parentheses).

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Key Question	Quality Statement	Regulation
Is it caring?	Kindness, compassion and dignity	9: person-centred care
		10: dignity and respect
	Treating people as individuals	9: person-centred care
		10: dignity and respect
		15: premises and equipment
	Independence, choice and control	9: person-centred care
		12: safe care and treatment
		(10: dignity and respect)
	Responding to people's immediate needs	9: person-centred care
		12: safe care and treatment
		(16: receiving and acting on complaints)
	Workforce wellbeing and enablement	9: person-centred care
		12: safe care and treatment
		17: good governance
		18: staffing

Quality statements directly relate to the Regulations listed. Regulations the CQC would also consider in its judgements are shown (in parentheses).

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Key Question	Quality Statement	Regulation
Is it responsive?	Person-centred care	9: person-centred care
		(10: dignity and respect)
		(11: need for consent)
	Care provision, integration, and continuity	9: person-centred care
		17: good governance
		(10: dignity and respect)
	Providing information	9: person-centred care
		17: good governance
	Listening to and involving people	16: receiving and acting on complaints
		17: good governance
	Equity in access	12: safe care and treatment
		17: good governance
		(9: person-centred care)
		(10: dignity and respect)
	Equity in experiences and outcomes	12: safe care and treatment
		17: good governance
		(9: person-centred care)
		(10: dignity and respect)
	Planning for the future	9: person-centred care
		(11: need for consent)

Quality statements directly relate to the Regulations listed. Regulations the CQC would also consider in its judgements are shown (in parentheses).

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Key Question	Quality Statement	Regulation
Is it well-led?	Shared direction and culture	10: dignity and respect
		12: safe care and treatment
		17: good governance
		(9: person-centred care)
		**12: statement of purpose*
	Capable, compassionate and inclusive leaders	7: requirements relating to registered managers
		18: staffing
		19: fit and proper persons employed
		(5: fit and proper persons: directors)
		**4: requirements where the service provider is an individual or partnership*
		**14: notice of absence*
	Freedom to speak up	10: dignity and respect
		12: safe care and treatment
		17: good governance
		(9: person-centred care)
	Workforce equality, diversity and inclusion	17: good governance
		18: staffing
	Governance, management and sustainability	17: good governance
		(12: safe care and treatment)
		**14: requirements where the service provider is an individual or partnership*
		**15: notice of changes*
		**16: notification of death of service user*
		**17: notification of death or unauthorised absence of a service user who is detained or liable to be detained under the Mental Health Act 1983*
		**18: notification of other incidents*
		**20: requirements relating to termination of pregnancies*
		**22A: form of notifications to the Commission*

	Partnerships and communities	12: safe care and treatment
		17: good governance
		(9: person-centred care)
	Learning, improvement and innovation	17: good governance
	Environmental sustainability – sustainable development	17: good governance

Quality statements directly relate to the Regulations listed. Regulations the CQC would also consider in its judgements are shown (in parentheses).

*indicates a Registration Regulation.

Key Question: Is it safe?
Quality Statements

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Learning culture

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

Safe systems, pathways and transitions

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

Safeguarding

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

Involving people to manage risks

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

Safe environments

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

Safe and effective staffing

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

Infection prevention and control

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

Medicines optimisation

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

Key Question: Is it effective?
Quality Statements

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Assessing needs

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

Delivering evidence-based care and treatment

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

How staff, teams and services work together

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

Supporting people to live healthier lives

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

Monitoring and improving outcomes

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

Consent to care and treatment

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

Key Question: Is it caring?
Quality Statements

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Kindness, compassion and dignity

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

Treating people as individuals

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

Independence, choice and control

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

Responding to people's immediate needs

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

Workforce wellbeing and enablement

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

Key Question: Is it responsive?
Quality Statements

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Person-centred care

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

Care provision, integration, and continuity

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

Providing information

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

Listening to and involving people

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

Equity in access

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

Equity in experiences and outcomes

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

Planning for the future

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

Key Question: Is it well-led?
Quality Statements

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Shared direction and culture

We have a shared vision, strategy and culture. This is based on transparency, equity, equality and human rights, diversity and inclusion, engagement, and understanding challenges and the needs of people and our communities in order to meet these.

