

How CQC regulates:

# Residential adult social care services



Provider handbook

October 2014

# **The Care Quality Commission is the independent regulator of health and adult social care in England**

## **Our purpose**

We make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve.

## **Our role**

We monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety and we publish what we find, including performance ratings to help people choose care.

## **Our principles**

- We put people who use services at the centre of our work.
- We are independent, rigorous, fair and consistent.
- We have an open and accessible culture.
- We work in partnership across the health and social care system.
- We are committed to being a high performing organisation and apply the same standards of continuous improvement to ourselves that we expect of others.
- We promote equality, diversity and human rights.

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# Foreword

Dear colleague

Thank you for taking the time to read this handbook, setting out how the Care Quality Commission will regulate residential services in adult social care.

More than a year's work of careful preparation and discussion has informed the development of our new approach. We started with the framework that CQC applies to all health and care services:

- **The five key questions** – is a service safe, effective, caring, responsive to people's needs and well-led?
- **The ratings** – to judge whether a service is outstanding, good, requires improvement, or is inadequate.

But the detail of our methodology (including the key lines of enquiry, the evidence we will consider and the ratings characteristics) has been developed in collaboration with people who use services, carers, providers, commissioners, national partners and our staff. The external and internal co-production groups as well as the round table discussions and workshops, the outcome of consultation and two phases of testing have all helped to shape the final design of the approach set out in this handbook.

I hope that you will be able to use the handbook to understand how we will regulate and inspect your services, what we are looking for, the standards we expect to see and what action we may take if necessary. We want to make sure that people using your service receive care that is safe, effective, high-quality and compassionate. Our ambition is to encourage services to improve so that they can be rated as good or outstanding.

The judgement framework – the key lines of enquiry, the ratings characteristics and the ratings principles – will not change until we have rated all of the adult social care services we regulate. However, we will update this handbook on occasions to take account of other changes – for example, the introduction of the new regulations and fundamental standards (including duty of candour and the fit and proper person requirement for directors) in April 2015.

At the heart of what we do are the people using services, their families and carers – asking the questions that matter to them, listening to their views, taking action to protect them when that is necessary and providing them with clear, reliable information. The detail in the handbook is all about making the Mum Test real – is this a service that we would be happy for someone we love and care for to use? If it is we should celebrate that; but if not, we will do something about it.

I hope you find the provider handbook helpful and I look forward to working with you to make sure services do indeed meet the Mum Test each and every time.

Best wishes

**Andrea Sutcliffe**  
Chief Inspector of Adult Social Care

# Introduction

This document describes our approach to regulating, inspecting and rating residential adult social care services. By residential adult social care services we mean care home services with nursing, care home services without nursing, and specialist colleges

In this approach, our inspectors use their professional judgement, supported by objective measures and evidence, to assess services against our five key questions.

Our approach includes the use of Intelligent Monitoring to decide when, where and what to inspect, methods for listening better to people's experiences of care, and using the best information across the system (see [section 4](#)).

We always ask the following five questions of services.

- Are they safe?
- Are they effective?
- Are they caring?
- Are they responsive to people's needs?
- Are they well-led?

We rate services to highlight where care is outstanding, good, requires improvement or inadequate and to help people compare them.

Our approach has been developed over time and through testing and consultation. We have worked with the public, people who use services, providers and organisations with an interest in our work to develop our approach.

We will continue to learn and adapt how the approach is put into practice from 1 October 2014. We are planning to refresh this document to take into account the new fundamental standards regulations that are due to come into force in April 2015.

However, the overall framework, including our five key questions, key lines of enquiry, characteristics of ratings and ratings principles will remain the same until we have rated every adult social care service at least once.

# 1. Our framework

Although we inspect and regulate different services in different ways, there are some principles that guide our operating model across all our work.

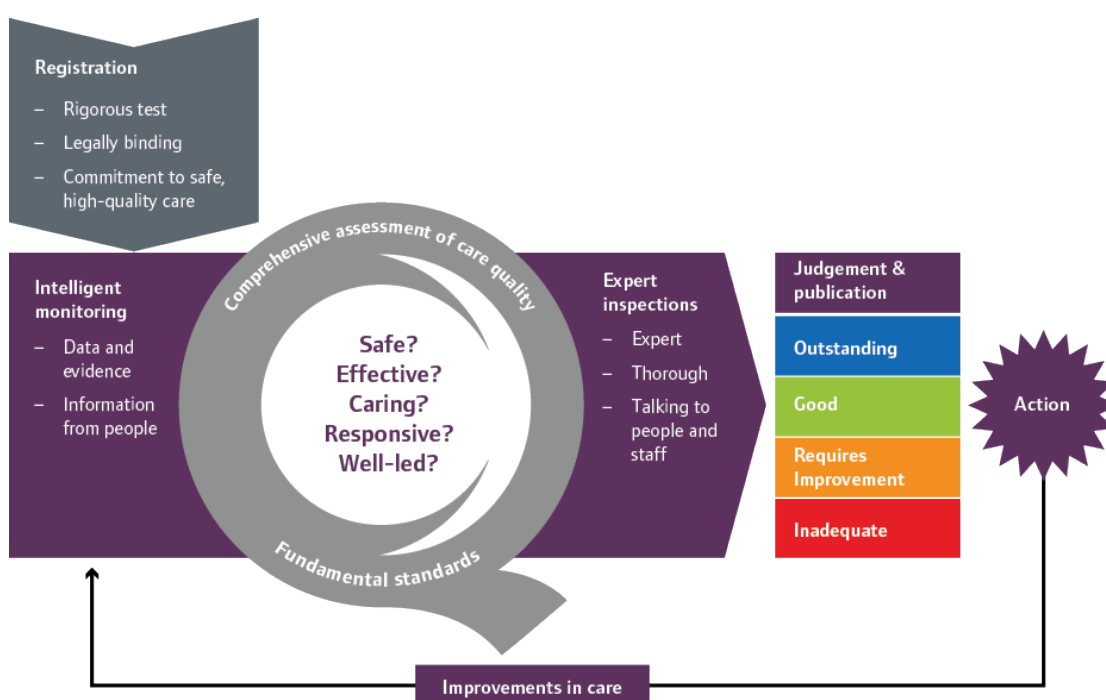
## Our operating model

The following diagram shows an overview of our overall operating model. It covers all the steps in the process, including:

- Registering those that apply to CQC to provide services (see [section 2](#) for more detail).
- Intelligent use of data, evidence and information to monitor services.
- Using feedback from people who use services and the public to inform our judgements about services.
- Inspections carried out by experts.
- Information for the public on our judgements about care quality, including a rating to help people choose services.
- The action we take to require improvements and, where necessary, the action we take to make sure those responsible for poor care are held accountable for it. Our enforcement policy sets out how we will do this.

Our model is designed to work with the existing regulations and to take account of the new fundamental standards, to be introduced in April 2015. We will issue guidance to help providers understand how they can meet the new regulations (see [section 11](#)).

**Figure 1: CQC's overall operating model**



## The five key questions we ask

To get to the heart of people's experiences of care, the focus of our inspections is on the quality and safety of services, based on the things that matter to people. We always ask the following five questions of services.

- Are they safe?
- Are they effective?
- Are they caring?
- Are they responsive to people's needs?
- Are they well-led?

For all health and social care services, we have defined these five key questions as follows:

<b>Safe</b>	By safe, we mean that people are protected from abuse and avoidable harm.
<b>Effective</b>	By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is evidence-based where possible.
<b>Caring</b>	By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.
<b>Responsive</b>	By responsive, we mean that services are organised so that they meet people's needs.
<b>Well-led</b>	By well-led we mean that the 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.

