CQC's impact on the quality of care

An assessment of CQC's contribution, and suggestions for improvement

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We hope that this report does justice to your inputs. Any errors or omissions are our responsibility!

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[1] Please note that CQC Consultancy is an independent consultancy business, and has no connection with CQC itself.

Introduction

This report was commissioned by the Care Quality Commission (CQC) as part of the evaluation of CQC's five-year strategy 'Shaping the Future', published in May 2016. It aims to provide an in-depth assessment of the relationship between CQC's regulatory approach, and improvement in quality of health and social care. This includes looking at how CQC works with provider organisations and other system partners involved in health and social care. The report builds on existing evidence about CQC's impact on quality, and takes this one-step further, by recognising more explicitly how CQC's contribution interacts with other influencers on quality.

The report seeks to support CQC in delivering its purpose by identifying areas where it can improve its approach. It does this by elucidating theories of change and associated evidence, encapsulated in simple diagrams, which CQC can use as the basis for redesigning its activities and for organisational and staff development. Crucially, these theories also highlight external conditions which need to be in place for CQC to have an impact. Some of these conditions relate to provider organisations and others to the wider health and care system. They suggest a challenging agenda for CQC to engage more productively with providers and system stakeholders to achieve on-going quality improvement, supported by learning from further research and evaluation.

Consultation with CQC senior managers identified three priority topics for investigation of CQC's impact:

1. **Interactions between CQC inspectors and provider staff**. A substantial amount of inspector time is spent interacting with provider staff, so this needs to be effective, but there is little evidence about the impact of interactions. This project sought to identify interactional practices that support provider improvement, to investigate the impacts that such practices have, and to explore how feasible it is for inspectors to adopt these practices.
2. **CQC assessment frameworks and guidance products**. Many respondents in CQC's annual provider survey say that CQC products have encouraged or enabled them to improve. However, there is little evidence about how exactly the products are helpful. This project sought to understand the accessibility of CQC products, how providers use them to support improvement, and what impacts result.
3. **Registration assessment and decisions**. It is technically difficult to assess some impacts of registration, and there is relatively little evidence. This project sought to identify impacts arising from registration which could contribute to quality improvement, and to understand how those impacts came about, with a view to informing future monitoring and evaluation.

This report focuses on these three priority topics. The findings from CQC's first stakeholder survey, which was developed as part of this project, are in CQC's Annual Report and Accounts for 2018/19. These findings are drawn on to inform the conclusion of this report.

The report is structured as follows. The first section summarises eight impact mechanisms, or levers for improvement, identified by previous research, which CQC has found helpful in thinking about different ways to support improvement. The next section details the extent of the evidence available, and the methods used in this project that were used to produce additional evidence. The following three sections describe what is now known about each of the three priority topics, in the form of a theory of change that shows how, subject to certain conditions, CQC activities can lever provider outcomes that lead to impact. The next section presents a general framework of these conditions for impact, which complements the eight mechanisms framework. The final sections draw out recommendations for action and further research, and give an overall conclusion.

Notes

In order to keep this report short and accessible, many of the detailed findings are reported in a supplementary document. A contents list for this supplementary document is given at the end of this report.

The data in this report and the supplementary document have been anonymised to encourage participants to give full and honest accounts. Where alternative names have been used to protect identities, no reference to any actual person or organisation is intended.

Eight impact mechanisms- the levers for improvement available to regulators

Previous research by the University of Manchester and the King's Fund identified eight ways in which regulators could lever improvement in the organisations they regulate. These mechanisms were then applied to looking at how CQC can impact on service quality[2]:

- **Anticipatory** – providers take actions in response to regulatory requirements before any interaction. For example, when CQC gives notice of an inspection visit, the provider may, prior to the visit, review of the quality of its services and take action to address issues found.
- **Directive** – CQC advises or instructs providers to take certain actions, often after a regulatory interaction. For example, on finding breaches of regulations, CQC may issue requirement notices or warning notices setting out improvements that a provider must make and by when.
- **Relational** – CQC exercises "soft power" – influence through credibility and expertise of regulatory staff. For example, a CQC inspector shares information about upcoming CQC policy changes that she believes may be relevant to a provider.
- **Organisational** – the regulatory regime changes organisational power dynamics and behaviours. Having been rated "requires improvement" by CQC, a provider decides to change its senior management team.
- **Informational** – CQC collates/produces and publishes information which others can then use (purchasers, providers, media, public/patient groups etc). For example, a local healthwatch group decides to focus a visit to a provider on issues identified in a CQC inspection report.
- **Stakeholder** – CQC seeks to work with and through stakeholder groups or organisations to influence provider performance. For example, CQC participates with other stakeholders in the quality oversight committees set up to drive improvement in trusts placed in special measures.
- **Lateral** – CQC encourages providers to interact/collaborate to learn from each other's experiences. For example, a provider reads inspection reports of nearby providers rated as outstanding and visits two of them to learn more about how they improved quality.
- **Systemic** – CQC seeks to influence the whole system (including policymakers and wider interests) often on common issues of concern requiring wider action. For example, CQC conducts and publishes a thematic review of the mental health system for children and young people.

Thinking about these mechanisms can be helpful in designing impactful regulatory policies and actions.

In this study the impact mechanisms framework was used in two ways. Firstly, to help understand how impacts are achieved, and the potential for enhancing impact through changes to invoke additional impact mechanisms. Secondly, to consider how the mechanism framework might itself be further developed, by identifying conditions that influence the mechanisms. The report therefore refers to the mechanisms at various points.

[2] Smithson et al (2018) Impact of the Care Quality Commission on provider performance: Room for improvement? The King's Fund, London. https://www.research.manchester.ac.uk/portal/files/77461382/cqc_provider_performance_report_september2018.pdf

Methods used and evidence collected

For each of the three priority topics a theory of change was developed to set out the current best understanding of how CQC activities can lead to provider outcomes, and thereby higher quality of care and increased provider capability to improve quality ("improvement capability"[3]). Key contextual influences and relevant impact mechanisms were identified and incorporated. Available evidence relevant to the theory of change was assessed in order to identify both support for the theory and any gaps in evidence. New data was then collected and analysed in order to further validate the theory and refine it as appropriate.

This section sets out the process that was undertaken for each priority topic. Note however that where possible the data collection for each topic was designed to also provide insights into other topic areas, and analysis incorporated any data which was relevant, irrespective of its source.

Interactions between CQC inspectors and provider staff

The theory of change was developed through document analysis, telephone interviews with a range of stakeholders internal and external to CQC, and a stakeholder workshop. 16 people were interviewed, and 10 participated in the workshop. The theory of change was also discussed by the project advisory group comprising 16 internal and external stakeholders, and by an internal steering group of 17 colleagues.

Additional data collection and analysis sought to address key gaps in the evidence base: the feasibility of changing inspector practice; the substantive impacts of interactions; and involving other stakeholders. A list of good interactional practices was developed based on academic literature, focus groups with providers conducted previously by CQC, and discussions in CQC's Citizenlab online forum[4]. The practices were then organised into a model containing ten good practice areas, based on key themes or activities (see
Figure 2 below).

Over a period of four months, nine CQC inspectors from across CQC then took on the role of 'action researchers'[5]. They considered the model, tried out changes in their approaches and reflected on their experiences in facilitated 'action learning set' meetings[6], drop-in phone calls and an online discussion forum. The inspectors also completed a semi-structured reflective online diary of their interactions, generating 50 valid diary entries. Towards the end of the period each participant was interviewed by phone. All of the material was then analysed to identify themes.

In parallel, provider staff who the inspectors interacted with were asked to give feedback on particular interactions via telephone interviews, and on their interactions with CQC inspectors in general via an online form. Interviewees were asked to score the inspector's efforts with regard to four indicative measures associated with the model, and to say which of 13 potential impacts the

[3] Improvement capability has 8 components: organizational culture; data and performance; employee commitment; leadership commitment; service-user focus; process improvement and learning; stakeholder and supplier focus; strategy and governance. Furnival, J., Boaden, R., & Walshe, K. (2017). Conceptualizing and assessing improvement capability: a review. International Journal for Quality in Health Care, 29(5), 604-611.

[4] CQC's Citizenlab is an online discussion and participation forum. It is an open forum, where organisations and individuals working in health and social care, as well as individuals in receipt of health and social care, and the organisations representing them, can join and engage in specific discussions about CQC's work.

[5] Action research seeks change through the simultaneous process of taking action and doing research, which are linked together by critical reflection.

[6] An action learning set meets to share experiences and ask each other questions, supported by a facilitator, in order to promote on-going curiosity, inquiry and reflection.

interaction generated, whether positive or negative. 21 provider staff were interviewed and 23 gave feedback online. A quantitative analysis of the scores and impact frequencies was conducted, plus thematic analyses of qualitative data from the interviews and from the online form. The themes from the inspector data and the provider data were then synthesised.

