



Policy for Managing Care Quality Commission Requirements

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Trust requirement]	November 2015	Natalie Mudge, Compliance and Standards Lead
Version	Date	Comments (i.e. viewed, or reviewed, amended approved by person or committee)
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V2.0	22 February 2018	Approved by Executive Leadership Board

POL029 – Policy for Managing CQC Requirements

Version	Date	Comments (i.e. viewed, or reviewed, amended approved by person or committee)
V2.1	03 June 2020	Amended by the Compliance and Standards Lead to reflect operational structure reporting and system changes
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POL029 – Policy for Managing CQC Requirements

Document Reference	Health and Social Care Act 2012 (Regulated Activities) Regulations 2014 Care Quality Commission (Registration) Regulations (Part 4) Key lines of enquiry, prompts and ratings characteristics for healthcare services (CQC: June 2017) Directorate: Clinical Quality Directorate
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Part of Trust's publication scheme	Yes

The East of England Ambulance Service NHS Trust has made every effort to ensure this policy does not have the effect of unlawful discrimination on the grounds of the protected characteristics of: age, disability, gender reassignment, race, religion/belief, gender, sexual orientation, marriage/civil partnership, pregnancy/maternity. The Trust will not tolerate unfair discrimination on the basis of spent criminal convictions, Trade Union membership or non-membership. In addition, the Trust will

EEAST: POL029 – Policy for Managing CQC Requirements
June 2020 V3.0

POL029 – Policy for Managing CQC Requirements

have due regard to advancing equality of opportunity between people from different groups and foster good relations between people from different groups. This policy applies to all individuals working at all levels and grades for the Trust, including senior managers, officers, directors, non-executive directors, employees (whether permanent, fixed-term or temporary), consultants, governors, contractors, trainees, seconded staff, homeworkers, casual workers and agency staff, volunteers, interns, agents, sponsors, or any other person associated with the Trust.

All Trust policies can be provided in alternative formats.

Contents

1.0	Introduction	7
1.1	CQC Operating Model.....	8
1.2	Enforcements and offences	8
1.3	Key Lines of Enquiry (KLOEs)	10
2.0	Purpose.....	11
3.0	Duties.....	11
3.1	Trust Board	11
3.2	Trust Chair	11
3.3	Quality Governance Committee	12
3.4	Chief Executive	12
3.5	Medical Director	12
3.6	Compliance and Standards Lead.....	12
3.7	Evidence collation	13
3.8	'Accountability Owners'	13
3.10	'Shared Users'	13
3.11	Communications Team.....	13
3.12	Operational and EOC Managers.....	13
4.0	Definitions.....	14
5.0	Development.....	14
5.1	Prioritisation of Work	14
5.2	Identification of Stakeholders	14
5.3	Responsibility for Document's Development	14
6.0	Reporting requirements.....	15
6.1	Key Lines of Enquiry (KLOEs)	15
7.0	CQC Inspections.....	16
7.1	Comprehensive Inspections.....	17
7.2	Focused Inspections.....	17
7.3	Inspection Process.....	17

POL029 – Policy for Managing CQC Requirements

7.4	Displaying of ratings	19
Appendix A Monitoring table	
	21	
Appendix B Equality Impact Assessment	
	24	

1.0 Introduction

In April 2010 it became a legal requirement for all healthcare providers to be registered with the Care Quality Commission (CQC) and comply with the Essential Standards of Quality and Safety (ESQS) and their associated outcomes.