Capable, compassionate and inclusive leaders

We have inclusive leaders at all levels who understand the context in which we deliver care, treatment and support and embody the culture and values of their workforce and organisation. They have the skills, knowledge, experience and credibility to lead effectively. They do so with integrity, openness and honesty.

Freedom to speak up

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

Workforce equality, diversity and inclusion

We value diversity in our workforce. We work towards an inclusive and fair culture by improving equality and equity for people who work for us.

Governance, management and sustainability

We have clear responsibilities, roles, systems of accountability and good governance. We use these to manage and deliver good quality, sustainable care, treatment and support. We act on the best information about risk, performance and outcomes, and we share this securely with others when appropriate.

Partnership and communities

We understand our duty to collaborate and work in partnership, so our services work seamlessly for people. We share information and learning with partners and collaborate for improvement.

Learning, improvement and innovation

We focus on continuous learning, innovation and improvement across our organisation and the local system. We encourage creative ways of delivering equality of experience, outcome and quality of life for people. We actively contribute to safe, effective practice and research

Environmental sustainability – sustainable development

We understand any negative impact of our activities on the environment and we strive to make a positive contribution in reducing it and support people to do the same.

Evidence Categories

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The CQC has grouped the different types of evidence it will look at into 6 categories.

Each category sets out the types of evidence it uses to understand:

- the quality of care being delivered
- the performance against each quality statement

This is to make its judgements more transparent and consistent.

To make clear what the CQC will look at in its assessments, it will set out the key evidence categories that it will focus on when assessing a particular quality statement. Some examples of types of evidence will be provided to make it easier to understand what the CQC will look at.

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

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

Evidence category: People's experience of health and care services

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

CQC definition:

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

Evidence from people's experience of care includes:

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

Evidence category: Feedback from staff and leaders

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CQC definition:

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

Evidence category: Feedback from partners

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CQC definition:

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

Evidence category: Observation

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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, the CQC will include it in this category, and not in the people's experiences category.

The CQC 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.

Evidence category: Processes

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CQC definition:

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

The CQC's assessments focus on how effective policies and procedures are. To do this, it will look at information and data sources that measure the outcomes from processes. For example, it 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

Evidence category: Outcomes

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CQC definition:

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

The CQC considers outcomes measures in context of the service and the specifics of the measure.

Some examples of outcome measures are:

- mortality rates
- emergency admissions and re-admission rates to hospital
- infection control rates
- vaccination and prescribing data

The CQC sources the information from:

- patient level data sets
- national clinical audits
- initiatives such as the patient reported outcome measures (PROMs) programme

Assessing Quality and Performance – Differences from the current model

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

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

- **Frequency of assessments:** It will no longer use the rating of a service as the main driver when deciding when it next needs to assess. Evidence it collects or information it receives at any time can trigger an assessment

- **Assessing quality:** It will make judgements about quality more regularly, instead of only after an inspection as it does currently. It will use evidence from a variety of sources and look at any number of quality statements to do this. Its assessments will be more structured and transparent, using evidence categories and giving a score for what it finds. The way it makes its decisions about ratings will be clearer and easier to understand

It will refine and improve how this approach works as it start to test and introduce it for providers.

Up-to-date, transparent assessments of quality

By using its assessment framework as part of its regulatory approach, it will have the flexibility to:

- update the ratings for key questions and overall ratings when things change, based on more frequent assessment of evidence

- collect and review evidence in some categories more often than others. For example, it may collect evidence of people's experiences more often than evidence about processes

- be selective in which quality statements it looks at – this could be one, several or all

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The CQC will use the best options to collect evidence depending on the type of key evidence for a quality statement. Evidence can be collected either on site or off site, or by using a combination.

