Our response to CQC Consultation:
Draft Adult Social Care Assessment Framework

Introduction and Organisational Context

Norfolk Care Association (NorCA) is the representative and development body for adult social care providers in Norfolk. We support and represent a broad range of providers across residential, nursing, domiciliary, supported living, extra care, and specialist care services. We welcome the opportunity to respond to this consultation on the draft adult social care assessment framework.

Our response is informed by direct engagement with our provider membership across Norfolk and our work at the interface between commissioning, regulation, and provider practice. We have structured this response to address the consultation questions in sequence, drawing on detailed analysis of the draft framework to identify both its strengths and areas requiring revision.

We wish to begin by noting that the development of a single, sector-specific adult social care framework is a positive and overdue step. The acknowledgement of the Care Provider Alliance's early feedback, and the explicit recognition of commissioning landscape factors, reflects a constructive intent. However, we have significant concerns about specific aspects of the framework that, if unaddressed, risk undermining its usefulness as both an assessment tool and a quality improvement resource for providers.

1. Will the framework support CQC to make clearer, more transparent judgements?

Partially. The revised structured key lines of enquiry (KLOEs) framed as questions is broadly positive. However, two structural problems significantly undermine the clarity and transparency of the judgement-making process.

The rating characteristics are not structured to support transparent judgement.

The current architecture presents four separate sets of rating characteristics - Outstanding, Good, Requires Improvement, and Inadequate - for each KLOE. Each set describes a distinct picture of quality at that level. This approach has a fundamental weakness: it makes it very difficult for providers, inspectors, or observers to understand how a specific practice or system maps to a rating level.

A provider seeking to understand whether their approach to a given KLOE is ‘Good’ or ‘Outstanding’ must read four separate descriptions, identify where their practice sits,

and infer the boundaries between levels. There is no single reference point - no core standard - against which to calibrate. The result is a framework that describes quality impressionistically rather than measuring it.

We would strongly advocate for a restructured approach in which:

- Each KLOE is defined by a set of clear core standard statements - what good practice looks like.
- A four-point rating scale then describes how practice relates to that standard: Exceeds (Outstanding), Meets (Good), Partially Meets (Requires Improvement), or Fails to Meet (Inadequate).
- The rating-level descriptors then elaborate the character of performance at each point, rather than defining an entirely separate picture of quality.

This approach, standard-anchored with a relational rating scale, is more legible, more equitable, and far better suited to supporting providers in building quality systems. It also mirrors approaches used in other regulated sectors and is consistent with how providers are advised to structure their own internal quality frameworks.

The framework does not consistently distinguish between what is within provider control.

The framework's stated intention to recognise the commissioning landscape is welcome. However, this principle is not consistently applied through the rating characteristics. Providers working within tightly commissioned environments, with staffing ratios limited by funding rates, or care packages, may be judged against standards that reflect resourcing decisions made elsewhere in the system. This is particularly acute in workforce, the ability to implement approaches such as trauma informed care that may be commissioner directed or limited, and the ability to assess, respond and innovate care and not be able to invest in new ways of working.

2. Will the framework help providers understand what CQC will look at?

The KLOEs are broadly well-scoped and the listing of topic areas within each gives providers a useful signal of inspection focus. This is an improvement on the previous approach.

However, the utility of the framework as a provider-facing resource is significantly limited by the structural issue identified above. A provider seeking to use this framework to build or audit their quality systems faces a document that describes quality in four separate registers for each KLOE, without a unified standard. This makes it difficult to use the framework as an organising spine for a quality management system.

We would also note that the Outstanding characteristics in particular are expressed in language that is difficult to translate into operational practice - a concern we address in detail under Question 4.

The framework and the limits of provider agency.

Whilst we acknowledge previous statements by CQC that its purpose is to assess whether care is sufficiently high quality and that this assessment should not be compromised by environmental factors we feel it is only fair, and operationally necessary, to distinguish between situations in which providers are able to take meaningful action to improve quality and those in which they cannot. A framework that holds providers to account for outcomes shaped by commissioning decisions, funding settlements, or system-level failures risks conflating poor care with constrained care, with significant consequences for providers' ratings, reputation, and morale. The framework states 'recognising the commissioning landscape and ensuring the framework distinguishes between areas within and outside of the control of the provider' as a key theme but we feel this is insufficiently followed through on.

This concern extends beyond the provider-commissioner relationship. The quality of care that people receive is substantially shaped by the functioning of the wider system: the effectiveness of local authority adult social care functions, the quality of integration between health and social care, the responsiveness of NHS community services, and the coherence of local safeguarding arrangements. Whilst we fully support the development of a sector-specific adult social care framework and recognise that CQC must assess what is within a provider's control, we ask that the framework and its implementation guidance explicitly acknowledge that overall care quality depends on an effective system. Where systemic failings are identified through inspection - whether in commissioning practice, health integration, or local authority function - these should be escalated through CQC's wider regulatory and system oversight responsibilities rather than translated into individual provider ratings.