The Strength of Evidence

Together, the process for developing the initial theory of change, pre-existing evidence that was collated, and the additional evidence that has been collected, make a good case in support of the theory of change for interactions between CQC inspectors and provider staff which is presented in the next section. The additional evidence all fitted with the initial theory, and enabled it to be refined further with some interesting insights.

As the approach to the research was qualitative it is not possible to assess the magnitude of the impacts from this work. The rich qualitative evidence demonstrates that substantial impacts can be achieved, given the right approach and circumstances, but inspector-staff interactions cannot on their own guarantee a particular level of impact. This underscores the importance of careful design of any initiatives to change interactions. Any future efforts to quantify impact would require very careful design in order to take account of the various conditions that influence interactions and their impacts, making attribution complex.

There is relatively little data about how interactions play out when the provider is not inclined to engage with CQC. While a strong relationship can help when quality issues or other problems arise, there is little specific empirical data, relating to CQC, concerning "difficult" providers and how best to engage them. There are elements of the theory of change which suggest some avenues, but there is a lack of data to confirm these. There may be evidence from the wider literature on regulation, such as on responsive regulation and associated "tit for tat" strategies which could also inform the approach[7], but this was beyond the scope of this project to consider.

CQC assessment frameworks and guidance products

Four hypotheses were formulated about how providers might use CQC products, by collating existing evidence and considering the eight impact mechanisms. These hypotheses were posted on CQC's CitizenLab, and emailed to Advisory group members for comment. A theory of change was developed to be consistent with the evidence.

This project sought to understand the accessibility of CQC products, how providers use them to support improvement, and what impacts result. A particular focus was on understanding why CQC ratings are correlated with organisations saying in the CQC Annual Provider Survey that CQC guidance helps them to improve.

A call for examples of impact of CQC products was issued through internal CQC and external networks (E.g., Citizenlab, and networks of advisory group members). All suggested examples were followed up with a short telephone interview to understand how they had been used and with what impacts. The content, format and accessibility of relevant CQC products were analysed, comprising: Key Lines of Enquiry (KLOEs) for Adult Social Care and Healthcare Services; Brief Guides for inspection teams; Relationships and sexuality in adult social care services; Smiling Matters - oral health care in care homes; GP mythbusters; and Equally Outstanding.

[7] Ayres, I & Braithwaite J (1992) Responsive regulation: Transcending the deregulation debate. Oxford University Press.

19 case examples were followed up by telephone interview, and six of these were selected to be investigated in more depth through case studies, because they indicated positive impacts and an interesting process which led to those impacts. So that the findings would have as wide an applicability as possible, the group of case studies as a whole was selected to have variety with regard to: CQC product types, topics and formats; provider types and sectors; and provider ratings at the start of the process. Practical issues were also a consideration, in particular gaining access to provider staff and documents within the limited time available for the project, although this only prevented one potential case study from being pursued.

The in-depth case studies were:

1. Use of the CQC Assessment Framework by an NHS hospital trust (previously rated requires improvement, currently rated good)
2. Use of the CQC Assessment Framework by an NHS hospital trust (previously rated requires improvement, currently rated requires improvement) and an NHS community healthcare trust (previously rated good, currently rated outstanding)
3. Use of the CQC Assessment Framework by a domiciliary care agency (previously rated good, currently rated outstanding)
4. Presentation of CQC products in workshops for care homes (previously rated inadequate and requires improvement, currently rated good)
5. Use of GP mythbusters by two Local Medical Committees and a GP practice (previously rated inadequate, currently rated good)
6. Use of Equally Outstanding by a care home (previously rated inadequate, subsequently rated requires improvement, currently rated outstanding)

A total of 19 people were interviewed for the case studies: 11 provider staff, 6 CQC colleagues and 2 stakeholders from the wider health and care system.

The investigation covered:

- The drivers for use of CQC products;
- How the products had been adapted and used in initiatives to support quality improvement;
- The implementation of those initiatives;
- The impacts which arose from use of the products;
- How CQC products contributed to those impacts; and
- Suggestions for increasing the impact of CQC products.

This was done through in depth, semi-structured telephone interviews with key informants from the provider; interviews with CQC inspectors or other stakeholders, where they had been involved; and, where possible, an analysis of relevant provider documents. Within each case study, data was triangulated where possible, commonalities and differences noted, and themes identified. Themes were then synthesised across all of the case studies, bearing in mind the characteristics of each case.

The Strength of Evidence

The theory of change for CQC assessment frameworks and guidance products is also well supported by the evidence. Again, the additional evidence generated during the project fitted with the initial theory. It also furnished greater detail and depth to a number of the elements within the theory of change, in particular with regard to what makes for an accessible product, the nature of the

organisational impact mechanism, and the importance of provider capacity and capability to improve.

As with the evidence on inspector-provider interactions, the evidence in relation to CQC products is also qualitative in nature. This means that it does not assess the number of providers whose actions are impacted by CQC products, although the CQC provider survey data does given some indication of the scale of use of products. There is also little evidence about how products can be made to impact on disengaged providers, the role of the anticipatory mechanism in this particular theory of change, nor what happens when product content does not align with other system messages, although in this latter case it is plausible that this may inhibit product use and impact. It may therefore be useful to conduct additional research in these areas.

Registration assessment and decisions

There is very limited existing evidence about the impact of registration. The evidence also says little about what makes registration useful and in what circumstances. The focus of this area of the project was therefore less about providing a robust conclusion about how registration has an impact. Rather, the aim was to provide a theoretical basis to inform future monitoring and evaluation by CQC.

A theory of change was developed through a document analysis, 15 telephone interviews with a range of stakeholders internal and external to CQC, a stakeholder workshop involving six people, and discussion in the project advisory group and internal steering group.

This was then tested through a case study identified in the same way as the case studies looking at use of CQC products. The case study investigated the registration of GP practices by a mental health trust, and involved interviews with 5 people.

The Strength of Evidence

The theory of change for registration assessment is plausible because of the stakeholder involvement in developing it and because it was not contested by different stakeholders[8]. However, further evidence is needed to assess and refine the theory, with the evidence regarding impact in particular being very limited. The CQC annual provider survey gives some information about how processes are perceived, but almost nothing about substantive positive impacts. What this work has therefore achieved is to provide a theory of change that can now be tested through the collection of additional evaluation evidence.

[8] Mayne J (2008) Contribution analysis: An approach to exploring cause and effect.

Contribution to impact of interactions between inspectors and provider staff

Overview

Interactions between inspectors and provider staff can contribute to higher quality care through a relationship characterised by openness and honesty, with timely and pro-active two-way discussion about:

- Care quality, the service provider's capability to improve quality ("improvement capability"), and external contextual factors that are affecting quality
- How CQC assesses and regulates care quality and the improvement capability of providers
- Plans for developing the above.

As depicted in Figure 1, such sharing and receipt of information and feedback can provide the basis for on-going mutual learning, and hence improvement of services and of regulation, although this may take time. Interactions need to be seen as part of an ongoing relationship between CQC and the provider, which may involve different individuals over time. Coordination is important, so that interactions are better informed and reinforce a positive relationship. This means coordination over time, as personnel change, and also across different people involved in different CQC-provider interactions (registration, relationship management, inspection).