Following the release of the Mid Staffordshire NHS Foundation Trust Public Inquiry, commonly known as the Francis Enquiry, the CQC made radical changes to the way they regulate to ensure people receive safe, high quality care. To do this, they ask five key questions:

Are services

- Safe
- Caring
- Effective
- Well-led
- Responsive to people's needs

From 01 April 2015, the CQC replaced the Essential Standards for Quality & Safety with the Fundamental Standards which sets out standards below which care must never fail. These standards as listed below, for all health and adult social care organisations, form part of changes to the law recommended within the Francis Enquiry;

- care and treatment must be appropriate and reflect service users' needs and preferences.
- service users must be treated with dignity and respect.
- care and treatment must only be provided with consent.
- care and treatment must be provided in a safe way.
- service users must be protected from abuse and improper treatment.
- service users' nutritional and hydration needs must be met.
- all premises and equipment used must be clean, secure, suitable and used properly.
- complaints must be appropriately investigated and appropriate action taken in response.
- systems and processes must be established to ensure compliance with the fundamental standards.

POL029 – Policy for Managing CQC Requirements

- sufficient numbers of suitably qualified, competent, skilled and experienced staff must be deployed.
- persons employed must be of good character, have the necessary qualifications, skills and experience, and be able to perform the work for which they are employed (fit and proper persons requirement).
- registered persons must be open and transparent with service users about their care and treatment (the duty of candour).

Providers of care must also display their CQC rating in a place where the public can see it, include this information on their website and make their latest report on their service available.

The role of the Trust Board, and in particular the Quality Governance Committee with its delegated responsibilities, provide a number of key quality functions one of which is to play a pivotal role in the assurance processes linked to the Care Quality Commission and the Care Act Regulations.

The CQC monitors, inspects and regulates services to make sure they meet fundamental standards of quality and safety, publishing what they find, including performance ratings.

1.1 CQC Operating Model

The regulations and the Fundamental Standards are an essential component of CQC's new approach, as set out in their strategy Raising Standards, Putting people first. The diagram of their operating model as shown below, summarises how they; register, monitor, inspect and award ratings to providers, take enforcement action and provide an independent voice on the quality of care.

Guidance for providers on meeting the regulations. Health and Social Care Act 2012 (Regulated Activities) Regulations 2014 (Part 3) (as amended)

1.2 Enforcements and offences

The CQC has a wide set of powers that enables them to enforce action including prosecution for certain regulations without first issuing a Warning Notice as listed below.

EEAST: POL029 – Policy for Managing CQC Requirements
June 2020 V3.0

POL029 – Policy for Managing CQC Requirements

A breach of the following offences may be prosecuted directly:

Regulation 11	Need for consent: care and treatment may only be provided with consent.
Regulation 16(3)	Receiving and acting on complaints: a summary of complaints, responses, correspondence and other relevant information identified must be provided to CQC within 28 days of a request.
Regulation 17(3)	Good governance: a report into how the registered person is complying with the good governance requirements and their plans for improvement of services delivered must be provided to CQC within 28 days of a request.
Regulation 20 (2)(a)	Duty of candour: registered persons must as soon as reasonably practicable notify a service user (or person lawfully acting on their behalf) when an unintended or unexpected incident occurs that has or could have resulted in death, severe harm, moderate harm or prolonged psychological harm to the service user.
Regulation 20(3)	Duty of candour: notifications given under Regulation 20(2)(a) must meet specific requirements.
Regulation 20A	Requirement as to display of performance assessments: providers must display on their website details of CQC's website, the most recent CQC rating and the date it was given. They must also display the most recent rating at each location where regulated activities are provided from and at the provider's principal place of business. Signs must be legible, conspicuously displayed and show the date the rating was given.

A defence to all of the above offences is available where the registered persons took all reasonable steps and acted with all due diligence.