## Key lines of enquiry

To direct the focus of the inspection, our inspection teams use a standard set of key lines of enquiry (KLOEs) that directly relate to the five key questions listed above.

Within the standard set of KLOEs we have identified a number of mandatory KLOEs which inspectors must use on every inspection. Having a set of mandatory KLOEs ensures consistency in what we look at under each of the five key questions and ensures we focus on those areas that matter most. This is vital for reaching a credible rating that allows comparison between similar services.

In addition to the mandatory KLOEs, inspectors may select any of the non-mandatory KLOEs. They make this selection by using their knowledge of the service, the information available to them before the inspection and their professional judgement. They will take into account areas of identified risk and areas of good practice. If they come across an area of concern or of good practice during an inspection they may decide at that point to look at



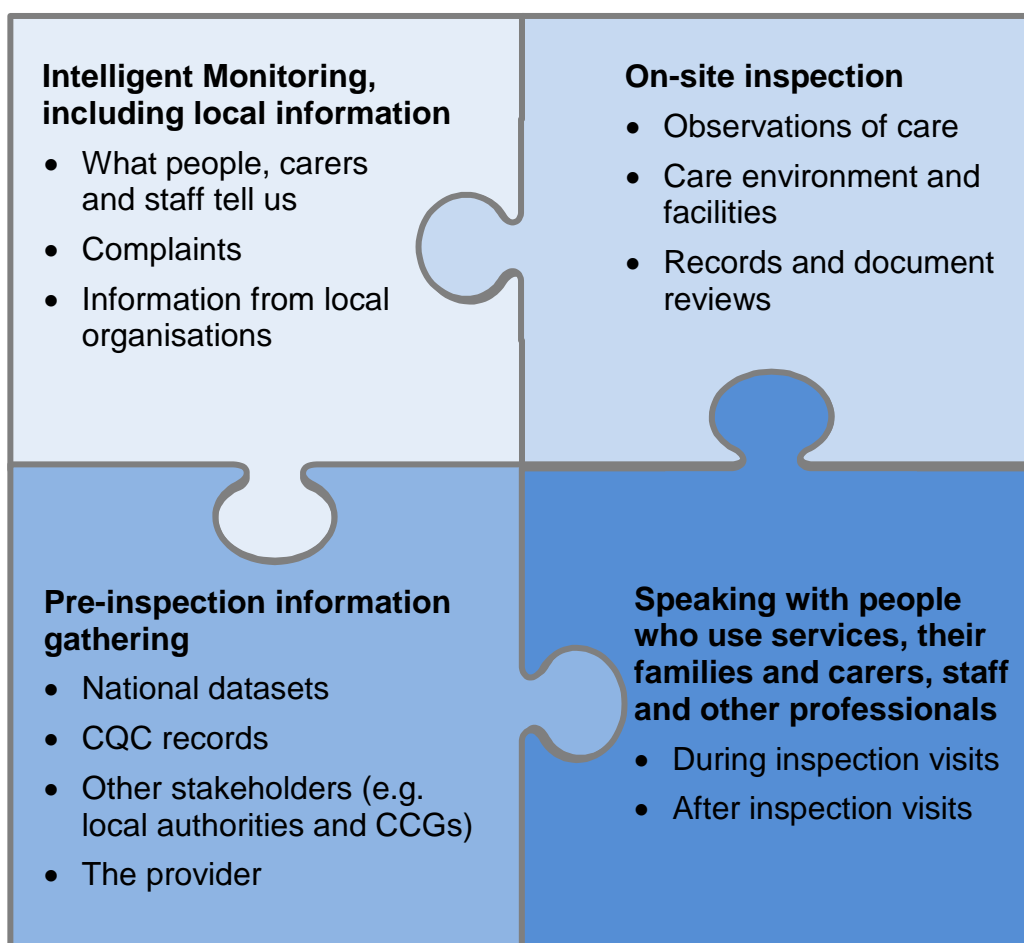
additional non-mandatory KLOEs. The KLOEs are set out in the separate document, [appendix A](#). The mandatory KLOEs are highlighted in yellow.

Each KLOE is accompanied by a number of questions that inspection teams may consider as part of the assessment. We call these prompts. The prompts are listed alongside each KLOE in [appendix A](#). They are not an exhaustive list and are not used as a checklist. Additionally we have listed potential sources of evidence for each KLOE to support inspectors in the inspection process.

Inspection teams use evidence from four main sources (see figure 2) to answer the KLOEs:

1. Information from Intelligent Monitoring (including information from people who use services and their families and carers).
2. Information from the ongoing relationship with the provider (including that provided in the Provider Information Return).
3. Information from the inspection visit itself (including observing care, the environment and facilities and reviews of records).
4. Information from speaking with people who use services, their families and carers, staff and other health and care professionals.

**Figure 2: The four main sources of evidence**



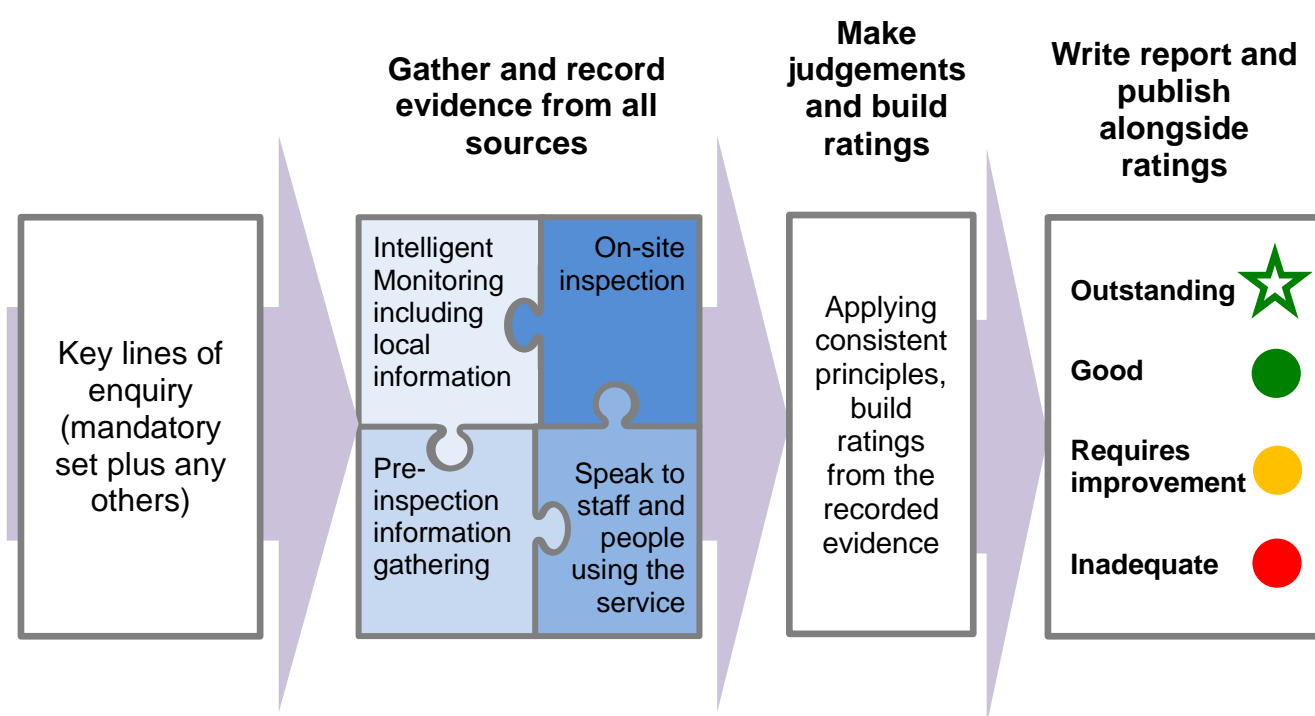
## Ratings

Ratings are an important element of our approach to inspection and regulation.