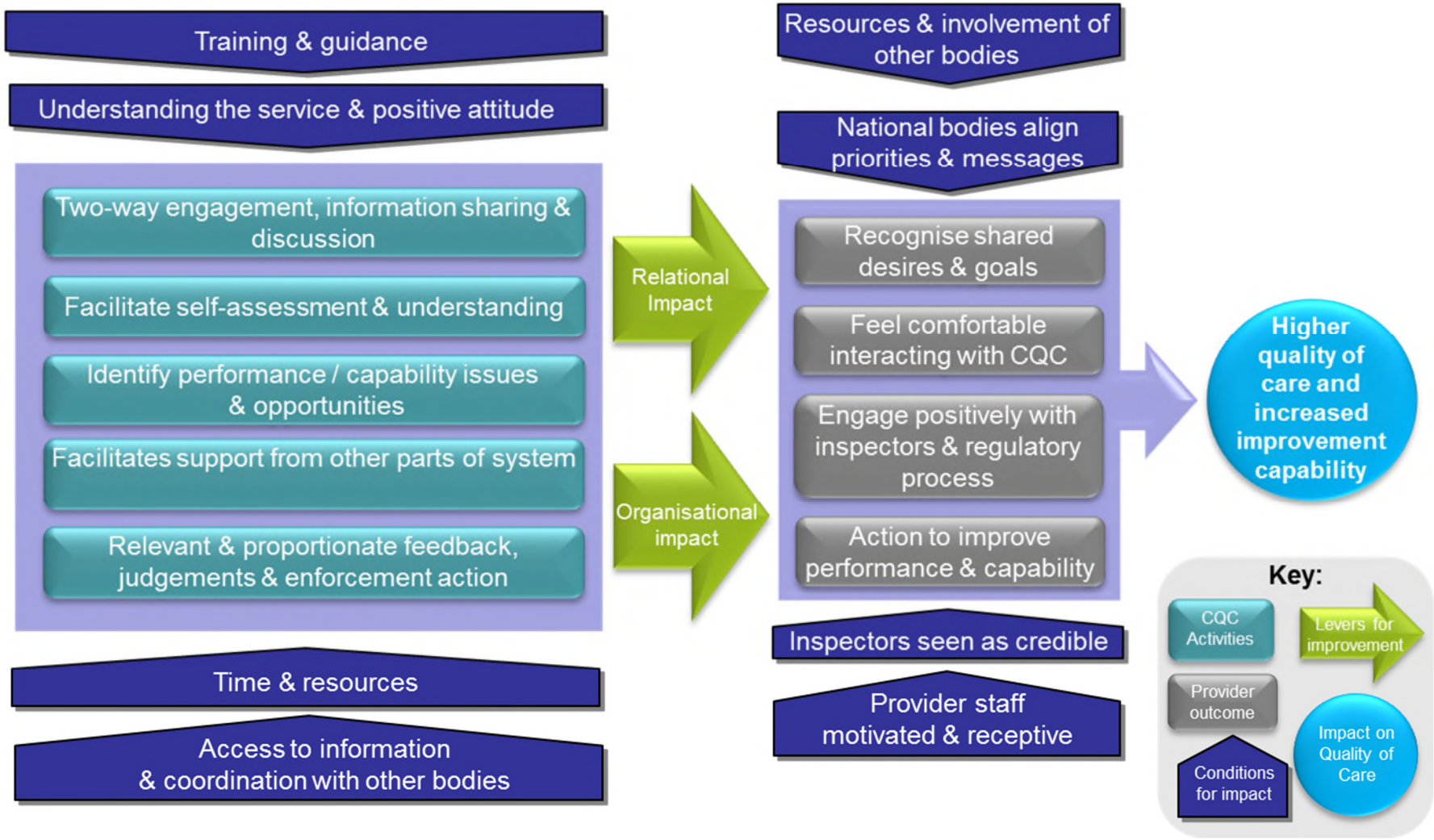


Figure 1: Theory of change for an inspector-provider interaction

Levers for improvement

Relationships are the key means through which interactions produce impact- this is known as the relational impact mechanism. Where this works effectively, trust and rapport are built between the individuals involved, through careful listening and communication. This is then a foundation for open sharing of relevant information about quality and improvement. However, the power dynamics and behaviours within the organisation are also crucial to this - the organisational mechanism. The interaction only directly affects the provider staff present, so impact is reliant on those staff either taking impactful action themselves, or being able to influence others within the organisation so that change will happen. Interactions need to take account of the roles of the staff who are present, and their situation within the provider organisation.

There is also potential for inspectors to enhance the impact of their direct interaction with provider staff by facilitating the involvement of partner organisations who can support provider change and development- the stakeholder mechanism. Such use of this mechanism should also further strengthen the relationship between the inspector and the provider. Inspectors may also signpost providers to examples of good practice within other services – the lateral mechanism. The theory of change recognises that enforcement action may be necessary and productive, but needs further development in order to fully integrate this directive mechanism.

Conditions for impact

We have discussed how different impact mechanism can lever for improvement in quality of care. However, various conditions will affect whether or not, or the degree to which, interactions will have an impact.

Time and Resources

Inspectors need time for interaction with providers and with key stakeholders. CQC as an organisation needs an approach where the nature, scheduling and allocation of staff to interactions with a provider are coordinated so that they contribute towards an on-going relationship. CQC also needs systems so that the organisation can learn from the intelligence and feedback that interactions generate.

Inspectors understanding the service and having a positive attitude

Provider perceptions of CQC inconsistency, poor behaviour or unresponsiveness can inhibit relationship development. Some providers experience a disjunction between a more positive and friendly approach in engagement meetings and a more negative and distant approach in inspection visits and reporting, which threatens to undermine the relationship.

The relationship can be supported by a central focus on improving the quality of care for people who use services. This can facilitate partnership with the provider if they share this goal and value CQC input, and potentially facilitate enforcement action if they do not. There also needs to be clarity about perspectives and contexts. It is helpful if both providers and inspectors understand and acknowledge where the other is coming from and why, and the constraints they are operating under. For example, the inspector understanding the resources that are available to the provider, their access to external support and capacity strengthening, and that they need to be viable. Conversely, the provider needs to understand that CQC has a duty to the public to publish independent assessments of care and take enforcement action if services are poor. Interactions should be challenging, but also respectful. Validation of the provider perspective by the inspector, which does not necessarily entail agreeing with it, can underpin this.

Reciprocity is important. Providers need to see that inspector behaviour towards them reflects the same values that they urge on providers, such as effectiveness, responsiveness and caring. For example, CQC/inspectors should model learning and improvement, encouraging critical feedback from providers and acting upon it. They should be responsive to the situation of the provider, and demonstrate that they care about the provider, who is integral to the care that service users receive. Teamwork is one of CQC's values, and providers want to work more in partnership with inspectors to develop, learn and improve, based on a clear understanding each other's roles, expertise and potential contribution, including boundaries and constraints (see above).

Inspector credibility, supported by training and guidance

Assessment should be holistic, recognising and communicating the value of multiple sources of evidence. A key part of this is inspectors obtaining information by engaging with provider staff more widely (E.g. connecting by coming to "where they are" and using their language). Recognising staff achievements and effort as part of getting a full picture is also motivational.

The professional competence of the inspector is also key. CQC staff need to be credible, with appropriate training and knowledge of good practices in service delivery and improvement. It is important to providers that inspectors have the technical knowledge and expertise to be able to assess service quality and provide insight to support improvement E.g. through constructive challenge. This is core to their function. Well-regarded inspectors combine being professional, knowledgeable and organised with being friendly and approachable. CQC information and feedback will be of greater value in enhancing care quality and provider improvement capability if inspections generally can reliably identify good practices and if CQC staff involved in relationships have the experience, confidence, independence and understanding of services to command credibility. The resources available (on both sides) for relationship management, together with staff recruitment, training, guidance and tools may affect this, with a need to take account of differences (e.g. between adult social care and hospitals; between large providers and small providers).

Access to information and coordination with other bodies who are aligned in terms of priorities, messages and resources

An open relationship facilitates the sharing of a greater amount of information, which is also more relevant to the other party's needs, more timely and better understood, so is more likely to be listened to and acted upon appropriately. Whether improvement happens also depends on relationships being established between individuals who can enable the enhanced information that is shared to influence their wider organisation (service provider and CQC). Who interacts with who is partly structured by which provider locations, and which managers, are registered.

CQC and large provider organisations also need to be able to capture, analyse and share information received through on-going relationships, combine it with other information, and then co-ordinate action. This could help CQC to be more "intelligence-driven", with better targeted, more effective inspections that may need fewer resources.

If the provider lacks improvement capability, then CQC may be able to help facilitate the appropriate involvement of other stakeholders, such as commissioners, other regulators and improvement agencies. This highlights the importance of on-going relationships between CQC and these other stakeholders (and between these stakeholders and service providers). It also shows the importance of ensuring that CQC and other stakeholders are aligned in terms of both their priorities and the messages they send to providers.

Inspector engagement with providers and other stakeholders in group settings gives greater scope for impact than one-to-one interactions with providers, by supplementing the relational mechanism with the lateral and stakeholder mechanisms. The case study of the presentation of CQC products in workshops for care homes is a good example of this. A CQC inspector gave a powerpoint presentation along with the local authority quality and improvement team and other local support agencies, and engaged participating care home managers and owners in group discussions about regulations and quality improvement. In this way the participants received information and support from each other, and from the support agencies, as well as from CQC.

Such group work should be feasible in urban areas, particularly in adult social care, but perhaps also in primary medical services and other sectors where inspectors have many providers in their portfolio. There is likely a wealth of experience in this type of engagement from inspectors across CQC. We suggest therefore that CQC works with inspectors to develop a model of inspector engagement with providers and other stakeholders in group settings, which can complement (and may in some instances replace) one-to-one inspector-provider engagement. Further research on how to go about establishing and sustaining such partnerships might complement this.