To be able to prosecute for the following offences, they need a further qualification, which is that the breach results in people who

POL029 – Policy for Managing CQC Requirements

use services being exposed to avoidable harm or significant risk of such harm occurring or suffering a loss of money or property as a result of theft, misuse or misappropriation

Regulation 12	Safe care and treatment: care and treatment must be provided safely.
Regulation 13	Safeguarding service users from abuse and improper treatment: sections 13(1) to 13(4).
Regulation 14	Meeting nutritional and hydration needs: service users' nutritional and hydration needs must be met. This applies where accommodation or an overnight stay on the premises is provided or where meeting a person's nutritional or hydration needs is part of the care and treatment arrangements

A breach of the following offences may be prosecuted directly:

- Regulation 12 Statement of purpose
- Regulation 14 Notice of absence
- Regulation 15 Notice of changes
- Regulation 16 Notification of death of service user
- Regulation 17 Notification of death or unauthorised absence of a person who is detained or liable to be detained under the Mental Health Act 1983
- Regulation 18 Notification of other incidents
- Regulation 19 Fees etc
- Regulation 20 Requirements relating to termination of pregnancies

In relation to these offences, there is no requirement for anyone to have been exposed to harm or placed at risk of harm as there is in the Health and Social Care Act 2012 (Regulated Activities) Regulations 2014. A breach of the regulation is an offence without this further qualification.

1.3 Key Lines of Enquiry (KLOEs)

In consultation with service users, family, carers, key providers and their staff, the CQC introduced the Key Lines of Enquiry (KLOEs). This process is centred on five key questions, which inspectors use to help establish whether a service is providing the high standard of care expected of them. The five key questions are as follows. Is a service:

EEAST: POL029 – Policy for Managing CQC Requirements
June 2020 V3.0

POL029 – Policy for Managing CQC Requirements

Safe? Service users, staff and visitors are protected from abuse and avoidable harm.

Effective? People's care, treatment and support achieves good outcomes, promotes a good quality of life and is evidence-based where possible.

Caring? Staff involve and treat people with compassion, kindness, dignity and respect.

Responsive? Services are organised so that they meet people's needs.

Well-led? Leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

2.0 Purpose

The purpose of this policy is to provide staff with information to understand their responsibility for collecting evidence and demonstrating compliance with the standards of quality and safety. (final document name to be included)

This policy also provides guidance for staff regarding the process to follow should the CQC undertake an unannounced inspection.

3.0 Duties

3.1 Trust Board

The Board will receive information on CQC compliance in order to seek assurance that internal controls are in place and are operating effectively in relation to ongoing registration with the CQC.

3.2 Trust Chair

The Trust Chair is responsible for informing the CQC that all Directors and Senior Managers acting at Trust Board level are

compliant with Regulation 5: Fit and proper person requirement for directors.

3.3 Quality Governance Committee

The Committee is directly accountable to the Board and seeks to provide assurance relating to systems and procedures concerning patient safety. The Committee will receive reports relating to CQC compliance and issues highlighted in order to provide assurance to the Board, or to raise concerns.

3.4 Chief Executive

The Chief Executive is the 'Registered Manager' in line with CQC requirements and is responsible for ensuring that people who use EEAST have their needs met in line with the 'Activities' for which the organisation is registered.

It is the duty of the Chief Executive's office to notify the Director of Nursing and Clinical Quality of any announcement of an assessment or request of information received from the CQC. This should be done at the earliest opportunity.

3.5 Medical Director

The Director is responsible for ensuring safe and robust systems are in place for the management of CQC evidence, compliance statements and for reporting to the Trust Board on any areas of concern.

3.6 Compliance and Standards Lead

The Compliance and Standards Lead is responsible for, the organisation's CQC monitoring and compliance system, this includes;

- Working with identified leads to ensure quarterly updates are completed in line with Trust and CQC requirements
- Ensuring evidence is robust and 'fit for purpose'
- Providing 'challenge' when appropriate as part of the ongoing monitoring against CQC standards
- Providing expert guidance
- Ensuring that all Trust premises are provided with a 'ratings poster' following an inspection and that this is in line with CQC requirements.

