Log my Care

Simplifying the new CQC framework

Contents

Intro

We're delighted to launch this resource looking at the new framework that the Care Quality Commission (CQC) will be rolling out. It is a simplified version of the CQC's own content about the new framework and how it will impact inspections for care providers.

The regulator has a lot of information available to help you stay prepared. However, it can be quite daunting to know where to start and what information to consume first.

That's why we've compiled everything you need to know, to eliminate the need to dig deeper into understanding what will be helpful to you and your care teams.

What's staying the same, what's changing, and what's new

What's staying the same

- The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Fundamental Standards (Regulations 9 to 20).
- All health and social care providers conducting regulated activities must make sure their staff receive relevant training for their roles regarding learning disabilities and autism.
- The Secretary of State (SofS) is required to produce a Code of Practice with regards to training on learning disability and autism.
- The five key questions (safe, effective, caring, responsive and well-led).
- The four-point ratings scale (Outstanding, Good, Requires Improvement and Inadequate).

What's changing

- The assessment approach is moving away from separate 'monitor,' 'inspect,' and 'rate' steps to a more frequent and flexible assessment.
- Interactions with the regulator will be made easier through a new online portal.
- Quality Statements will replace Key Lines of Enquiry (KLOEs), reducing duplication and focusing on key topic areas.
- Teams with expertise from different sectors will collaborate for more effective assessments.
- Assessments will be made more regularly, using various sources and structured assessments with clearer ratings.

What's new

- New technology will transform how the CQC works, with updates shared with stakeholders.
- A single assessment framework will now apply to all service types and levels, replacing the previous multiple frameworks for different provider sectors.

What's new [continued]

- A new scoring system based on evidence categories is implemented.
- The use of an online portal and streamlined notifications illustrates the integration of new technologies for more efficient and accessible interactions.
- The commitment to more frequent, structured assessments implies a new, agile approach to monitoring and evaluating care quality.

Key questions and quality statements

Under each key question (safe, effective, caring, responsive, well-led) there are a set of quality statements. These describe what good care looks like and link to the regulations.

What are Quality Statements?

- **Quality statements** aim to clarify expectations for providers and reduce duplication compared to the current Key Lines of Enquiry (KLOEs).
- These statements, expressed as 'We Statements,' define commitments for providers, commissioners, and system leaders to ensure high-quality, person-centred care.
- **Quality statements will replace KLOEs** and apply to all CQC-assessed services, streamlining 120 KLOEs into 34 quality statements for clarity.
- The focus is on outcomes rather than inputs, with published **Evidence Categories specifying the types of evidence required for compliance with Quality Statements**, varying by service type.

Safe

- Learning culture
- Safe systems, pathways and transitions
- Safeguarding
- Involving people to manage risks
- Safe environments
- Safe and effective staffing
- Infection prevention and control
- Medicines optimisation

Caring

- Kindness, compassion and dignity
- Treating people as individuals
- Independence, choice and control
- Responding to people's immediate needs
- Workforce well being and enablement

Effective

- 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
- 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

Responsive

- 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

Well-led

- Shared direction
- 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

Evidence categories

To make their judgements more structured and consistent, CQC have added six categories of evidence they will collect.

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

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

The six evidence categories are:

- **People's experience of health and care services**
- **Feedback from staff and leaders**
- **Feedback from partners**
- **Observation**
- **Processes**
- **Outcomes**

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 experience 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

Evidence from people's experience of care includes:

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

Feedback from staff and leaders

- This evidence is 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

Feedback from partners

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

This organisations include, for example:

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

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 context.
- All observation is carried out on site.

Processes

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

Outcomes

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

We source the information from:

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

People's experience of health and care and I/We statements

CQC defines 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".

I/we statements describe what good, citizen-focused, personalised care and support looks like from the point of view of people themselves.

I statements are part of CQC's assessment framework. They reflect what people have said matters to them.

They have a key role in the People's experience evidence category to help CQC gather, listen to and act on people's experiences. Their experience of care will inform CQC's decision-making and lead them to take appropriate action.

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

'I' statement: When I move between services, settings or areas, there is a plan for what happens next and who will do what, and all the practical arrangements are in place.

'We' statement: We work in partnership with others to establish and maintain safe systems of care in which people's safety is managed, monitored and assured, especially when they move between different services.

Assessing quality and performance: How CQC gathers evidence

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

How CQC gathers evidence

- 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 CQC can collect themselves. Examples of some evidence that CQC 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
- CQC can gather evidence from people who work in a service either on site or off site, or by using a combination.
- CQC will also work with other people and organisations to collect evidence, for example local Healthwatch groups and our Experts by Experience. They can help CQC reach out to people, families and carers and engage with communities whose voices are seldom heard.
- This means that CQC may not always need to physically visit to gather this evidence and update ratings.

Collecting evidence on site

CQC will carry out site visits when it's the best way to gather the evidence we need. These are still called inspections. For example, they'll do this:

- so they can talk to people about their experience of care in some types of service
- where people have communication needs that make telephone or video conversations challenging (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 they have already gathered in a setting
- to observe the care environment and how staff interact with people.

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

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

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

CQC will carry out site visits more frequently where:

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

Inspections

When CQC makes a site visit to gather evidence, it is still called an inspection. Inspections are one way in which we will gather evidence. They remain a valuable tool in their approach.

CQC will spend their time on site:

- observing care
- observing the care environment, including equipment and premises
- speaking to people using the service and the staff
- They may carry out an inspection visit to collect evidence without giving notice beforehand. CQC would do this, for example, in response to a specific concern.

How they reach a rating

CQC will introduce a scoring framework into their assessments.

Where appropriate, they'll continue to describe the quality of care using 4 ratings: outstanding, good, requires improvement, or inadequate.