As shown in figure 3 below, our ratings are always based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data, and information from the provider and other organisations.

We award them on a four-point scale: outstanding, good, requires improvement, or inadequate.

**Figure 3: How KLOEs and evidence build towards ratings**



We have developed characteristics to describe what outstanding, good, requires improvement and inadequate care looks like in relation to each of the five key questions. These are in [appendix B](#).

These characteristics provide a framework which, together with professional judgement, guides our inspection teams when they award a rating. They are not an exhaustive list and are not used as a checklist. They are applied using the professional judgement of the inspection team taking into account best practice and recognised guidelines, with consistency assured through the quality control and assurance process. The starting point of the characteristics is the description of a good service. This is consistent with our approach of looking for good when we inspect services.

Not every characteristic has to be present for the corresponding rating to be given. This is particularly true at the extremes. For example, if the impact on the quality of care or on people's experience is significant, then displaying just one of the characteristics of inadequate could lead to a rating of

inadequate. Even those rated as outstanding are likely to have areas where they could improve. In the same way, a service does not need to display every one of the characteristics of good in order to be rated as good.

## Equality and human rights

One of CQC's principles is to promote equality, diversity and human rights. This is a means to an end and not an end in itself. The end is good quality care for all. Respecting diversity, promoting equality and ensuring human rights will help everyone using health and social care services to receive good quality care.

To put this into practice, we have developed a human rights approach to regulation. This looks at a set of human rights principles in relation to the five key questions we ask. These principles are: fairness, respect, equality, dignity, and autonomy, right to life and rights for staff. We have developed definitions of these principles through public consultation and linked these to the Human Rights Act 1998 and the Equality Act 2010. People who use services have told us that these principles are very important to them.

Using a human rights approach that is based on rights that people hold, rather than what services should deliver, also helps us to look at care from the perspective of people who use services.

Residential services are different from other health and social care services in that they are where people live and, for most people, where they spend the vast majority of their time. Consequently the positive application of human rights principles in residential services can have a great impact on people's lives. There is a particular need for us to make sure that people using adult social care services can exercise autonomy as this is often the key to people being able to exercise a range of human rights in their daily lives.

Our human rights approach is integrated into our approach to inspection and regulation as this is the best method to make sure equality and human rights are promoted in our work. We have integrated the human rights principles into our key lines of enquiry, ratings characteristics, Intelligent Monitoring, inspection methods, learning and development for inspection teams and into our policies around judgement making and enforcement.

You can also read our equality and human rights duties impact analysis on our website. It lays out, in more detail:

- What we know about equality and human rights for people using adult social care.
- What we have done to date to put our human rights approach into practice.
- What we plan to do in the future – to ensure that we promote equality and human rights in our regulation of residential services.

## **Monitoring the use of the Mental Capacity Act 2005 including the Deprivation of Liberty Safeguards**

The Mental Capacity Act (2005) is a crucial safeguard for the human rights of adults who might (or may be assumed to) lack mental capacity to make decisions, including whether or not to consent to proposed care or treatment interventions. The Mental Capacity Act (MCA) provides the essential framework for balancing autonomy and protection when staff are assessing whether people aged 16 and over have the mental capacity to make specific decisions at the time they need to be made. The MCA clearly applies where a service works with people who may have cognitive difficulties due to dementia, an acquired brain injury or a learning disability. But providers must also recognise that a person may lack mental capacity for a specific decision at the time it needs to be made because of a wide range of reasons which may be temporary. Providers must know how they should then proceed.

Any decision taken on behalf of a person lacking capacity must be made in their best interests and be the least restrictive option that can be identified to meet a specific need.

We have a duty to monitor the use of the Deprivation of Liberty Safeguards in all hospitals and care homes in England, and check on their use when we inspect the places where they are used. Hospitals and care homes must tell us about the outcome of any application to deprive someone of their liberty using the Safeguards or by an order of the Court of Protection.

Where it is likely that a person lacking mental capacity to consent to the arrangements to be given essential care or treatment, is deprived of their liberty, we will look for evidence that efforts have been made to reduce any restrictions on freedom, so that the person is not deprived of their liberty. Where this is not possible we will check that the deprivation of liberty has been authorised as appropriate, by use of the Deprivation of Liberty Safeguards, the Mental Health Act 1983, or by an order of the Court of Protection.

The importance of working within the empowering ethos of the wider MCA is reflected in our inspections. A specific KLOE about consent takes account of the requirements of the Mental Capacity Act and other relevant legislation.

During our inspections, we will assess how well providers are using the MCA to promote and protect the rights of people using their services.

In particular, we will look at how and when capacity is assessed, how mental capacity is maximised and, where people lack mental capacity for a specific decision, how that decision is made and recorded in compliance with the MCA.

We will look for evidence that restraint, if used to deliver necessary care or treatment, is in the best interests of someone lacking mental capacity is proportionate and complies with the MCA.

## Concerns, complaints and whistleblowing

Concerns raised by people using services, those close to them, and staff working in services provide vital information that helps us to understand the quality of care. We will gather this information in three main ways:

- Encouraging people who use services and staff to contact us directly through our website and phone line, and providing opportunities to share concerns with inspectors when they visit a service.
- Asking national and local partners (for example, the Ombudsmen, the Local Authority and Healthwatch) to share with us concerns, complaints and whistleblowing information that they hold.
- Requesting information about concerns, complaints and whistleblowing from providers themselves.

We will also look at how providers handle concerns, complaints and whistleblowing in every inspection. A service that is safe, responsive and well-led will treat every concern as an opportunity to improve, will encourage its staff to raise concerns without fear of reprisal, and will respond to complaints openly and honestly. The Parliamentary and Health Service Ombudsman, the Local Government Ombudsmen and Healthwatch England will set out standard expectations for complaints handling, which are consistent with our assessment framework, and describe the good practice we will look for.

We will draw on different sources of evidence to understand how well providers encourage, listen to, respond to and learn from concerns. Evidence sources may include complaints and whistleblowing policies, indicators such as a complaints backlog and staff survey results, speaking with people who use services, carers, families and staff and reviewing case notes from investigations.

## 2. Registration

Before a provider can begin to provide a regulated activity, they must apply to CQC for registration and satisfy us that they are meeting a number of registration requirements.

Registration assesses whether all new providers who may be organisations, individuals or partnerships, have the capability, capacity, resources and leadership skills to meet relevant legal requirements, and are therefore likely to demonstrate that they will provide people with safe, effective, caring, responsive and high-quality care.

The assessment framework ensures that our registration inspectors gather and consider comprehensive information about proposed applicants and the services they intend to provide, including where providers are varying their existing registration, to make judgements about whether applicants are likely to meet the legal requirements of the regulations.

Judgements about, for example, the fitness and suitability of applicants, the skills, qualifications, experience and numbers of key individuals and other staff; the size, layout and design of premises; the quality and likely effectiveness of key policies, systems and procedures; governance and decision-making arrangements; and the extent to which providers and managers understand them and use them in practice.

These judgements will not stifle innovation or discourage good providers of care services, but ensure that those most likely to provide poor quality services are discouraged and prevented from doing so.

## 3. How we work with others

Good ongoing relationships with stakeholders are vital to our inspection approach. These relationships allow CQC better access to qualitative as well as quantitative information about services, particularly local evidence about people's experience of care. Local relationships also provide opportunities to identify good practice and to work with others to raise standards.