Provider staff motivated and receptive

CQC can help to motivate, direct and support the efforts of the provider, and in this way acts as a facilitator, but at the end of the day it is the provider that does the improving. Providers with improvement capability, such as motivated and capable leadership, can improve with little obvious input from CQC apart from the anticipatory impact of inspection and rating, or the motivation generated by a poor rating and inspection report, to trigger action.

An inspection visit is more likely to have a substantial impact than a monitoring meeting. The inspector and provider investment of resources are both substantially greater for a visit. Inspection visits can also be less open and positive than monitoring interactions. This approach to interactions may therefore be particularly influential towards improvement in and around an inspection visit. Circumstances may also be particularly favourable in the period after the issuing of a CQC rating that disappoints the provider; even more so if that poor rating can help mobilise improvement support from other agencies.

There remains an issue of how to manage interactions if either the inspector or the provider does not want to be open and engaged. Lack of provider engagement, where the provider seems to be acting in their own self-interest, can be a concern for inspectors. Some providers are also concerned about authoritarian inspectors who they feel do not listen to them. Both parties may feel potentially vulnerable. Inspectors and providers may have goals which are in tension with the "solidarity"-based relationship described in this report. For example, the publication of ratings of inadequate or requires improvement, and inspection reports which contain criticisms, can sometimes present challenges to improvement and the inspector-provider relationship. We would suggest CQC considers further research to measure disengagement and estimate the number of such providers. Approaches to increase provider engagement while also carrying out any necessary enforcement activity could then be developed. Aspects of the interactions theory of change, such as understanding perspectives and contexts, could well still be relevant to this.

Ten interactional practices that encourage quality improvement

The project has identified 10 practices that CQC inspectors can use in their interactions with provider staff in order to encourage quality improvement. The contribution that each practice makes is shown in
Figure 2, and specific things that inspectors can do are given in the supplementary document. For example, inspectors can solve problems jointly with provider staff. The inspector may know what other providers have done to address similar issues, or how they have gone about generating possible solutions. By mentioning these in discussions with the provider, the inspector may increase the provider's knowledge base, contributing to the production of better results. Inspectors can also build staff learning capability. Among other things, they can encourage staff to reflect on their practice and on the performance of their service. If staff do this, then they will be better able to improve services proactively and independently of CQC input.

Figure 2: Provider outcomes produced by 10 key interactional practices

Challenges in establishing relationships that encourage improvement

In thinking about whether or how to move more towards an approach to interactions like that in the theory of change, the feasibility of doing so needs to be considered. Changes in practice are possible and can be productive. However, the theory of change is dependent on various contextual factors and developing and supporting inspectors to follow such a model faces a number of obstacles. In particular:

- Inspectors have varying views about what constitutes good practice. This would appear to be particularly the case with regard to what is acceptable regarding offering support, advice and facilitation. Our data highlights various ways in which inspectors can provide helpful guidance to providers without that making an explicit or implied promise that improvement will result. Inspectors can state the grounds on which they make a suggestion, hence highlighting that it is provisional, E.g., "I understand that some providers have found it helpful to ….". They can make it explicit that the provider needs to assess the suggestion and decide whether to make use of it, E.g., " … you could think about whether that might work for you". Or they can phrase suggestions as questions, E.g., "Have you thought about …?" etc. There may be a need for CQC to provide a stronger lead as regards the priority to be given to support for improvement, and to develop a framework that gives inspectors appropriate boundaries within which they have the flexibility to be responsive to providers.
- Inspectors vary in their skills and experience, so would need training and development in order to fully follow the model. Our data gives pointers toward identifying relevant training and development, but a training needs assessment would likely be needed.
- Inspectors may feel constrained in what they can do by CQC processes, priorities and targets (E.g. around frequency, timing and nature of interactions). Careful consideration would need to be given to resource planning and to integration with CQC's overall model of interactions.
- Related to this, inspectors may have high workloads which limit their opportunities to engage with providers and to take up training and development

Contribution to impact of CQC assessment frameworks and guidance products

Overview

CQC can contribute to care quality by producing accessible, up to date assessment frameworks and guidance products, and making providers aware of them. Providers utilise the products to improve care in two ways:

- Directly: by identifying opportunities for improvement and ways of bringing about those improvements
- Indirectly: by setting up quality monitoring/assurance systems aligned with the quality expectations of CQC, as indicated in CQC's products. These systems help with identifying opportunities for improvement and tracking progress.

The provider then takes action to improve quality. Using CQC products as part of quality assurance and improvement processes helps to develop and foster a shared view of quality, as the provider refers to CQC standards and examples of quality in calibrating their own assessments of quality, and uses the same terms and expressions as CQC when communicating about quality – a shared language. This is self-reinforcing. Providers see that the processes lead to improved quality of care, so they continue to use CQC products and the shared view of quality is strengthened further.

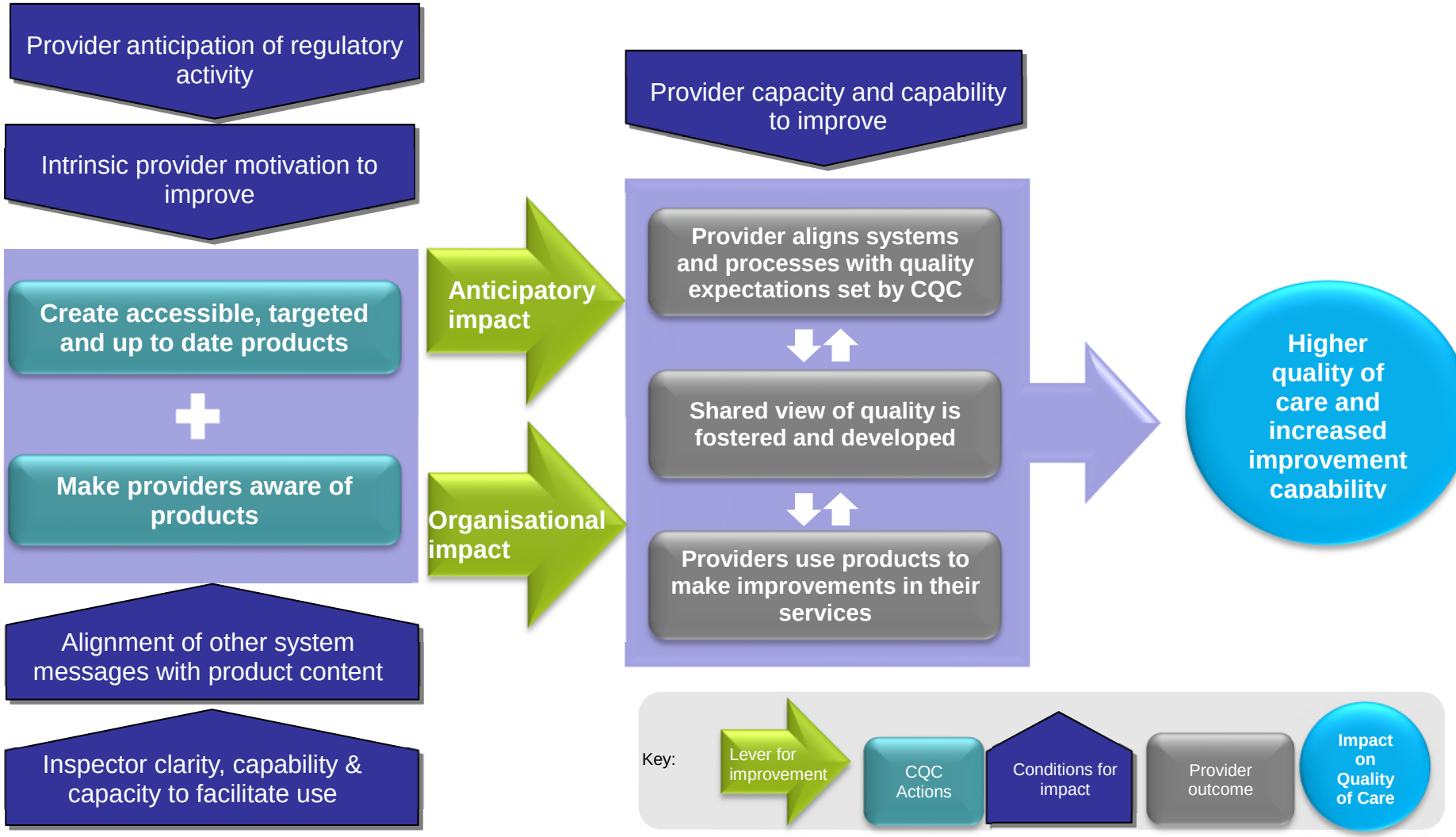


Figure 3: Theory of change for CQC assessment frameworks and guidance products

Levers for improvement

Providers know that they will be rated by CQC at some point in the future, and this is important to them, so they proactively take measures that they think will produce the desired rating level. The anticipatory impact mechanism therefore plays an important role in driving providers to use CQC products. CQC assessment frameworks and guidance products are an obvious source of information for providers wanting to improve quality and increase their rating. There are also anticipatory incentives for the provider to make their data and reporting systems compatible with CQC's assessment framework: during inspections providers will be able to draw on information held in these systems to demonstrate quality very clearly to inspectors; and supplying information in response to CQC requests as part of monitoring processes and preparation for inspection will be more efficient. This further contributes to a shared view of quality through an on-going focus on similar categories and language.