3.7 Evidence collation

The Trust has a compliance software system and library of evidence to demonstrate completion of actions and in identifying the ways in which the Trust complies with the KLOEs within each CQC domain

3.8 'Accountability Owners'

The 'Accountability Owners' are defined as individuals who have Trust level responsibility for designated KLOEs. They are responsible for the following areas within their designated KLOEs on an ongoing quarterly basis;

- Identifying, evaluating and linking evidence
- Liaising with the 'Shared Users' within their designated KLOEs to ensure all prompts are assessed
- Determining CQC compliance ratings
- Determining and updating actions where required

3.9 'Shared Users'

The Shared Users are responsible for the following areas within their designated KLOEs on an ongoing quarterly basis;

- Identifying, evaluating and linking evidence
- Providing quarterly assessment updates for their relevant prompts
- Determining and updating actions where required

3.10 Communications Team

The Communications Team are responsible for ensuring that all Trust websites, both public and internal, are updated with an inspection assessment rating within 21 calendar days and in the approved CQC format, in line with the associated statutory requirement.

3.11 Operational and EOC Managers

Operational and EOC Managers are responsible for ensuring that all premises within their locality display the 'ratings poster' provided by the Compliance and Standards Lead within 21 calendar days of issue and that this is in a prominent position so that all staff and visitors are able to see it.

4.0 Definitions

The Care Quality Commission (CQC)

The Care Quality Commission is the regulator of health and adult social care in England. They make sure that the care that people receive meets the standards of quality and safety and they continuously monitor the compliance with these standards using enforcement where necessary.

Intelligent Monitoring Tool

The CQC have developed an Intelligent Monitoring Tool which enables organisations to report against set criteria electronically. For ambulance services the only criteria is in relation to when changes are required to be made regarding their registration, such as change of registered location, statement of compliance etc.

Evidence

The evidence used to demonstrate compliance with standards. This will be a variety of sources such as; patient feedback, staff feedback, national and local audits, performance, internal and external monitoring and governance reports etc.

5.0 Development

5.1 Prioritisation of Work

The need for a policy to outline the Trust's requirements and processes in relation to the Essential Standards of Care was identified by the Compliance and Standards Lead and supported by recommendations following an internal audit.

5.2 Identification of Stakeholders

For the purposes of this Policy, stakeholders are all people who access or use the service or those who act on their behalf

5.3 Responsibility for Document's Development

The Compliance and Standards Lead is responsible for the review and update of this policy every three years unless prompted earlier by CQC or Regulation amendments.

This Policy will be approved in line with internal processes.