### **Working with people who use services, families and carers**

People's experiences of care are vital to our work; they help to inform when, where and what we inspect. We want people to tell us about their care at any time through our website, helpline and social media, and we are committed to engaging with the public to encourage people who use services, their carers and advocates to share their views and experiences with us.

We do this through raising awareness among the public, working with local Healthwatch, community, voluntary and other organisations, care professionals, providers, experts by experience and through public events and focus groups.

### **Working with providers**

Our approach will identify, highlight and celebrate good practice and we want to inspire providers to strive to be outstanding and continuously improve the care they provide.

A CQC head of inspection, local inspection manager or inspector will be responsible for developing and maintaining relationships with registered persons at a local level. They will have primary responsibility for day-to-day communication, information exchange and management of our relationship with providers.

Our approach includes continuous monitoring of local data and intelligence and risk assessment. Where risks are identified our inspection staff will check what the provider is doing to address the risk.

Service providers also routinely gather and use information from people who use services, carers, other representatives and the public. We will make use of this information, including surveys of people who use services, visitors and staff, as well as information about the number and types of complaints people make about their care and how these are handled.

## **Working with corporate providers**

CQC defines any provider operating more than 20 locations as a 'corporate provider'. This can include smaller providers where necessary, based on individual circumstances.

Corporate providers operate services across all sectors but the majority provide adult social care services. A Deputy Chief Inspector from the Adult Social Care directorate has the lead responsibility for CQC's strategy for working with corporate providers. The purpose is to maintain central oversight of the quality and risk profiles of corporate providers, so that we can identify risks and issues and provide timely, co-ordinated regulatory responses at national, regional and local levels. This will include our statutory duties in respect of market oversight that we take on from April 2015. Through our relationship with corporate providers we also seek to improve our understanding of the picture of care provision across the whole country.

A relationship manager is allocated to each corporate provider. The relationship manager may be from our central Corporate Provider Team or from one of our operational regions. There are no set criteria: size, complexity and national interest are taken into account in deciding who should hold the relationship. Where appropriate, a relationship manager from the relevant sector (for example, mental health hospitals), will be allocated. The relationship manager will hold regular meetings with the provider to exchange information and discuss the organisation's performance. There is no set frequency for these meetings.

### **Market oversight**

We are working with the adult social care sector to develop our approach to our market oversight regulatory duty. Under this new duty we will assess the financial sustainability of the largest and most 'difficult to replace' providers, taking account of the relationship between the quality of the care being provided and the organisation's finances. The new duty may lead to changes to some aspects of how we engage with those corporate providers who meet the criteria for the market oversight scheme.

We will publish guidance on market oversight early in 2015, before the new duty starts on 6 April 2015.

## **Working with local organisations and community groups**

Our intention is to more actively involve local community groups and voluntary organisations in our work so they can share information and concerns about social care services. We will also involve more people who use services to help us to plan, monitor and evaluate our work; and we will involve people who use services in our inspections.



One of the main groups we work with are local Healthwatch organisations. Local Healthwatch staff and volunteers work to make sure the voices and experiences of people who use services, carers, families and the public are heard. They also influence the planning, provision and improvement of health and social care services and represent people's views on the health and wellbeing boards set up by local authorities.

Our inspection staff will have a regular and two way relationship with local Healthwatch in every area, co-ordinating our programmes and giving them the opportunity to share their evidence about social care services, including their 'enter and view' reports when they have visited services themselves.

We are also developing our relationships with other local groups who work with people using adult social care services. These include:

- Learning disability partnership boards
- Local learning disability groups
- Advocacy groups
- Older people and carers groups
- Groups for people living with dementia
- Volunteers and volunteer agencies who work in social care.

Our local inspection teams will make contact with these groups to help plan inspections, using their knowledge of people's experiences of social care in the area.

We are also working with a number of national voluntary sector partners, and we have made a commitment to work with local equality groups in order to gather their views of care services.

We will consider all the information we gather from these sources, alongside the information we gather directly from people who use services, to help us to:

- Design our approach to inspection.
- Plan our inspections.
- Inform our judgement about the quality of care and the rating we give.

## **Working with partner organisations**

### **Working with local authorities**

We have organised our Adult Social Care Inspection Directorate in a way that reflects local authority boundaries, so that we can work effectively with every local authority on commissioning, information sharing and safeguarding. Our managers will meet regularly with commissioners from local authorities to share information from contract monitoring visits, inspections and other sources. Our inspectors will attend local safeguarding meetings and managers will attend local safeguarding boards on an annual basis to provide

a CQC update as appropriate. We are developing a portal that will allow the two-way sharing of information between local authorities and CQC. We will pilot this in autumn 2014 with a view to it being operational by spring 2015.

As part of our development of local relationships our managers will liaise regularly with health and wellbeing boards and overview and scrutiny committees, based in local authorities. Health and wellbeing boards identify the current and future health and social care needs of local communities. We will share information with them to inform integrated commissioning as well as gathering information from them about the picture of social care and its integration with health care across an area.

### **Working with clinical commissioning groups (CCGs)**

Our adult social care staff have local relationships with CCGs who commission certain services for people in local communities. These include care in rehabilitation centres and care homes with nursing for people with continuing healthcare needs. Our inspection managers will meet with CCG commissioners on a regular basis to share information. This is an opportunity for commissioners to tell us about the outcome of their contract monitoring visits and we can tell them about our inspections and other relevant information. The information sharing helps us both to keep up to date with developments and plan our inspections. We will also ask them for evidence to help us understand people's needs and experience of adult social care in an area, so that we can better understand the quality of care in individual services.

## 4. Intelligent Monitoring

‘Intelligent Monitoring’ is how we describe the processes we use to gather and analyse information about services. This information helps us to decide when, where and what to inspect. By gathering and using the right information, we can make better use of our resources by targeting activity where it is most needed.

We have always used the important information in statutory notifications in this way, alongside other information about safeguarding alerts and information provided by others such as people who use services, staff and the public. We do not have a lot of quantitative data consistently collected across the sector but we are taking steps to improve this. With our new, more thorough model we intend to use our available information to check whether there is a risk that services do not provide either safe or quality care.

The Intelligent Monitoring tool is built on a set of indicators that relate to the five key questions we ask of all services – are they safe, effective, caring, responsive and well-led? The tool analyses a range of information including people’s experiences of care, staff experience and analysis of statutory returns to CQC (for example, notifications of serious incidents). The indicators raise questions about the quality and safety of care and provide supporting information, but they are not used on their own to make final judgements. These judgements will always be based on what we find at inspection, alongside Intelligent Monitoring data and information from the service provider.

We have developed an initial set of indicators that we will use for adult social care services. Our scoping work identified the sources of information set out in table 1. We know there are limitations in the coverage of national datasets, but we will start by making best use of currently available information and then determine how we will improve this over time. We will also carry out additional evaluation and engagement to determine the most useful indicators to inform our work.

Where our Intelligent Monitoring identifies risks we will follow these up as part of our inspection process.

**Table 1: Example indicators for adult social care services**

Outcome measures and safety events	Information from people using services and the public	Information from and about staff
<ul style="list-style-type: none"> <li>• Notification outliers – death, serious injury and abuse.</li> <li>• Incidence of pressure sores, medication errors, falls.</li> <li>• Admissions to hospital for preventable conditions.</li> <li>• Previous inspection judgements and enforcement actions.</li> <li>• Safeguarding alerts and concerns.</li> </ul>	<ul style="list-style-type: none"> <li>• People’s experiences of care.</li> <li>• Local Healthwatch and other local groups.</li> </ul>	<ul style="list-style-type: none"> <li>• Concerns raised by staff to CQC (whistleblowers).</li> <li>• Absence of, or frequent changes in, registered manager.</li> <li>• Staff to client ratio, qualifications and training of staff, turnover, vacancies (Skills for Care).</li> </ul>

## 5. Inspection

Our inspections are at the heart of our regulatory model and are focused on the things that matter to people. Within our approach we have two types of inspection, both of which respond to risk (table 2).

