East of England Ambulance Service NHS Trust

Policy for Managing Care Quality Commission Requirements

Document Reference	POL029
Document Status	Approved
Version:	V4.0

DOCUMENT CHANGE HISTORY		
Initiated by	**Date**	**Author (s)**
Trust requirement]	November 2015	Head of Compliance, CQC Compliance Manager
Version	**Date**	**Comments (i.e. viewed, or reviewed, amended approved by person or committee)**
V1.0	17 February 2016	Approved by Executive Leadership Board (via email)
V2.0	22 February 2018	Approved by Executive Leadership Board

Version	Date	Comments (i.e. viewed, or reviewed, amended approved by person or committee)
V3.0	18 June 2020	Approved by Compliance and Risk Group

Version	Date	Comments (i.e. viewed, or reviewed, amended approved by person or committee)
V3.0	22 May 2023	Extension to March 2024 approved by Compliance and Risk Group
V3.0	25 March 2024	Extension to September 2024 approved by Compliance and Risk Group
V4.0	September 2024	Approved by the Compliance and Risk Group.

Document Reference	Health and Social Care Act 2012 (Regulated Activities) Regulations 2014 Care Quality Commission (Registration) Regulations (Part 4) Care Quality Commission Quality Statements Directorate: Clinical Quality Directorate
Recommended at Date	Continuous Improvement Regulatory Group 26th September 2024
Approved at Date	Compliance and Risk Group 30th September 2024
Valid Until Date	30 September 2027 or earlier if prompted by changes in legislation or CQC requirements.
Equality Analysis	Yes
Linked procedural documents	None
Dissemination requirements	All Trust staff and members of the public via publication on the Trust website
Part of Trust's publication scheme	Yes

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

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

All Trust policies can be provided in alternative formats.

Contents

1.0 Introduction

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

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

Are services

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

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

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

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

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

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

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

In 2023, the CQC advised a new 'Single Assessment Framework' would replace the 'Key Lines of Enquiry'. However, the five key questions (Safe, Effective, Caring, Responsive and Well-Led) remain, along with the existing ratings (outstanding, good, requires improvement and inadequate).

The CQC has prioritised a people-centred approach, developing their new strategy in collaboration with the public, service providers and partners.

The focus will also be on promoting a stronger learning and safety culture, improving the quality of care where it's needed most, and addressing inequalities in healthcare.

The assessment approach:

The new assessment framework retains the 5 key questions and the 4-point ratings scale. The framework will assess services against quality statements. These have replaced the key lines of enquiry (KLOEs), prompts and ratings characteristics.

The CQC will gather evidence both on site and off site to make an assessment. The types of evidence we will consider are grouped into 6 evidence categories:

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

Assessments may be responsive (in response to information of concern) or planned. In both cases, the CQC will be flexible and may expand the scope of an assessment as needed.

Key Questions and quality statements:

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Fundamental Standards (Regulations 9 to 20) have not changed. The new quality statements (example outlined below) are informed by these key regulations.

The Single Assessment Framework is made up of five key questions and under each key question, is a set of quality statements, is the service:

- Safe
- Effective
- Caring
- Responsive
- Well-Led

Quality statements are the commitments that providers, commissioners and system leaders should live up to. Expressed as 'we statements', they show what is needed to deliver high-quality, person-centred care.

The quality statements show how services and providers need to work together to plan and deliver high quality care. They directly relate to the regulations listed.

- Sub-topics contained within the Quality Statements can be found in Appendix A.

Each of the sub topics has a quality statement in which all providers, commissioners and system leaders are expected to live up to.

1.1 Enforcements and offences

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

A breach of the following offences may be prosecuted directly:

Breach of regulations	
Regulation 11	Need for consent: care and treatment may only be provided with consent.
Regulation 16(3)	Receiving and acting on complaints: a summary of complaints, responses, correspondence and other relevant information identified must be provided to CQC within 28 days of a request.
Regulation 17(3)	Good governance: a report into how the registered person is complying with the good governance requirements and their plans for improvement of services delivered must be provided to CQC within 28 days of a request.
Regulation 20 (2)(a)	Duty of candour: registered persons must as soon as reasonably practicable notify a service user (or person lawfully acting on their behalf) when an unintended or unexpected incident occurs that has or could have resulted in death, severe harm, moderate harm or prolonged psychological harm to the service user.

Breach of regulations	
Regulation 20(3)	Duty of candour: notifications given under Regulation 20(2)(a) must meet specific requirements.
Regulation 20A	Requirement as to display of performance assessments: providers must display on their website details of CQC's website, the most recent CQC rating and the date it was given. They must also display the most recent rating at each location where regulated activities are provided from and at the provider's principal place of business. Signs must be legible, conspicuously displayed and show the date the rating was given.

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

To be able to prosecute for the following offences, they need a further qualification, which is that the breach results in people who use services being exposed to avoidable harm or significant risk of such harm occurring or suffering a loss of money or property as a result of theft, misuse or misappropriation

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

A breach of the following offences may be prosecuted directly:
Regulation 12 Statement of purpose
Regulation 14 Notice of absence
Regulation 15 Notice of changes

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

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

2.0 Purpose

The purpose of this policy is to provide staff with information to understand their responsibility for collecting evidence and demonstrating compliance with the standards of quality and safety.

3.0 Duties

3.1 Trust Board

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

3.2 Trust Chair

The Trust Chair is responsible for informing the CQC that all Directors and Senior Managers acting at Trust Board level are compliant with Regulation 5: Fit and proper person requirement for directors.