CQC products can also change organisational power dynamics and behaviours – invoking the organisational impact mechanism. This may happen if key actors in the organisation decide on the basis of the product that a change is needed to organisational structures, processes or culture, or if the product is targeted at, or picked up by, a particular group within the organisation. For example, Key Lines of Enquiry (KLOEs) may be more likely to be seen as useful by managers than by clinicians, who may be more interested in clinical guidelines. Impact may then depend on the relative power and influence of managers vis-à-vis clinicians.

A good relationship between the inspector and the provider means that the inspector can increase take-up of relevant CQC products through signposting, and helping provider staff to interpret the content – the relational mechanism. In addition, CQC products may facilitate providers making contact with exemplar organisations highlighted in the products in order to learn from their experiences – the lateral impact mechanism.

Conditions for impact

The process whereby, and degree to which, CQC products are used by providers to improve care will be shaped by a number of conditions.

Provider Anticipation of regulatory impact

The anticipatory mechanism may be triggered by incentives offered by the regulatory regime. Extrinsic motivations such as CQC ratings may be important drivers towards the start of the change process. This can be in anticipation of a future good or outstanding rating, or in response to a rating of inadequate or requires improvement. Following an inspection, the inspection report and associated guidance from the inspector may be influential, and so represent a particular opportunity to help shape the provider's approach to improvement, and their use of other CQC products.

Provider motivation to improve

Use of CQC products may occur due to the provider's own motivation to do the best for people using their services. Over time, CQC's five key questions can become part of everyday language and thinking, and quality systems incorporating assessment can become embedded processes. Ultimately, a culture of improvement can take root where action is not driven by CQC regulation or management direction, but by a desire among staff to improve quality of care for people using their service.

Inspector clarity, capability and capacity to facilitate use of products

The inspector's knowledge of CQC products, their capability to communicate key content, and their ability to bolster provider motivation may also influence things, indicating a further set of training and development needs. Ironically, the volume of guidance and communications from CQC and other agencies may make it difficult for providers to focus on a clear and manageable set of priorities for improvement. CQC inspectors can both make providers aware of products, channelling their attention towards products that may be most helpful to their situation, and make those products more accessible to providers, by explaining their purpose, contents and how they can be used.

Individual providers see that one of the areas where CQC can offer value to them is through the knowledge that CQC and its inspectors have built up about the various quality issues that providers have encountered, and the various ways in which they have attempted to address those issues. Such knowledge is potentially particularly valuable for providers that are not well networked and are struggling to improve. Some providers can feel overwhelmed by the prospect of having to improve following an inspection. There is a danger that providers go off on the wrong track or are distracted by all the "noise" in the system. They may need help to understand why they are not compliant and what they need to do to develop, so that they can engage in focused, productive action. As noted in the section on inspector interactions with provider staff, it is possible for CQC inspectors to provide helpful guidance without this constituting an instruction or advice that could compromise their role. Facilitating use of CQC products can be a way of achieving this.

Other system messages align with product content

Whether, and how, a product is used will also be affected by the extent to which the messages within it fit with messages from other stakeholders – whether they are the same, complementary or contradictory. Providers lacking improvement capability can benefit from support to help them improve. CQC is not an improvement agency, but can play a role in helping providers to access improvement support, by: helping to network providers so that they can support each other; and facilitating input from improvement agencies, not just through signposting, but also through active partnership with those agencies. Alignment of messages between CQC and other stakeholders supports this to happen.

Provider capacity and capability to improve

As for the inspector interactions with provider staff, the improvement capability of the provider is a key influence on whether CQC products will be used to improve quality and have an impact. Improvement in quality from a low level (requires improvement or inadequate), to a high level (good or outstanding) is possible, but will likely take time (years), resources (time, and sometimes money), know how, and committed and skilful management. If these things are not present within the organisation then they can be developed, E.g., by bringing in new managers with the right capabilities; and CQC and other stakeholders imparting know-how, celebrating achievements and providing motivational support and encouragement. Where a culture of acceptance of poor care has grown up, then provider staff may need educating about what good care looks like. This may, in part, be achieved by signposting to CQC products, but by supporting the provider's improvement capability, CQC would also increase the provider's ability to use CQC's products to improve even further.

Using CQC Assessment Frameworks within provider Quality Systems

If CQC assessment criteria do not change too frequently, then CQC regulation can promote the development and use of quality systems based on the KLOEs, with the following characteristics:

Characteristic of the quality system	Driver
Emphasises the collection and reporting of evidence about quality that CQC recognises	CQC will assess evidence as the basis for its ratings/reports, and these ratings/reports are important to the provider
Uses similar methods to CQC, particularly inspection visits in large healthcare organisations	CQC inspection visits have been seen to produce insights Appreciation that being able to articulate quality during CQC inspection visits is a skill. Provider staff can acquire it through practice (being subject to internal inspections mimicking CQC inspection). Assessing quality is a skill that contributes to improvement. Provider staff can acquire it through practice (E.g., as members of an internal inspection team)
Maps onto the CQC key questions and KLOEs	The key questions, KLOEs and prompts cover many of the areas the provider sees as relevant to quality, and are sufficiently high level to be widely applicable CQC looks at similar questions/topics in its assessments, so following these makes it easier to respond to CQC information requests
Is used as the basis of action planning and quality improvement	Improving/maintaining CQC ratings is important to the provider Improving quality is important to the provider

Where there is little input from CQC or other support agencies to provide explanation and guidance, then the design of the CQC products themselves comes to the fore. Organisations and their contexts are different, so it is inevitable that they will need to adapt CQC products to meet their particular needs and circumstances. CQC products differ in how they attempt to address this issue. For example, the assessment frameworks tend to be quite abstract and high level, and in the form of long documents, so that they can be applicable to many situations and cover a whole sector. In contrast, each GP mythbuster is short and very specific, focused on a particular issue. There are many different mythbusters spanning a wide range of issues - for any organisation some will be relevant and others irrelevant.

Providers find it easier to work with concrete examples and pieces of guidance than with more abstract frameworks. The former are very easy to relate to the provider's situation, so a quick decision can be made about relevance, and adaptation to local circumstances is likely to be a relatively simple "copy and paste" into the provider's own materials or framework. This is a practical process for busy practitioners who want a quick and efficient way of identifying issues relevant to the quality of care that they provide, and of then coming up with action to address those issues. Toolkits such as Equally Outstanding, can also facilitate this process, because they contain a variety of tools that providers can choose from to suit their circumstances.

As well as using KLOEs, a provider may access inspection reports of other providers in order to identify common things that poorly rated providers are getting wrong, and things that good or outstanding providers are getting right. Some then visit other providers to learn more. CQC can make this a more efficient process for providers, by identifying and publicising common issues, good

practices, and ideas for improvement; and by encouraging providers to address those issues and adopt good practices.

Challenges in using products to encourage improvement

Providers using CQC assessment frameworks to develop their own quality frameworks must do a significant amount of work in order to understand exactly how each KLOE relates to their particular service. For example, provider services may include activities which are not regulated by CQC, or services may be structured in different ways. They then need to do further work to write more specific questions and prompts, in straightforward language, that for staff who are not quality specialists are able to use.

Starting with a concrete example, with supplementary links to particular KLOEs and further guidance, as is done in some mythbusters, does some of the work of mapping the assessment framework to the provider's service, helping provider staff to understand the KLOE. We therefore suggest that CQC makes its assessment frameworks more accessible by developing specific examples for different types of services and showing how they link to KLOEs and ratings characteristics. Mythbusters could provide a good model for this: specific, "bite-sized" pieces of information that are easy to find on the CQC website. By mapping examples and KLOEs it would also be possible to list relevant examples under KLOEs, which could also be valuable. However, we would suggest examples as the main entry route for providers, following the principle of connecting with providers -giving them information that they can relate to – so that there is less need for inspectors or others to perform a translation function.

CQC gives out some mixed messages about its role in and support for quality improvement. Products such as assessment frameworks that appear to be used by many providers to support quality improvement are not designed for providers, but for inspectors. Some documents for inspectors hint or state that they might be used by providers, but contain cautionary notes about doing so. There appears to be a reticence about making clear, accessible information available that could help providers to improve, so providers have to make the best use they can of documents intended for inspectors. Thus, CQC inspectors find brief guides for inspectors useful as a way of communicating to providers what CQC is looking for, because they are "the nearest we can get to telling them what to do (which we aren't allowed to do)!".