**Table 2: Inspection types**

Type of inspection	Description
<b>Comprehensive</b> (sections <a href="#">6</a> and <a href="#">7</a> )	<ul style="list-style-type: none"> <li>• Reviews the provider in relation to the five key questions leading to a rating on each on a four-point scale.</li> <li>• Risk based decision about when to inspect<sup>1</sup>.</li> <li>• Frequencies will normally be:<sup>2</sup> <ul style="list-style-type: none"> <li>– <b>Services that are rated as ‘outstanding’:</b> within two years of the last comprehensive inspection</li> <li>– <b>Services that are rated as ‘good’:</b> within 18 months of the last comprehensive inspection</li> <li>– <b>Services that are rated as ‘requires improvement’:</b> within 12 months of the last comprehensive inspection</li> <li>– <b>Services that are rated as ‘inadequate’:</b> within six months of the last comprehensive inspection.</li> </ul> </li> </ul>
<b>Focused</b> (section <a href="#">8</a> )	<ul style="list-style-type: none"> <li>• Follow-up to a previous inspection, or to respond to a particular issue or concern.</li> <li>• May not look at all five key questions.</li> <li>• Team size and composition depends on the focus of the inspection.</li> </ul>

Depending on the nature of the risk in some instances we may undertake a comprehensive inspection in response to concerns.

<sup>1</sup> Our risk based decisions will take into account the vulnerability of some people’s circumstances, the lack of any other oversight in some instances (for example, people who are self-funding their care) and the lack of robust data about the sector.

<sup>2</sup> Subject to available resources.

## How we inspect

Our inspections will usually be unannounced. In a few instances, where there are very good reasons, we may let the provider know we are coming. For example, we may contact small homes to check that people are home before setting off to inspect.

## Other inspections

We will also undertake a number of random inspections of good and outstanding services each year that are not due an inspection in accordance with the timescales above.

We also undertake other inspection and regulation activities that are not covered in this handbook, such as thematic and combined inspections.

## Combined inspections

We have developed a tailored approach to inspection for different types of health and social care services.

We recognise that some providers have a wide range of services that sit in more than one of our inspection approaches. Where such arrangements exist and the range of services are either provided from one location or to a local population, we want to assess how well quality is managed across the range of services and give ratings for the provider or the location that reflect this. Therefore, when we inspect we will use our different approaches in combination to reflect the range of services that are provided (we call this a 'combined' inspection).

Our overall aims in these circumstances are to:

- Deliver a comparable assessment of the five questions for each type of service, whether it is inspected on its own or as part of a combined provider.
- At provider or location level, assess how well quality and risks are managed across the range of services provided.
- Generate ratings and publish reports in a way that is meaningful to the public and people who use services, the provider and our partners.
- Be proportionate and flexible to reflect the way the services are provided and consider any benefits derived from service integration.
- Use appropriate inspection methods and an inspection team with the relevant expertise to assess the services provided.
- Wherever possible, align steps throughout the inspection process in order to minimise the burden on providers.

Between comprehensive inspections we will undertake focused inspections as necessary. These may only look at some of the services or aspects of a service. The relationship holder for a provider will have oversight of this and consider any implications for our understanding of the provider's performance more broadly.

## 6. Planning the inspection

To make the most of the time that we are on site for an inspection, we must make sure we have the right information to help us focus on what matters most to people. This influences what we look at, who we will talk to and how we will shape our inspection team. The information we gather during this time is also used as evidence when we make our ratings judgements.

As described in sections [3](#) and [4](#) above, we analyse information from a range of sources including information from people who use services, information from other stakeholders, and information sent to us by providers.

We collate our analysis into an 'information pack' for the inspection team. Our inspectors use this information along with their knowledge of the service and their professional judgement to plan the inspection.

### **Gathering information from people who use services, the public, staff who work in the service and other stakeholders**

Before the inspection site visit we gather a range of information. This includes:

- Comments and feedback we have received since the last inspection from people who use services, their relatives and carers and members of the public. These may be from phone calls, letters and emails or through the 'share your experience' page on our website. They include information about compliments, complaints and concerns.
- We consider all information from staff who raise concerns, and offer to speak to any current or former staff we know of, either before or during the inspection.
- Information from Healthwatch, overview and scrutiny committees and health and wellbeing boards – from our local liaison.
- Information from local voluntary and community groups, including equality groups.
- Safeguarding alerts
- Comments and feedback from stakeholders involved in the care of people who use the service, such as commissioners of services, local authority teams and health professionals.
- Comments, feedback and information from other agencies such as fire authorities and environmental health departments.



## Gathering information from the provider:

To prepare for an inspection we analyse information from a range of sources, including the provider themselves. This includes:

- The Provider Information Return
- Statutory notifications
- Registration applications
- Action plans and updates provided after requirements have been made
- Any other information received.

## Provider Information Return (PIR)

We use a Provider Information Return (PIR) to provide us with more information about a service. PIRs are electronic forms that providers complete and submit online. We are planning to move towards an online facility that will allow providers to keep PIRs up to date to help guide our activity.

The PIR asks providers to give us information for each of the five key questions. The sections ask about what providers do to ensure that the service is safe, effective, caring, responsive, and well-led; any improvements they have identified that are needed and how they plan to make those improvements.

The PIR helps us to understand the provider's perspective and, when necessary, challenge it constructively. This will allow us to assess how providers view themselves in terms of quality against the five key questions and to understand how their improvement plans reflect this, ahead of an inspection. Providers are asked to confirm that the information they submit is complete and accurate.

Some sections ask for additional information, mostly linked to the key questions. This includes:

- Information about the people using services – for example data about admissions, deaths, drugs and medicines, nutrition and hydration, who commissions their care, other services and professionals involved in their care.
- Information about staff – for example arrangements for their supervision and training.
- Information about the service – for example the registered manager, involvement in initiatives or any awards for the quality of care and support provided application of Mental Capacity Act 2005 policies and procedures.

There is linked guidance to help providers complete the form, and explain what information we are looking for.

Following our initial request, we may ask providers to submit additional information, particularly if the initial submission highlights areas that need to be clarified before the inspection visit.

We expect providers to be open and honest with us, sharing all appropriate information. A lack of openness and transparency will be taken into account when we assess the well-led question.

When we receive the PIRs, we use statistical tools and the expertise of our Intelligent Monitoring staff to prepare information packs for inspectors to help them plan their inspections.

We require providers to send us the PIR information under Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. If we do not receive the information we will not normally award better than 'requires improvement' for the well-led question. This is because a good provider should have the information readily available through their own internal monitoring and quality assurance information.

We will not normally take enforcement action in these circumstances, but rely on the published ratings to encourage providers to submit PIRs in the future.

## **Planning the focus of the inspection**

All the pre-inspection information and intelligence informs our inspectors of areas of increased risk and/or where good practice has been identified. They draw on this information to focus their planning which includes:

- Considering how to best engage with people who use the service, their relatives, carers and friends to get a range of views and experiences about the services.
- Deciding on the areas of focus, and identifying any non-mandatory KLOEs for inclusion in the inspection as necessary.
- Identifying and briefing members of the inspection team based on the specific skills, knowledge and experience needed and the size and complexity of the service.
- Planning to follow up any Warning Notices and/or outstanding actions previously required of the provider
- Making an outline plan for the site visit.