6.0 Reporting requirements

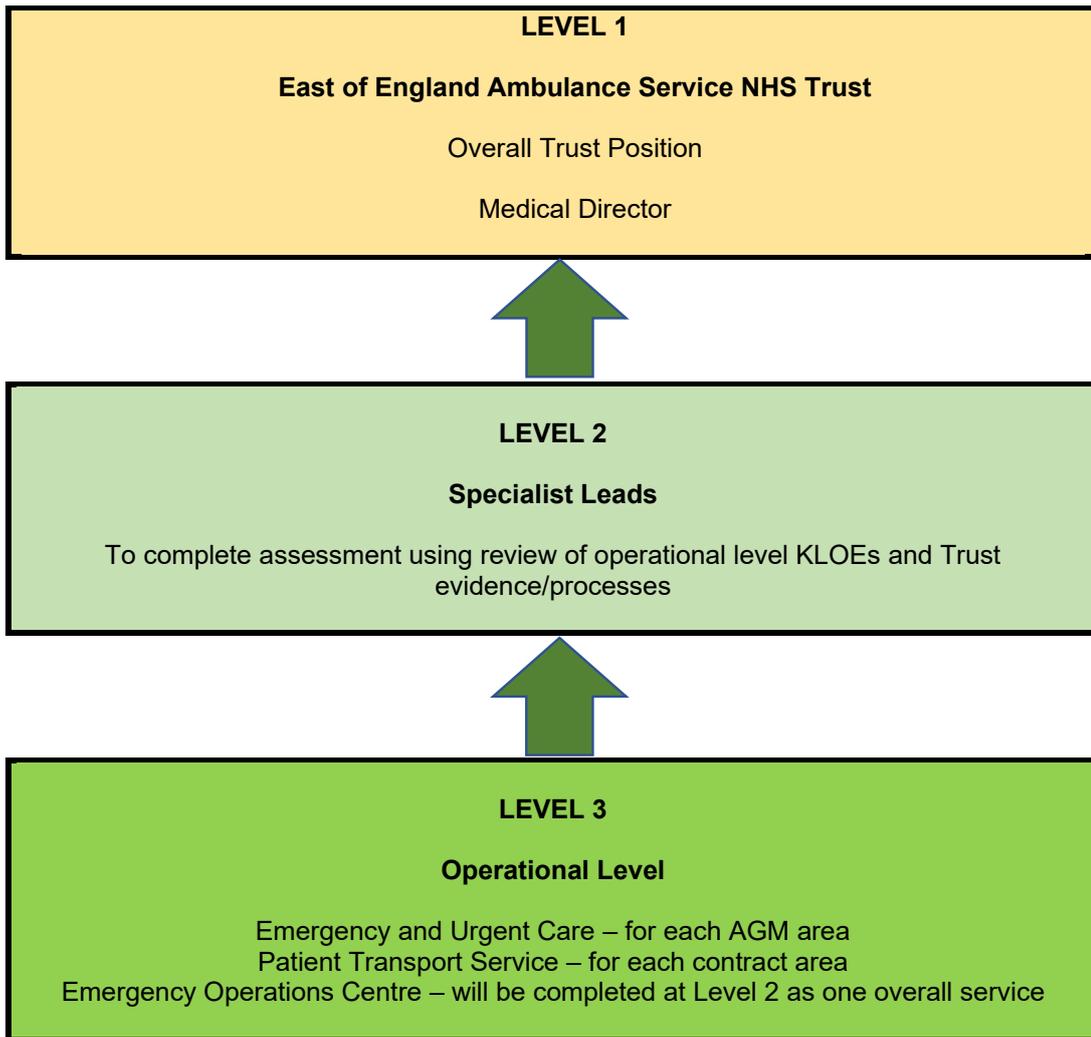
6.1 Key Lines of Enquiry (KLOEs)

In order to ensure that the Trust is providing a safe quality service and is compliant with the Health and Social Care Act Regulations, it is required to provide evidence against the CQC's KLOEs and underpinning prompts as described within the Fundamental Standards and Ambulance Provider Handbook.

- Safe
- Effective
- Caring
- Responsive
- Well-led

To enable robust monitoring and assurance, there are three levels of assessment, from operational level to overall Trust status which are required to be undertaken at least on a quarterly basis.

POL029 – Policy for Managing CQC Requirements



7.0 CQC Inspections

Inspections are carried out by a mixture of inspectors, healthcare professionals and Experts by Experience.

How frequently they inspect, the size of the inspection team they use and whether or not they inform the service that they are coming will depend on the type of service they are inspecting.

Following the inspection, each provider will receive an overall rating of either: Outstanding, Good, Requires Improvement or Inadequate.

POL029 – Policy for Managing CQC Requirements

7.1 Comprehensive Inspections

These inspections are utilised for undertaking regular checks on health and social care services used to make sure those services are providing care that is safe, caring, effective, responsive to people's needs and well-led.

7.2 Focused Inspections

These are smaller in scale than comprehensive inspections, although they follow a similar process, and are carried out for two reasons:

- To look at something they are concerned about, which might have been raised during a comprehensive inspection or through the CQC monitoring work.
- If there is a change in a care provider's circumstances. This might mean that they have been involved in a takeover, a merger or an acquisition.

A focused inspection doesn't always look at all five key questions. The size of the team and who's involved depend on what the inspection is looking at.