The process whereby CQC products are used by providers to improve care will be shaped by a number of conditions. The anticipatory mechanism may be triggered by incentives offered by the regulatory regime or by the provider's own motivation to do the best for their service users. The inspector's knowledge of CQC products, their capability to communicate key content, and their ability to bolster provider motivation may also influence things, indicating a further set of training and development needs. And again, as for the inspector interactions with provider staff, the improvement capability of the provider is a key influence on impact. The "absorptive capacity" of the organisation[9], which is related, is also relevant.

[9] Absorptive capacity is the organisation's propensity to look externally for intelligence and guidance, and its capability to assimilate and apply that intelligence

Contribution to impact of registration assessments and decisions

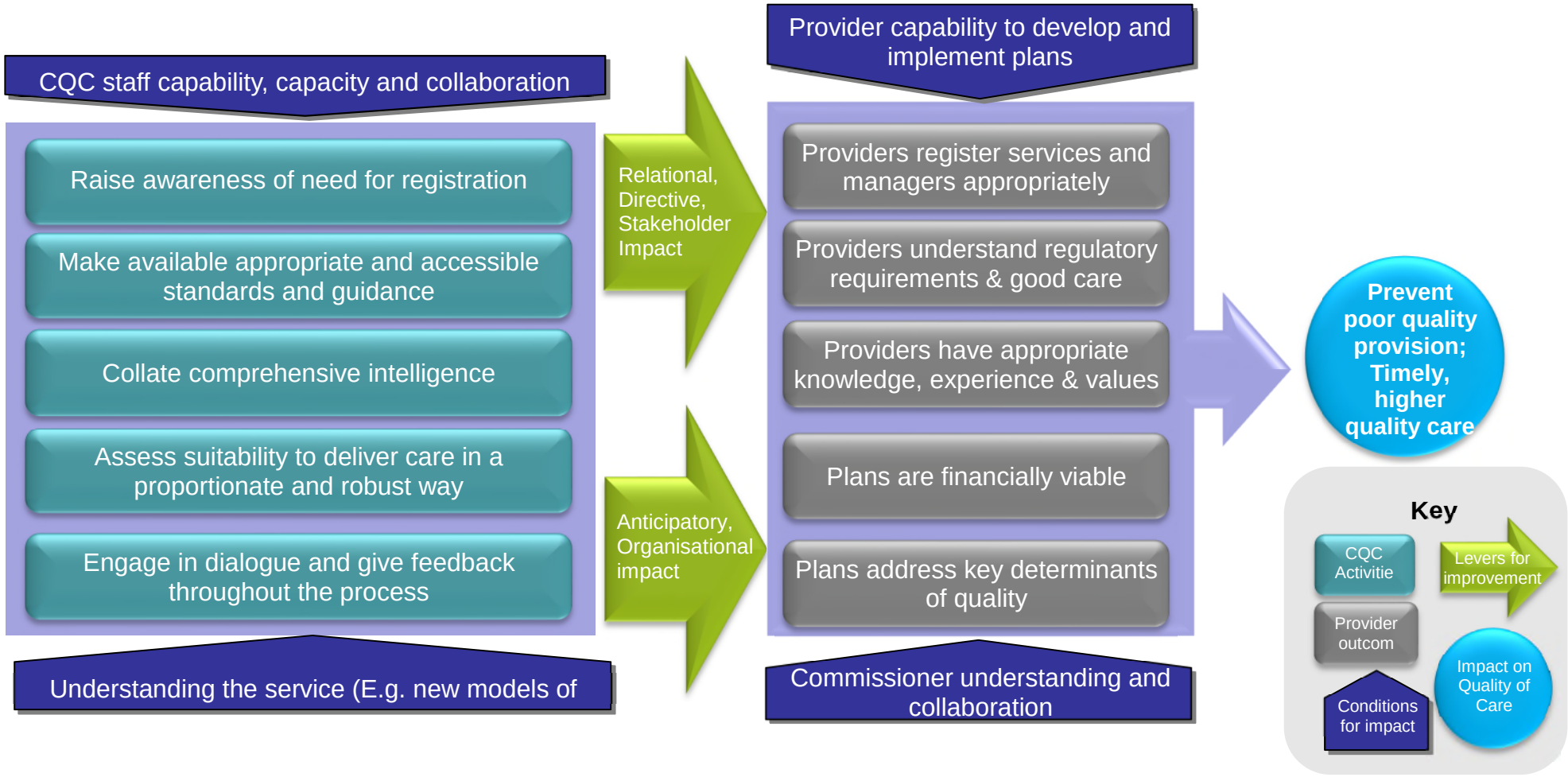
Overview

Registration can contribute to the quality of care of new services by ensuring that: successful applicants have appropriate knowledge, experience and values; their plans are financially viable; and their plans address key determinants of quality, such as an appropriate service model, staffing, and policies and procedures. Applications lacking these features are refused, reducing the risk of poor quality services being established.

Applicants also learn about registration and other regulatory requirements, plus what constitutes good care. This further supports the provision of high quality care, compliance with regulations, and appropriate future registration applications and re-applications, which can be processed efficiently.

Registration achieves these impacts through various activities. Raising awareness of the need for registration among providers, commissioners and other stakeholders, means that the system has good coverage. There are few services operating without necessary registration, and these are reported and dealt with. Standards and guidance are appropriate and accessible to providers. The assessment process is proportionate to risk, with a suitably thorough assessment that takes account of information about the current application and the wider record of the provider, and is also timely, so that service plans are not disrupted and provision delayed. Inspectors engaging applicants in discussion and providing feedback throughout the process (prior, during and after application) contributes to impact by facilitating CQC inspector learning about the applicant and proposed service, the applicant learning about the registration process and requirements, and both learning about what makes for a good service.

Figure 4: Theory of change for registration assessment and decisions



Levers for improvement

Registration uses a number of the impact mechanisms to achieve impact. For example, there is an anticipatory component. Applicants access guidance before applying, and this helps them in devising their plans and submitting an application which contains the necessary information. Applicants also know that the service will continue to be subject to regulation, incentivising them to consider how the service will achieve a good rating.

The organisational mechanism is crucial to registration contributing to higher quality care. Service plans assessed during registration then need to be implemented, which may involve setting up a new organisation, or changing an existing one. Registration of managers achieves its impact through those managers influencing the way their organisation delivers care.

Registration may also direct applicants, if necessary highlighting where an application falls short of requirements and that the application must address these or be rejected. Registration may also be subject to conditions. The relational mechanism operates as the inspector engages in dialogue with the applicant, seeking to understand any issues and communicate guidance. Applicants may also liaise with previous applicants to learn about the registration process or the relevant service model or design issues – the lateral mechanism. The stakeholder mechanism operates when, informed by CQC guidance or staff, commissioners, service users and others identify unregistered services, and when commissioners specify services in line with registration requirements and determinants of good care.

Conditions for impact

If registration is to be impactful, CQC inspectors need to have the capability and time to assess applications appropriately and engage in productive dialogue with applicants. This is particularly the case with regard to innovative models of care, where CQC registration, inspection and other staff need to share information and collaborate with each other and with providers in order to develop appropriate standards, guidance and assessment processes. Registration and inspection also need to collaborate in order to collate comprehensive information about the wider record of applicants who are existing providers. Commissioners need to collaborate with registration so that service specifications do not drive inappropriate service models and applications, and there is clarity about accountability for integrated care provision. Finally, registration relies on providers having the capability to develop suitable plans and then implement them.

Understanding the service (E.g., new models of care)

Registration of innovative service models in particular is a complex process which new applicants may well find difficult and confusing if they rely purely on written guidance currently provided by CQC: this guidance is lengthy and may not be straight forward to interpret. Responsive support and advice from registration inspectors at an early stage can help new applicants to navigate the process more quickly, although it may still be lengthy and time consuming. Such support and advice is likely to be appreciated by the provider, and so may strengthen the relationship with CQC. The pre-engagement service for registration of services for people with learning disabilities or autism may offer an opportunity for assessing impact.

There may be scope for CQC to develop and share specific guidance as new service models are registered, based on learning from early applications, in order to guide future applicants, registration inspectors and inspectors. New applicants may also gain insight from getting in touch with previous applicants, although commercial considerations can be a barrier to information sharing.