## **The inspection team**

In many cases, a single inspector and an Expert by Experience will be sufficient for most of our inspections in adult social care. However, to ensure we gather sufficient and robust evidence to support a judgement on whether a service is safe, responsive, caring, effective and well-led, there will be certain circumstances or situations where a planned inspection would be strengthened by any or all of the following:

- A larger inspection team.
- Having members with specific skills.
- More time being spent in the service.

Our Experts by Experience are at the heart of our new regulatory model and are part of our inspection team, focusing on the things that matter most to people. Our Experts by Experience are people who have had a personal experience of care, either because they use (or have used) services themselves or because they care (or have cared) for someone using services. We work with Experts by Experience on the majority of our inspections. They will be members of our inspection team and will provide feedback on what they have found, either in person or through the inspector, depending on their time in the home and their availability on the day. They will help our inspectors make their judgements.

As well as Experts by Experience, the team may also include additional inspectors or specialists with specific skills, for example, dementia specialists or pharmacy inspectors. Factors taken into account when making decisions about who is part of the team will include the size or complexity of a service, increased levels of risk or services where enforcement action is already being taken or is possible. In larger and/or complex services we may also need to spend more time in the service.

## 7. Site visits

Site visits are a key part of our inspection process, giving us an opportunity to talk to people using services, staff and other professionals to find out about their experiences. They also allow us to observe care being provided and to review people's records to see how their needs are managed both within and between services.

### The start of the visit

At the start of the inspection, the inspector will explain to the senior person on duty (this could be the registered person, nominated individual or senior person in charge):

- The five key question areas
- Whether any additional key lines of enquiry will be inspected
- Whether they are following up on any previous issues
- The proposed length of the inspection
- The roles of the inspection team members
- Who they plan to speak with
- Documents they want to review
- How they will feed back about what was found during the inspection.

### Gathering evidence

The inspection team use the key lines of enquiry (KLOEs) and information available during the planning stage to structure their visit and focus on specific areas of concern or potential areas of outstanding practice. They collect evidence against the KLOEs using the methods described below.

### Gathering information from people who use services

People who use services are at the centre of our inspection process. We will ensure that we focus on what matters to them by:

- Using the key lines of enquiry which are focused on areas important to them
- Referring to their views and comments when we make judgements about the services they are using.

During our visit we will gather the views of people who use services and those close to them. We will do this by speaking to people who use the

service both individually and in groups. We will also speak to their friends and relatives who are visiting during the inspection. We may also arrange to do this after the inspection visit if we are not able to see them on the day.

We think it is important that we also collect evidence about the experience of people who use services who may not be able to fully describe this themselves – for example, people with learning disabilities and those living with dementia and other conditions that may affect their ability to communicate. Where there are these types of communication barriers we will use our Short Observational Framework for Inspection (SOFI 2)<sup>3</sup> as appropriate.

Where there are language barriers we will use interpreters.

### **Gathering information from staff**

We will speak with the staff on duty at the time of the inspection. This might include:

- Registered manager or senior person in charge
- Care and support staff
- Cleaning staff
- Catering staff
- Maintenance staff.

### **Other inspection methods/information gathering**

Other ways of gathering evidence will include:

- Observing care (but not intimate personal care).
- Tracking individual care pathways.
- Talking to volunteers, community professionals and other visitors to the service.
- Looking at the environment including individual and communal rooms
- Reviewing records.

Throughout our information gathering we will make notes about what we see, hear and read. We will inform the people we speak to that we are doing this

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<sup>3</sup> Short Observational Framework for Inspection (SOFI 2) is an observational tool used to help us collect evidence about the experience of people who use services, especially those who may not be able to fully describe this themselves because of cognitive or other problems. It enables inspectors to observe people's care or treatment looking particularly at staff interactions. SOFI is used alongside our other methods and tools and does not replace talking to people in the service who are able to tell us their views.

and that we will use the information when we are making our judgement about a service.

In some situations where we have concerns we may also need to gather evidence under the provisions of the Police and Criminal Evidence Act 1984 (PACE). This may include seizing some forms of evidence, using photographs and taking copies of documents.

If we do this, we will explain to the senior person on duty what we are doing and why.

## **Continual evaluation**

When there is a team carrying out the inspection, the lead inspector will continually review the emerging findings with the team. This keeps the team up to date with all issues and enables the focus of the inspection to be shifted if new areas of concern are identified. The review enables the team to identify what further evidence might be needed in relation to a line of enquiry and which relevant facts might still be needed to corroborate a judgement or, where appropriate, a rating. Additional key lines of enquiry may be followed as a result of findings at this point.

When there is a single inspector they will take the time to review their inspection plan through the day, considering what further evidence they need in order to be able to make a robust judgement.

## **Visiting at night, in the early morning and at weekends**

Residential care services provide care and support for people 24 hours a day, seven days a week. On occasion we may visit the service to observe or talk to people at different times of the day, at night and at the weekends. This may be so that we can get a full picture of the care at the home or it may be in response to concerns.

## **Safeguarding**

If an inspector witnesses or discovers a safeguarding issue during an inspection they follow our safeguarding protocol and bring the matter to the attention of the manager or provider of the service. If the inspector believes that a person using the service may be at risk of abuse, or is experiencing abuse at that time, they will take immediate action to stop the abuse happening, if appropriate and safe to do so. When appropriate we can make referrals directly to the local authority. Our safeguarding protocol is available on our website [here](#).

## Feedback on the visit

At the end of the inspection visit, the inspector will hold a feedback meeting with the registered manager, nominated individual or other senior person in charge on the day of the inspection. Other members of the inspection team will also be present whenever possible. At this point in the inspection the inspector will only be able to give high level feedback which will not include what the rating for the service might be.

At this meeting the inspector will:

- Give a high level summary of what has been found during the visit.
- Highlight any issues that have emerged.
- Identify any immediate actions the provider needs to take.
- Explain that this is preliminary feedback and we cannot make a judgement until we have considered all the evidence together.
- Say when the report can be expected, how any factual inaccuracies can be challenged and what the publishing arrangements are.
- Answer any questions from the registered manager or nominated individual and receive their feedback on the inspection process so far.
- Say what the next steps will be.

## 8. Focused inspections

There will be circumstances when we will carry out a focused inspection rather than a comprehensive inspection. Focused inspections may address specific breaches of the regulations or respond to specific concerns.

Focused inspections do not look at all five key questions; they focus on the areas indicated by the information that triggers the focused inspection.

We carry out a focused inspection when we are following up on areas of concern, including:

- Concerns that were originally identified during a comprehensive inspection and have resulted in enforcement action or requirements being made. The focused inspection is normally within three months of the date the provider said they would no longer be in breach of the relevant legal requirement, or soon after the date set out in a Warning Notice.
- New concerns that have been raised with us outside an inspection through other sources such as information from Intelligent Monitoring, people who use services, members of the public, staff or other stakeholders.

### **The focused inspection process**

Although they are smaller in scale, focused inspections broadly follow the same process as a comprehensive inspection but without a Provider Information Return.

The nature of the concerns and the risks involved will inform decisions about the scope of the inspection, when to visit, what evidence needs to be gathered, the size of the team and which specialist advisers to involve.

Focused inspections can change ratings at the key question level, and in certain circumstances, can also change an overall location rating.

To change an overall location rating, the evidence must satisfy the relevant characteristics of ratings. This includes the requirement for a consistent track record for ratings of 'good', which will usually impact on the likelihood of achieving a rating of 'good' in the weeks and months immediately after a 'requires improvement' rating. In addition, if the focused inspection is carried out more than six months after the comprehensive inspection, the revised key question ratings will not usually lead to a change of the overall rating. This is because we will not be able to make judgements about all aspects of the service at a reasonably similar time, which we must be able to do to award an overall rating.