7.3 Inspection Process

Planning phase

Prior to any inspection, the CQC will request a vast array of information from the Trust as well as other agencies/organisations such as: National Reporting and Learning System (NRLS), NHS Litigation Authority, Clinical Commissioning Groups, Acute Trusts, HealthWatch etc, to enable triangulation of evidence.

Start of the inspection

At the start of the inspection, the inspector or inspection team usually meets senior staff. At this meeting, they will explain:

- Who the inspection team are.
- The scope and purpose of the inspection.
- How they will communicate their findings.

POL029 – Policy for Managing CQC Requirements

Inspections will begin with a presentation by the care provider, in which they give their own view of their performance

Gathering evidence

The inspection team will use the [key lines of enquiry](#) and information from the planning stage to structure their visit and focus on areas of concern or areas where the service is performing particularly well. The team will collect evidence against the key lines of enquiry by:

- Gathering the views of people who use services. This includes:
 - Speaking to people individually and in groups.
 - Using comment cards placed in GP surgeries or busy areas in hospitals.
 - Holding [public listening events](#).
 - Using information gathered from complaints and concerns from people who use services.
- Gathering information from staff.
- Other inspection methods include:
 - Observing care.
 - Looking at individual care pathways.
 - Reviewing records.
 - Inspecting the places where people are cared for.
 - Looking at documents and policies

Feedback

At the end of the visit, the inspector or senior members of the inspection team will hold a feedback meeting with senior staff. At this meeting, the inspection team:

- Will provide a summary of what has been found during the visit.
- Highlight any issues that have arisen.
- Identify any action the service provider needs to take immediately.
- Outline any plans for further announced visits.
- Explain how they will make their judgements and publish them

7.4 Displaying of ratings

There are four ratings that the CQC give to health and social care services:

	<i>Outstanding</i> The service is performing exceptionally well.
	<i>Good</i> The service is performing well and meeting CQC expectations.
	<i>Requires improvement</i> The service isn't performing as well as it should and we have told the service how it must improve.
	<i>Inadequate</i> The service is performing badly and we've taken action against the person or organisation that runs it.

The CQC will provide the service with an overall rating and would also normally give a rating for each of the five key lines of enquiry.

In inspections of ambulance trusts, they will also give a rating for the specific services:

Ratings must be displayed no later than 21 calendar days after they have been published on the CQC's website.

Ratings must be displayed legibly and conspicuously to make sure the public, and in particular the people who services, can see them.

In line with CQC requirements, ambulance trusts are required to display three types of poster:

1. Provider Poster Overall rating and five key questions
2. Premises poster Overall rating and five key questions

POL029 – Policy for Managing CQC Requirements

- | | |
|--|--|
| 3. Activity poster (core services/population groups) | Overall rating and five key questions (if available) for each activity |
|--|--|

Ratings are not required to be displayed on ambulances.

In respect of EEAST, ratings will be displayed at the three locality offices, within the EOCs and at all station entrances. They must also be displayed on the Trust's website.

Appendices

- A Monitoring Table
- B Equality Analysis

Appendix A Monitoring table

What	Who	How	Frequency	Evidence	Reporting arrangements	Acting on recommendations	Change in practice and lessons to be shared
Completion of quarterly assessments	Compliance and Standards Lead	Review of - assessment through compliance software	Quarterly	Completed assessments and associated evidence	Compliance and Risk Group for monitoring purposes Quality Governance Committee for assurance. The Board for information.	CRG will act on recommendations made by the Compliance and Standards Lead	Good levels of assessment/evidence will be shared with other leads to improve quality of self-assessments

POL029 – Policy for Managing CQC Requirements

What	Who	How	Frequency	Evidence	Reporting arrangements	Acting on recommendations	Change in practice and lessons to be shared
Display of ratings following publication of CQC inspection	Compliance and Standards Lead in conjunction with operational teams and IPC auditors	IPC auditor to check each premise whilst undertaking quality assurance visits and report back to Compliance and Standards Lead	Within 21 days of a published CQC inspection report	IPC Quality Assurance visits	Compliance and Risk Group for monitoring purposes Quality Governance Committee for assurance. The Board for information	CRG will act on recommendations made by the Compliance and Standards Lead.	None identified to date