Provider capability to develop and implement plans

The quality of the service ultimately delivered depends not only on the service model, but also on its subsequent implementation by the provider, and for new models this is likely to be a learning process. This again points towards CQC facilitating networking between services and applicants, and also towards coordination and feedback between inspectors and registration inspectors in order to identify any issues which may be occurring during implementation and delivery. This can then inform future registration and monitoring. The value of registration and inspection collaborating to support existing providers when they need to register new services is also highlighted. Registration is not necessarily, or even usually, a one-off encounter with a provider at the start of a new service, but may occur at various points in time, and so CQC should continue to consider coordination and learning between registration and inspection.

Challenges in increasing the impact of registration

While recognising some important differences, this research emphasises key commonalities between registration and inspection. Both seek to support the provision of good quality care by making appropriate assessments of provider capability and capacity, to motivate and inform development, and, where necessary, enforcement action which may close a service or prevent it being established. All eight of the impact mechanisms are relevant to registration, and registration also involves provision of guidance, and interactions between CQC and provider staff. The conditions for impact identified in the theory of change for registration assessment and decisions are also similar.

The challenges identified in previous sections also apply to registration. Thus registration inspectors vary in their views about what constitutes good practice, vary in their skills and experience, may feel constrained by CQC processes, priorities and targets, and may have high workloads. CQC products related to registration could be made more accessible and useful for providers, and the improvement capability of the provider is a key influence on impact. There are also additional challenges in measuring the impact of registration.

In the following section, we draw together common conditions needed for impact into a general framework for CQC to use. Most of our recommendations for action for CQC apply equally to registration as to inspection, and should be read with this in mind.

Conditions needed for impact – A framework

This project has developed three theories of change showing how CQC activities contribute to provider outcomes, and thereby to impacts on the quality of care. The theories of change have explicitly incorporated relevant impact mechanisms, while also identifying various conditions which affect CQC's contribution. This provides an opportunity to consider at a more general level what the key conditions for impactful regulation in health and social care are, and how these conditions and the impact mechanisms interact. See Figure 4 for a diagrammatic representation: The nature of CQC activities, how they pull levers for improvement, and how these translate into impact, are influenced by conditions for impact.

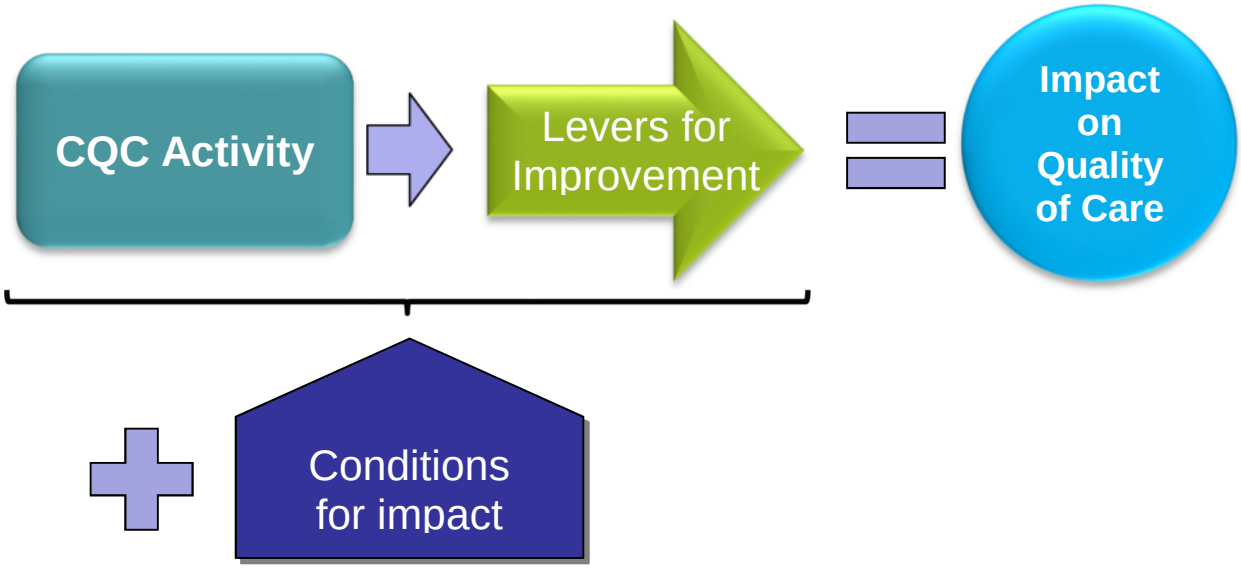


Figure 4: How CQC activities have an impact

For all of the theories of change, the primary focus is on CQC and the provider: interactions between inspectors and provider staff; CQC guidance used by providers; and CQC registration of a provider service or manager. It is not therefore surprising that direct, bilateral mechanisms (anticipatory, directive, relational and organisational) are prominent in the theories of change. However, in all of the theories of change there is also potential for indirect, multilateral mechanisms to support impact. This is a reminder that CQC and the provider do not exist in isolation, but alongside other stakeholders, such as other providers, commissioners, support agencies and people who use services. These stakeholders constitute the wider governance of services beyond formal regulation by CQC and other regulators.

Five key conditions can be identified, which influence the nature and extent of provider outcomes, and consequent impacts on quality, in all of the theories of change:

1. Provider capability and capacity to plan and improve
2. Provider motivation to improve (intrinsic and extrinsic; in anticipation of, and following, regulatory activity)

3. Inspector and CQC credibility, capability and capacity
4. CQC alignment and collaboration with key system stakeholders (regarding incentives, guidance, improvement support)
5. Clear understanding of organisations and their roles (E.g. CQC understanding of providers and services; provider and commissioner understanding of CQC)

These encompass five characteristics (capability, credibility, motivation, credibility and clarity) and three organisation types (provider, regulator – CQC, and system stakeholders). Putting these as separate dimensions gives a comprehensive framework of conditions (see **Error! Reference source not found.**), which is consistent with the evidence and theories of change in this report, and with the previous research on the impact mechanisms conducted by the University of Manchester and the King's Fund[10]. This makes it suitable to be used in planning, in conjunction with appropriate monitoring and evaluation.

[10] Smithson et al (2018) Impact of the Care Quality Commission on provider performance: Room for improvement? The King's Fund, London