3.3 Quality Governance Committee

The Committee is directly accountable to the Board and seeks to provide assurance relating to systems and procedures concerning

patient safety. The Committee will receive reports relating to CQC compliance and issues highlighted in order to provide assurance to the Board, or to raise concerns.

3.4 Chief Executive

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

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

3.5 Chief Paramedic (Allied Health Professional) and Director of Quality

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

3.6 Head of Compliance

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

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

3.7 Evidence collation

The Trust has a compliance software system (with integrated evidence storage platform) to demonstrate completion of actions

and in identifying the ways in which the Trust complies with the Care Quality Commission's Single Assessment Framework/Quality Statements within each Key Question.

3.8 'Accountability Owners'

The 'Accountability Owners' are defined as individuals who have Trust level responsibility for designated quality statements. They are responsible for these on an ongoing basis;

- Identifying, evaluating and linking evidence
- Liaising with the 'Shared Users' (other contributors) within their designated quality statements to ensure thorough assessments are completed
- Determining CQC compliance ratings
- Determining and updating actions where required

3.9 'Shared Users'

The Shared Users are responsible for the following areas within their designated quality statements on an ongoing biannual basis;

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

3.10 Communications Team

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

3.11 Operational and EOC Managers

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

4.0 Definitions

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

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

5.0 Development

5.1 Prioritisation of Work

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

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

5.3 Responsibility for Document's Development
The Head of Compliance is responsible for the review and update of this policy every three years unless prompted earlier by CQC or Regulation amendments.
This Policy will be approved in line with internal processes.

6.0 Reporting requirements

6.1 Quality Statements

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

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

To enable robust monitoring and assurance, there are two levels of assessment, which are required to be undertaken at least on an annual basis and which will be supported by local operational processes.

LEVEL 1

East of England Ambulance Service NHS Trust

Overall Trust Position

Chief Paramedic (Allied Health Professional) & Director of Quality

LEVEL 2

Specialist Leads

To complete assessment using review of operational Quality Statements and Trust evidence, processes and data/intelligence

7.0 CQC Ratings

Ratings must be displayed legibly and conspicuously to make sure the public, and in particular the people who services, can see them. In line with CQC requirements, ambulance trusts are required to display three types of poster:

1. Provider Poster	Overall rating and five key questions
2. Premises poster	Overall rating and five key questions
3. Activity poster (core services/population groups)	Overall rating and five key questions (if available) for each activity

Ratings are not required to be displayed on ambulances.

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

Appendices

A	Quality Statements
B	Monitoring Table
C	Equality Analysis

Appendix A Quality 'We' Statements

Definitions	
SAFE	Learning culture Safe systems, pathways and transitions Safeguarding Involving people to manage risks Safe environments Safe and effective staffing Infection prevention and control Medicines optimisation
EFFECTIVE	Assessing needs Delivering evidence-based care and treatment How staff, teams and services work together Supporting people to live healthier lives Monitoring and improving outcomes Consent to care and treatment
CARING	Kindness, compassion and dignity Treating people as individuals Independence, choice and control Responding to people's immediate needs Workforce wellbeing and enablement
RESPONSIVE	Person-centred care Care provision, integration, and continuity Providing information Listening to and involving people Equity in access Equity in experiences and outcomes Planning for the future
WELL-LED	Shared direction and culture Capable, compassionate and inclusive leaders Freedom to speak up Workforce equality, diversity and inclusion Governance, management and sustainability Partnerships and communities Learning, improvement and innovation Environmental sustainability – sustainable development

Appendix B Monitoring table

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

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

What	Who	How	Frequency	Evidence	Reporting arrangements	Acting on recommendations	Change in practice and lessons to be shared
		managers to provide assurance that current posters are displayed on each of their premises					

Appendix C Equality Impact Assessment

<table>
<tr><th colspan="2">EIA Cover Sheet</th></tr>
<tr><td>Name of process/policy</td><td>Policy for Managing CQC Requirements</td></tr>
<tr><td>Is the process new or existing? If existing, state policy reference number</td><td>Existing
POL029</td></tr>
<tr><td>Person responsible for process/policy</td><td>Head of Compliance</td></tr>
<tr><td>Directorate and department/section</td><td>Clinical Quality Compliance and Standards</td></tr>
<tr><td>Name of assessment lead or EIA assessment team members</td><td>Head of Compliance</td></tr>
<tr><td>Has consultation taken place? Was consultation internal or external? (please state below):</td><td>No – content is defined to meet statutory requirements</td></tr>
<tr><td>The assessment is being made on:</td><td>
<table>
<tr><td>Guidelines</td><td></td></tr>
<tr><td>Written policy involving staff and patients</td><td>X</td></tr>
<tr><td>Strategy</td><td></td></tr>
<tr><td>Changes in practice</td><td></td></tr>
<tr><td>Department changes</td><td></td></tr>
<tr><td>Project plan</td><td></td></tr>
<tr><td>Action plan</td><td></td></tr>
<tr><td colspan="2">Other (please state)
Training programme.</td></tr>
</table>
</td></tr>
</table>

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

Please provide evidence: Equality, diversity and inclusion evidence is collected and provided as evidence for any CQC assessments
Are there any concerns that this policy/procedure/practice/event could have a negative impact on any of the following characteristics? No **Race** ☐ **Religion/belief** ☐ **Marriage/Civil Partnership** ☐ **Gender** ☐ **Disability** ☐ **Sexual orientation** ☐ **Age** ☐ **Gender re-assignment** ☐ **Pregnancy/maternity** ☐ Please provide evidence: Not applicable
Action Plan/Plans - SMART Not applicable
Evaluation Monitoring Plan/how will this be monitored? Not applicable