The same ratings principles apply as for a comprehensive inspection.

When a focused inspection identifies significant concerns, it may trigger a comprehensive inspection.



# 9. Judgements and ratings

## Making judgements and ratings

Inspection teams base their judgements on all the available evidence, using their professional judgement. For each key question rating the judgement is made following a review of the evidence under key lines of enquiry (KLOE), drawing from the evidence coming from the four sources of information: our ongoing relationship, Intelligent Monitoring, pre-inspection work and from the inspection visit itself. This link between KLOEs, the evidence gathered under them, and the rating judgements lie at the heart of our approach to ensuring consistent, authoritative judgements on the quality of care.

When making our judgements, we consider the weight of each piece of relevant evidence. In most cases we need to corroborate our evidence with other sources to support our findings and enable us to make a robust judgement.

When we have conflicting evidence, we will consider the weight of each piece of evidence, its source, how robust it is and which is the strongest. We may conclude that we need to seek additional evidence or specialist advice in order to make a judgement.

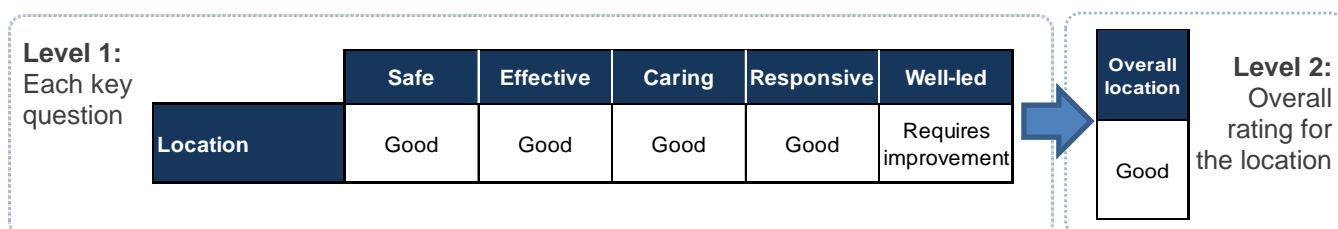
## Ratings

### What do we give a rating to?

We rate services at two levels.

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

Figure 4: The levels at which services are rated



## **Not awarding a rating**

Sometimes, we will have inspected but will not be able to award a rating. This could be because:

- The service is new or not fully operational, or
- We do not have enough evidence (for example it is a 40 bedded care home that has recently opened but only eight people are living there at the time of the inspection).

In these cases we will use the term 'inspected but not rated'.

## **How we decide on a rating**

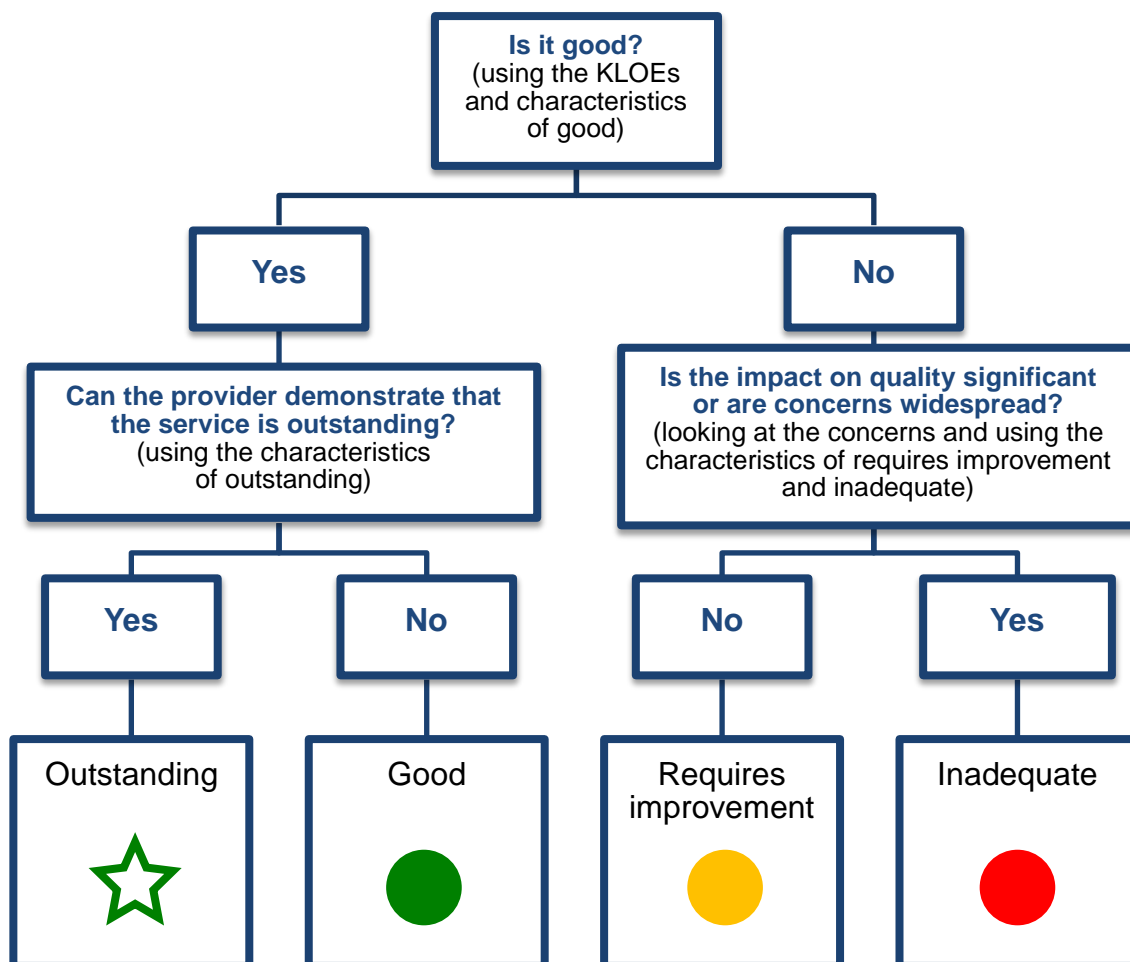
When awarding ratings for the five key questions, our inspection teams consider the evidence they have gathered for each of the KLOEs and use the guidance supplied to decide on a rating.

In deciding on a key question rating, the inspection team look to answer the following questions:

- Does the evidence demonstrate that we can rate the service as good?
- If yes – does it exceed the standard of good and could it be outstanding?
- If no – does it reflect the characteristics of requires improvement or inadequate?

The following flowchart (figure 5) shows how this works.

**Figure 5: How we decide on a rating**



### Aggregating ratings

When aggregating ratings, our inspection teams follow a set of principles to ensure consistent decisions. Our principles are set out in [appendix C](#).

The principles will normally apply but will be balanced by inspectors using their professional judgement. Our ratings must be proportionate to all of the available evidence and the specific facts and circumstances.

Examples of when we may use professional judgement to depart from the principles include:

- Where the concerns identified have a very low impact on people who use services.
- Where we have confidence in the service to address concerns or where action has already been taken.
- Where a single concern has been identified in a small part of a very large and wide-ranging service.

# 10. Reporting, quality control and action planning

## Reporting

An inspection report is produced following each inspection. It is drafted in collaboration with members of the inspection team in a clear, accessible, format using plain English. 'Easy read' report summaries are written to meet the needs of the people using the service where appropriate. Our reports include our ratings judgements.

Our reports focus on what our findings about each of the five key questions mean for the people who use the service. We describe the good practice we find, as well as any concerns we have. In our reports we clearly set out any evidence about breaches of regulations along with the action that we tell the provider they need to take. In our reports we also identify where a provider could improve their service. We do this by making 'recommendations'.