When they assess evidence, they assign scores to the key evidence categories for each quality statement that they're 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 we have used to reach decisions.

Scoring

Using scoring as part of our assessments will help us be clearer and more consistent about how we've 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

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

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

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

Any changes in evidence category scores can then update the existing quality statement score.

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, we build up scores from quality statements to an overall rating. This depends on the type of assessment.

For service providers

- The quality statement scores are combined to give a total score for the relevant key question.
  This score generates a rating for each key question (safe, effective, caring, responsive, and well-led).
- CQC then aggregates the scores for key questions to give a rating for their view of quality at an overall service level.

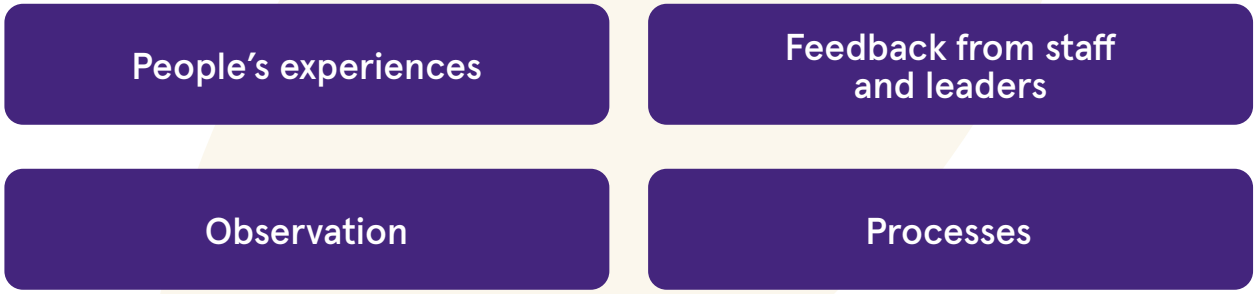
CQC will initially only publish the ratings for providers, but they intend to publish the scores in future.

How they reach a rating - example for a GP practice

To assess quality against a particular quality statement, operational colleagues specialising in GP practices will look at the required evidence categories. In this example, we are just looking at the infection prevention and control quality statement.

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.

In general practice, the required categories for this are:



We would look at individual pieces of evidence under each category and based on the strength of what we find, give a score of 1 to 4.

For example, in the ‘people's experience’ evidence category, CQC may look at:

- patient surveys
- complaints and compliments

To gather evidence in the ‘feedback from staff and leaders’ and ‘observation’ categories, we might schedule:

- an inspection to look at the care environment
- a call to speak with staff at the GP practice

We would then combine this new evidence with what we already hold on ‘processes’ to help us form a view of quality.

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

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

We calculate this as a percentage so that we have more detailed information at evidence category and quality statement level, and can share this. In time, this will support benchmarking information.

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

We convert this back to a score so it is easier to:

- understand
- combine with other quality statement scores to calculate the related key question score.

We use these thresholds to convert percentages to scores:

In this case, the percentage score of 69% converts to a score of 3.

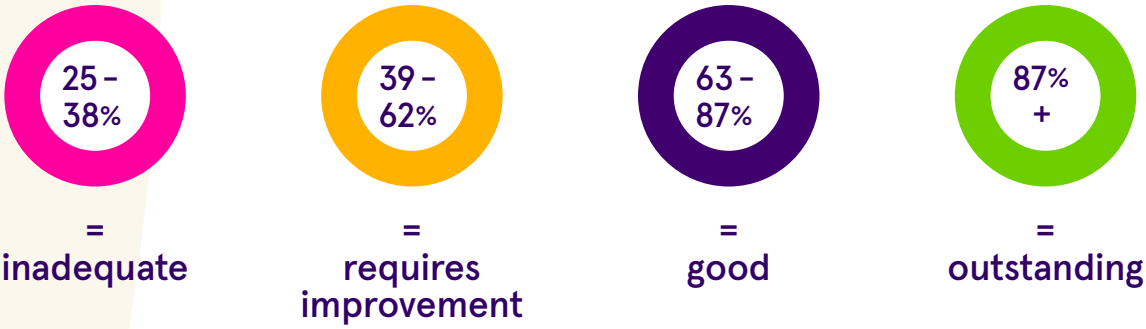
We then use this score to give us an updated view of quality at key question level. In this case it is for the safe key question:

Example: combining quality statement scores to give a key question rating

Quality statement	Score	Existing or updated score
Learning culture	2	existing
Safe systems, pathways and transitions	3	existing
Safegaurding	3	existing
Involving people to manage risks	2	existing
Safe environments	3	existing
Infection prevention and control	3	updated
Safe and effective staffing	2	existing
Medicines optimisation	3	existing
Total score for the safe key question	**21**	

Again, we calculate a percentage score. We divide the total (in this case 21) by the maximum possible score. For the safe key question, this is 8 quality statements multiplied by the highest score for each statement, which is 4. So the maximum score is 32. Here, it gives a percentage score for the key question of 65.6% (this is 21 divided by 32).

At key question level we translate this percentage into a rating rather than a score, using these thresholds:



= inadequate

= requires improvement

= good

= outstanding

Therefore, the rating for the safe key question in this case is good.

"Did you know?"

- Roll-out starts on Nov 2023 with the South network, then roll out to other geographical networks in a staged way by March 2024
- Providers will be contacted and informed of when they'll be part of the new rollout.
- CQC will continue to use the same regulatory approach in areas the single assessment framework hasn't been implemented.

Log my Care is the most user-friendly platform for digital care management. Empowering the care sector since 2017, our flexible solution enables providers of all sizes to deliver proactive care and finally have oversight of their service.

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Jennifer Bridgen
Registered Manager at Care Taylor Made

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