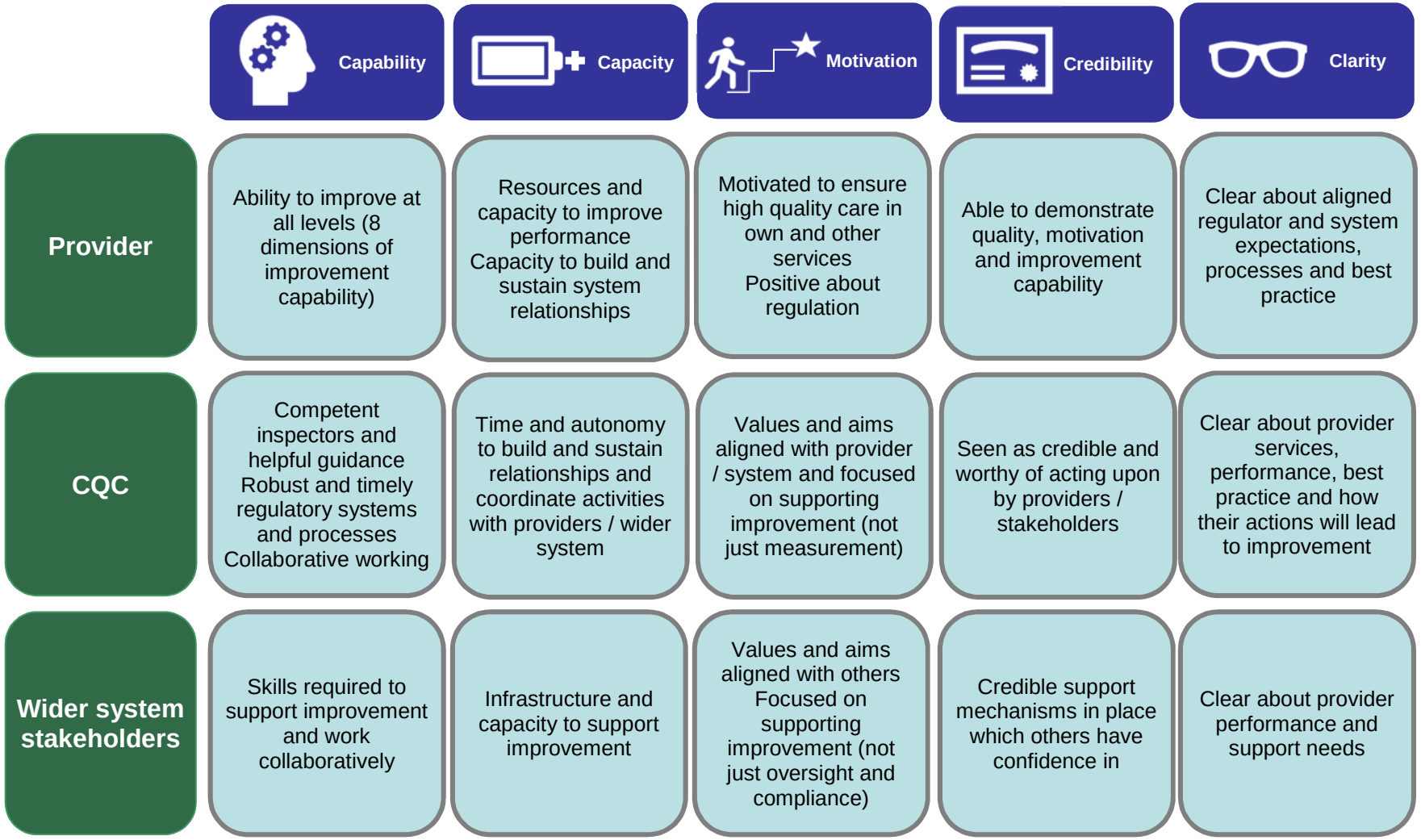


Figure 5: Conditions affecting CQC's contribution to impact

Recommendations

The conditions framework indicates a range of factors that support CQC's impact on the quality of care. By comparing the current situation with the framework, and considering ways of addressing shortfalls, CQC can identify and prioritise areas for development. The findings of this report suggest some particular actions, and some topics for research, evaluation and monitoring in order to inform further action. These are listed below under different elements of the conditions framework.

CQC inspector capability - training and development:

- Use the insights from this project to develop CQC's inspector competency framework with regard to interaction skills and techniques, working with stakeholders, and communicating CQC products and their contents. This should include registration inspectors.
- Conduct a training needs assessment with regard to the newly identified competencies
- Design training and development opportunities to meet identified priority needs, addressing potential barriers to access such as workload and location
- Consider ways in which individual inspectors and registration inspectors can obtain useful feedback on their performance from providers, stakeholders, specialist advisors and other inspectors, and be supported to act on that feedback to improve performance

Inspector capacity:

- Review CQC processes, priorities and targets regarding the frequency, timing and nature of interactions between CQC inspectors (including registration inspectors) and provider staff to assess how well they match provider need for input, and consider the feasibility of a system that is more responsive to local intelligence and relationships. This may also involve consideration of the roles of other CQC staff, or the need for new staff roles.

CQC clarity:

- Consider how the organisation can give a stronger lead to staff and stakeholders about what constitutes legitimate encouragement and support for improvement, E.g., defining and explaining terms such as 'advice' and 'signposting', and sharing examples of good practice.

Provider capability:

- Review guidance products that are used by providers (whether primarily intended for provider use or not), in order to design products that are more accessible to providers. For example, make CQC assessment frameworks more accessible to provider staff by developing specific examples for different types of services and showing how they link to KLOEs and ratings characteristics.

Provider motivation:

- Consider further research to measure provider disengagement (E.g. perhaps develop indicators in the annual provider survey, or a measure for inspectors to apply to their portfolio), estimate the number of such providers, and see what relationship this has to

quality indicators and improvement trajectories. This might link to recent work by CQC about how CQC inspectors can identify and respond to 'closed cultures' in services[11].

- If indicated by the above research, develop approaches to increase provider engagement while also carrying out any necessary enforcement activity

Provider clarity:

- Identify and publicise common issues, good practices, and ideas for improvement for different types of provider at all levels of performance. Encourage and support providers to address those issues and adopt the good practices. Consider developing a small number of specific national priority improvement topics and associated improvement products that can give a focus to provider service improvement and support efforts of stakeholders, avoiding overload

Stakeholder collaboration to develop provider improvement capability and support:

- Map and report on the capacity, capability and accessibility of support to develop improvement capability that is currently available to providers in each locality and sector, identifying good practice in support provision. This assessment could be based on the well-led framework, adapted as necessary to cover all the dimensions of improvement capability.
- Map and report on provider improvement capability in each locality and sector, based on existing assessments from the well-led framework. As part of this, consider the effectiveness of CQC in assessing and reporting on provider improvement capability, and in motivating and supporting the development of improvement capability.
- Develop a model of CQC staff engagement with providers and other stakeholders in group settings, learning from existing practice. As part of this work, consider how this model can complement one-to-one provider engagement by CQC staff, and be integrated into the workloads of inspectors, or other CQC staff as appropriate.
- Consider in the different sectors how CQC supports providers to improve during the period from the announcement of an inspection through to post-inspection action planning and implementation, so that this window of opportunity for improvement is maximised.

Further research, evaluation and monitoring:

- CQC should incorporate evaluation into the above actions as appropriate, particularly where there is scope to learn more about CQC's contribution to quality
- CQC should consider how it could monitor the various elements of the conditions framework, updating its annual provider survey, inspector survey and stakeholder survey as appropriate.
- CQC should consider evaluating the impact of the pre-engagement service for registration of services for people with learning disabilities or autism, as a starting point for understanding how registration can achieve impact through collaboration with providers, inspection and other stakeholders.

[11] New supporting information for inspectors and Mental Health Act reviewers addresses the risk factors of closed environments. https://www.cqc.org.uk/news/stories/new-supporting-information-inspectors-mental-health-act-reviewers-addresses-risk

- CQC has achieved systemic impact through its local system reviews, but these are currently in abeyance, and this project found little evidence of systemic impact. It may be however that if CQC places more emphasis on working with local stakeholders, as suggested in this report, and as more integrated care providers are established, that there will be opportunities to achieve systemic impact in other ways. Exploratory research could seek to identify possibilities for systemic impact.

Conclusion – CQC's contribution story

CQC and inspector credibility and appropriate input (relational and directive mechanisms), together with anticipation of regulatory activity (anticipatory mechanism) can be important drivers that motivate a provider to embark on an improvement journey, and help give that journey direction in the early stages. Provider improvement capability, capacity and intrinsic motivation are needed for significant, sustained improvement, and may need to be built. Ongoing inspector feedback and encouragement, relevant CQC products, and facilitation of helpful input (E.g., support agencies, commissioners, other providers) can contribute to this building process (lateral, stakeholder and organisational mechanisms). Over time, provider experience of successful improvement through assessment of quality and appropriate improvement initiatives can become a self-sustaining cycle which leads to a culture of improvement and reduces the need for CQC and inspector input. There remains a need for some monitoring and interaction in order to address issues of quality, motivation, capability or capacity which may arise.

This project has gathered evidence which shows that CQC and its inspectors can, and do, contribute to provider improvement capability and quality of care in these ways. The challenge is to enable this to happen more consistently and across the whole of CQC. In order to achieve this, inspector training and development will be needed, together with changes to policies and processes (E.g. concerning the nature and frequency of inspection visits and monitoring), and a greater focus on working with other key stakeholders locally (E.g. support agencies and commissioners). The conditions framework and theories of change presented in this report, together with the recommendations for action and the detailed information in the supplementary document, may be useful tools to inform the development of CQC strategies and operations, and for providers and other stakeholders to see how they might support CQC in its own improvement journey.

Contents of the supplementary document

The supplementary document provides access to detailed research evidence which was gathered as part of this project to assess the contribution that CQC makes to the quality of health and social care. The evidence relates to three topics:

1. Interactions between CQC inspectors and provider staff
2. CQC assessment frameworks and guidance products
3. Registration assessment and decisions

The supplementary document can be read either in conjunction with this main project report, or used on its own as a practical resource to support quality improvement. We particularly hope that the case studies of improvement contained in the supplementary document will provide valuable insights to enable better partnership working between CQC, service providers and other stakeholders, and more productive use of CQC products.

We suggest that readers use the contents list below to identify material contained in the supplementary document that is relevant to them:

Contents

1. A detailed model of good interactions from an inspector perspective
2. Analysis of Action Learning Set meetings and drop-in calls with inspectors
3. Analysis of inspector online diary entries
4. Analysis of one-to-one "exit" phone calls with inspectors
5. Analysis of Feedback from providers
6. CQC Assessment Frameworks and Guidance documents with Examples of Impact
7. Case study: Use of the CQC Assessment Framework by an NHS hospital trust
8. Case Study: Use of the CQC Assessment Framework by an NHS hospital trust and an NHS community healthcare trust
9. Case Study: Use of the CQC Assessment Framework by a domiciliary care agency
10. Case study: Presentation of CQC products in workshops for care homes assessed as "requires improvement"
11. Case study: Use of GP mythbusters by two Local Medical Committees and a GP practice
12. Case study: Use of Equally Outstanding by a care home
13. CQC registration assessment frameworks and guidance documents with examples of impact of registration
14. Case Study: Registration of GP practices by a mental health trust