## Quality control

We have made a commitment to having strong internal quality control and assurance mechanisms, including regional and national panels that consider a sample of ratings judgements to check consistency.

Consistency is one of the core principles that underpins all our work. We have put in place an overall approach for CQC to embed validity and consistency in everything we do. The key elements of this are:

- A strong and agreed core purpose for CQC
- A clear statement of our role in achieving that purpose
- Consistent systems and processes to underpin all our work
- High-quality and consistent training for our staff
- Strong quality assurance processes
- Consistent quality control procedures.

We involve people who use services, their families and carers in our national quality assurance panels.

Following quality checks the draft report is sent to the provider for comment in relation to factual accuracy. The report is finalised following any necessary changes and sent to the provider. We also write to the provider with the overall summary of the report for them to share with each person using their service, their family and carers and the staff of the service.

## **Action planning**

Providers in breach of regulations must send us a written report of the action they are going to take to achieve compliance with the Health and Social Care Act 2008, associated regulations and any other legislation they are in breach of. Providers should inform us in writing when they have completed the actions.

We will follow up actions we tell providers to take. We may follow up by contacting the provider or visiting the service (see [section 8](#) on focused inspections).

## **Publication**

We publish inspection reports and ratings on our website soon after completion of our quality assurance process.

# 11. Enforcement and actions

## Types of action and enforcement (under existing regulations)

Where we have identified concerns we decide what action is appropriate to take. The action we take is proportionate to the impact or risk of impact that the concern has on the people who use the service and how serious it is.

We can tell providers to send us an action plan that explains what they will do about any legal requirements that are not being met.

Where the concern is linked to a breach in regulations, we have a wide range of enforcement powers given to us by the Health and Social Care Act 2008. We use Warning Notices to tell providers that they are not complying with a condition of registration, requirement in the Act or a regulation, or any other legal requirement that we think is relevant. We can follow up with more serious action (including prosecution) if it is not dealt with. We can also take urgent action if we believe that people will, or may be, exposed to the risk of harm..

Our enforcement policy describes our powers in detail and our general approach to using them.

We may also make 'recommendations' to help a provider move to a higher rating (from requires improvement to good), even though a regulation has not been breached.

We include in our report any recommendations, actions we tell the provider to take and enforcement action taken.

We follow up any concerns or enforcement action. If the necessary changes and improvements are not made, we can escalate our response, gathering further information through a focused inspection. However, we always consider each case on its own merit and we do not rigidly apply the enforcement rules when another action may be more appropriate.

## Relationship with the new fundamental standards regulations

The Department of Health is introducing new regulations to replace the current registration requirements. The new regulations, called 'fundamental standards', are more focused and clear about the care that people should expect to receive. These regulations are expected to come into full force in April 2015. Until that time we will continue to enforce against the existing regulations.

We will issue guidance to help providers to understand how they can meet the new regulations and, when they do not, what actions CQC will take. We will publish an update to this handbook to reflect the new regulations.

### **New requirements: fit and proper person and duty of candour**

Two new requirements, the fit and proper person requirement and the duty of candour, will apply from April 2015 for residential and other adult social care services. They will apply to NHS bodies from mid November 2014 (or very closely after this date subject to Parliamentary approval). The fit and proper person requirement will play a major part in ensuring the accountability of directors and board members. It places a clear duty on health and social care providers to make sure directors and board members (or their equivalents, including interim post holders) meet the criteria set out.

The new statutory duty of candour will mean that people, and where appropriate their families, must be told openly and honestly when unanticipated things happen that cause them serious or moderate harm. They should be given an apology, an explanation, practical and emotional support, and assurances about their continuity of care.

These new requirements are incorporated into our assessment framework and registration processes. Where we find that providers are not conforming to these regulations we will report this and take action as appropriate.

### **Responding to inadequate care**

As well as using our enforcement powers, CQC will also work with other organisations, including other regulators and commissioners, to ensure action is taken on concerns that we identify.

We are developing a new regime of special measures which we will introduce in April 2015.

### **Challenging the evidence and ratings**

We want to ensure that providers can raise legitimate concerns about the evidence we have used and the way we apply our ratings process, and have a fair and open way for resolving them.

The following routes are open to providers to challenge our judgements.

#### **Factual accuracy check**

When providers receive a copy of the draft report (which will include their ratings) they are invited to provide feedback on its factual accuracy. They can challenge the accuracy and completeness of the evidence on which the ratings are based. Any factual accuracy comments that are upheld may result in a change to one or more ratings. Registered persons have 10 working

days to review draft reports for factual accuracy and submit their comments to CQC.

## **Warning Notice representations**

If we serve a Warning Notice, we give providers the opportunity to make representations about the matters in the Notice. The content of the Notice will be informed by evidence about the breach which is in the inspection report. This evidence will sometimes have also contributed to decisions about ratings. As with the factual accuracy check, representations that are upheld and that also have an impact on ratings may result in relevant ratings being amended.

## **Request for a rating review**

Providers can ask for a review of ratings.

The only grounds for requesting a review is that the inspector did not follow the process for making ratings decisions and aggregating them. Providers cannot request reviews on the basis that they disagree with the judgements made by CQC, as such disagreements would have been dealt with through the factual accuracy checks and any representations about a Warning Notice if one was served.

Where a provider thinks that we have not followed the published process properly and wants to request a review of one or more of their ratings, they must tell us of their intention to do so once the report is published. We will reply with full instructions on how to request a review.

Providers will have a single opportunity to request a review of their inspection ratings. In the request for review form, providers must say which rating(s) they want to be reviewed and all relevant grounds. Where we do not uphold a request for review, providers cannot submit a subsequent review of the ratings from the same inspection report.

When we receive a request for review we will explain on our website that the ratings in a published report are being reviewed.

The request for review process will be dealt with by CQC staff who were not involved in the original inspection, with access to an independent reviewer.

We will send the outcome of the review to the provider following the final decision. Where a rating is changed as a result of a review, the report and ratings will be updated on our website as soon as possible.

The review process is the final CQC process for challenging a rating. Providers can challenge our decisions elsewhere – for example by complaining to the Parliamentary and Health Services Ombudsman or by applying for judicial review.



## Complaints about CQC

We aim to deal with all complaints about how we carry out our work, including complaints about members of our staff or people working for us, promptly and efficiently.

Complaints should be made to the person that the provider has been dealing with, because they will usually be the best person to resolve the matter. If the complainant feels unable to do this, or they have tried and were unsuccessful, they can call, email or write to us. Our contact details are on our website.

We will write back within three working days to say who will handle the complaint.

We'll try to resolve the complaint. The complainant will receive a response from us in writing within 15 working days saying what we have done, or plan to do, to put things right.

If the complainant is not happy with how we responded to the complaint, they must contact our Corporate Complaints Team within 20 days and tell us why they were unhappy with our response and what outcome they would like. They can call, email or write to our Corporate Complaints Team. The contact details are on our website.

The team will review the information about the complaint and the way we have dealt with it. In some cases we may ask another member of CQC staff or someone who is independent of CQC to investigate it further. If there is a more appropriate way to resolve the complaint, we will discuss and agree it with the complainant.

We will send the outcome of the review within 20 working days. If we need more time, we will write to explain the reason for the delay.

If the complainant is still unhappy with the outcome of the complaint, they can contact the Parliamentary and Health Service Ombudsman. Details of how to do this are on the Parliamentary and Health Service Ombudsman's website.

**Note:**

Please also see the separate [appendix](#) document to this handbook, which contains important information.

Appendix A: Key lines of enquiry

Appendix B: Characteristics of each rating level

Appendix C: Ratings principles

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