POL029 – Policy for Managing CQC Requirements

		Operational managers to provide assurance that current posters are displayed on each of their premises					
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Appendix B Equality Impact Assessment

EIA Cover Sheet																	
Name of process/policy	Policy for Managing CQC Requirements																
Is the process new or existing? If existing, state policy reference number	Existing POL029																
Person responsible for process/policy	Compliance and Standards Lead																
Directorate and department/section	Clinical Quality Compliance and Standards																
Name of assessment lead or EIA assessment team members	Compliance and Standards Lead																
Has consultation taken place? Was consultation internal or external? (please state below):	No																
The assessment is being made on:	<table border="1"> <tr> <td>Guidelines</td> <td></td> </tr> <tr> <td>Written policy involving staff and patients</td> <td>X</td> </tr> <tr> <td>Strategy</td> <td></td> </tr> <tr> <td>Changes in practice</td> <td></td> </tr> <tr> <td>Department changes</td> <td></td> </tr> <tr> <td>Project plan</td> <td></td> </tr> <tr> <td>Action plan</td> <td></td> </tr> <tr> <td>Other (please state) Training programme.</td> <td></td> </tr> </table>	Guidelines		Written policy involving staff and patients	X	Strategy		Changes in practice		Department changes		Project plan		Action plan		Other (please state) Training programme.	
	Guidelines																
	Written policy involving staff and patients	X															
	Strategy																
	Changes in practice																
	Department changes																
	Project plan																
	Action plan																
Other (please state) Training programme.																	

Equality Analysis					
What is the aim of the policy/procedure/practice/event?					
To maintain a quality assured evidence base and measure compliance with the Health and Social Care Act 2012 (Regulated Activities) Regulations 2014.					
Who does the policy/procedure/practice/event impact on?					
Race	x	Religion/belief	x	Marriage/Civil Partnership	x
Gender	x	Disability	x	Sexual orientation	x
Age	x	Gender re-assignment	x	Pregnancy/maternity	x
Who is responsible for monitoring the policy/procedure/practice/event?					
Compliance and Standards Lead					
What information is currently available on the impact of this policy/procedure/practice/event?					
The Policy meets all requirements /guidance released by the Department of Health in relation to data protection as well as legislative requirements / standards set by, amongst others, the Care Quality Commission					
Do you need more guidance before you can make an assessment about this policy/procedure/ practice/event?					
No					
Do you have any examples that show that this policy/procedure/practice/event is having a positive impact on any of the following protected characteristics?					
Equality, diversity and inclusion evidence is collected and provided as evidence for any CQC assessments.					
Race	x	Religion/belief	x	Marriage/Civil Partnership	x
Gender	x	Disability	x	Sexual orientation	x
Age	x	Gender re-assignment	x	Pregnancy/maternity	x

POL029 – Policy for Managing CQC Requirements

Please provide evidence: Equality, diversity and inclusion evidence is collected and provided as evidence for any CQC assessments

Are there any concerns that this policy/procedure/practice/event could have a negative impact on any of the following characteristics?

No

Race	<input type="checkbox"/>	Religion/belief	<input type="checkbox"/>	Marriage/Civil Partnership	<input type="checkbox"/>
Gender	<input type="checkbox"/>	Disability	<input type="checkbox"/>	Sexual orientation	<input type="checkbox"/>
Age	<input type="checkbox"/>	Gender re-assignment	<input type="checkbox"/>	Pregnancy/maternity	<input type="checkbox"/>

Please provide evidence:

Not applicable

Action Plan/Plans - SMART

Not applicable

Evaluation Monitoring Plan/how will this be monitored?

Not applicable