Collecting evidence off site

This includes data that other organisations have already collected as well as information that the CQC can collect. Examples of some evidence that it can collect entirely off site can include:

- data on outcomes of care
- anonymised information from people's records
- feedback and complaints to a service provider
- feedback to CQC from people and their representatives about their experiences

It can gather evidence from people who work in a service either on site or off site, or by using a combination.

It will also work with other people and organisations to help it collect evidence, for example local Healthwatch groups and our Experts by Experience. They can help the CQC reach out to people, families and carers and engage with communities whose voices are seldom heard.

This means that it may not always need to physically visit to gather this evidence and update its ratings.

Collecting evidence on site

It will carry out site visits when it's the best way to gather the evidence it needs. These are still called inspections. For example, it will do this:

- so it can talk to people about their experience of care in some types of service
- where people have communication needs that make telephone or video conversations challenging (or not suitable at all)
- where there are concerns around transparency and confidentiality (for example, to make sure someone isn't overheard or being influenced by others)
- to check the validity of evidence it has already gathered in a setting
- to observe the care environment and how staff interact with people

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

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

- understanding which evidence to collect
- corroborating and analysing evidence
- interviewing key staff

It will carry out site visits more frequently where:

- there is a greater risk of a poor or closed culture going undetected in a service

- it is the best way to gather people's experience of care
- the CQC has concerns about transparency and the availability of evidence
- it has a statutory obligation to do so. For example, as a member of the National Preventative Mechanism it must visit places of detention regularly to prevent torture and other ill-treatment.

Inspections

When the CQC makes a site visit to gather evidence, it is still called an inspection. Inspections are one way in which it will gather evidence. They remain a valuable tool in its approach. The CQC might use them when a service is registering with it and when it is assessing quality in services that are already registered.

It will spend its time on site:

- observing care
- observing the care environment, including equipment and premises
- speaking to people using the service and the staff

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

Assessing Quality and Performance – How the CQC reaches a rating

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To support the transparency and consistency of our judgements, it will introduce a scoring framework into its assessments.

Where appropriate, it will continue to describe the quality of care using its 4 ratings: outstanding, good, requires improvement, or inadequate.

When it assesses evidence, it assigns scores to the key evidence categories for each quality statement that it is assessing. Ratings will be based on building up scores from quality statements to an overall rating. This approach makes clear the type of evidence that it has used to reach decisions.

Scoring

Using scoring as part of its assessments will help the CQC be clearer and more consistent about how it has reached a judgement on:

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

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

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

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

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

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

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

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

The CQC will collect different evidence when it assesses local authorities and integrated care systems.

Evidence could be information that it either:

- already has, for example from statutory notifications
- actively looks for, for example from an on-site inspection

Depending on what it finds, the CQC gives a score for each evidence category that is part of the assessment of the quality statement. All evidence categories and quality statements are weighted equally.

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

Scoring system

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

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

Any changes in evidence category scores can then update the existing quality statement score. The CQC will follow these initial 3 stages for all assessments:

1. Review evidence within the evidence categories we're assessing for each quality statement
2. Apply a score to each of these evidence categories
3. Combine these evidence category scores to give a score for the related quality statement

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

For service providers

- The quality statement scores are combined to give a total score for the relevant key question. This score generates a rating for each key question (safe, effective, caring, responsive, and well-led)

- The CQC then aggregates the scores for key questions to give a rating for its view of quality at an overall service level

It will initially only publish the ratings for providers, but it intends to publish the scores in future.

For local authorities

- The quality statement scores are combined to give an overall score and a rating

Ratings will be indicative for the pilot assessments until the CQC moves to ongoing assessment.

For integrated care systems

- The quality statement scores are combined to give a theme score

- Theme scores are then combined to give a score for each of the 3 themes and an overall score and rating

Rules and limiters

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

If the key question score is within the:

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

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

The CQC does not have rules or limiters for different combinations of evidence category scores. But it can apply its professional judgement if the quality statement score produced does not reflect quality for that topic.

Its judgements go through quality assurance processes.

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