3. Will the framework help CQC and providers identify and address inequalities in care?

The framework references equity, equality, and inclusion throughout and this is positive. References to protected characteristics, the Equality Act 2010, inequitable outcomes, and structural barriers to access appear consistently across all five key questions. This reflects a welcome alignment with the broader direction of travel in adult social care policy and is an advance on the previous framework.

We particularly note the following as positive:

- The explicit inclusion of equity in access, outcomes, and experience as KLOE-level considerations, not merely as supplementary indicators.

- The attention to communication needs, the Accessible Information Standard, and digital exclusion within Timely and Equitable Access.
- The incorporation of protected equality characteristics in workforce culture under Well-Led.

We have some reservations, however, about whether the framework sufficiently distinguishes between inequalities that providers can directly address and those that are systemic in origin - rooted in commissioning decisions, funding structures, or referral pathways. Providers should be assessed on their response to inequality within their sphere of influence, with appropriate recognition given where systemic factors constrain their options.

4. Comments on the Key Lines of Enquiry

The KLOEs are, in the main, well-framed and appropriately scoped. The use of structured questions is welcome, and the topic area listings provide useful orientation. Our substantive concerns are about the rating characteristics that sit beneath the KLOEs, addressed under Question 5.

We would observe that the relationship between some KLOEs and their scope listings could be tighter. For example, the Safe Systems, Pathways and Transitions KLOE encompass delegation of clinical activities - a complex area with specific legal and governance implications - alongside care co-ordination and continuity. Given the significance and developing nature of healthcare delegation in social care settings, there may be a case for a dedicated KLOE or for clearer signposting within this one.

We support the decision not to include environmental sustainability in this iteration of the framework. There is a need to understand a proportionate response in this area that is deliverable within current operating context. We also wish to emphasize that the CQC should restrict itself to those factors that determine the quality of care received by an individual.

5. Comments on Rating Characteristics

This section represents our most detailed feedback. We have identified two categories of concern: (a) Outstanding-level characteristics that are expressed in language that is difficult to evidence and potentially unfair in its application; and (b) characteristics at other levels that are ambiguously worded, context-dependent, or likely to produce inconsistent judgements.

A. Outstanding characteristics that are difficult to evidence or inherently context-dependent

A well-constructed Outstanding standard should be achievable in principle by any provider in the sector, and evidencable through observable practice, documentation,

or outcomes. Several Outstanding characteristics in this draft fail this test - either because they depend on circumstances the provider cannot control, or because the language used is inherently impressionistic and resistant to consistent interpretation.
We set out our primary concerns below:

Safeguarding - Outstanding

> *The approach to safeguarding is innovative, rights-based and comprehensive, which transforms people's lives and protects their safety, wellbeing and autonomy.*

The word 'transforms' is particularly problematic here. Transformation implies a before-and-after change of significant magnitude. For many providers, especially those supporting people whose needs are stable and well-met, there may be no opportunity to demonstrate 'transformation' - not because safeguarding practice is inadequate, but because the people they support are already safe, supported, and have their rights respected. An Outstanding provider of this kind would be unable to satisfy this characteristic. 'Transforms' should be replaced with language about embedding and sustaining rights-based practice and its positive impact on people's wellbeing.

Safe Environments - Outstanding

> *Psychological safety is embedded in the environmental design. Trauma-informed design principles are applied, and staff are highly skilled and confident in recognising and responding to emotional and sensory needs as part of the care environment.*

Trauma-informed design is a specialist area that is not yet standard practice across the adult social care sector. Our concern is the ability for providers to deliver this across all settings and client groups; for example, in short commissioned domiciliary visits or where client communication is limited. We also note that this is yet another additional area of expertise providers are required to gain. Whilst we recognise the value of trauma informed approaches, we question whether requiring providers to gain additional domain expertise or strengthening a focus on strong person-centred care approaches will achieve better care quality results.

Safe Systems, Pathways and Transitions - Outstanding

> *Multi-disciplinary teams work cohesively across boundaries with shared accountability. Where appropriate, partners hold joint ownership of safety and manage shared risks comprehensively.*

The ability to achieve this depends heavily on the behaviour and capacity of health system partners - ICB teams, GP practices, community nursing. A provider that has proactively pursued joint working but has been unable to secure consistent partner engagement should not be penalised for systemic gaps outside their control. Equally one that is commissioned only with single team expertise should not

be penalised for not being able to demonstrate MDT approaches. Outstanding should recognise the quality of the provider's effort and contribution to joint working, not only outcomes that require partner reciprocity.

Safe Staffing - Outstanding

> *Recruitment processes are inclusive, values-based, and co-designed with people who use services. They go beyond compliance to actively seek diverse talent that reflects the community.*

Co-designing recruitment processes with people who use services is an excellent aspiration but requires the people using the service to wish to be involved in this way, and the capacity and accessibility infrastructure to support meaningful participation. For services supporting people with high levels of cognitive or communicative impairment, this standard may be effectively unachievable without misrepresenting the nature of involvement. The characteristic should acknowledge the importance of proportionate and accessible co-production rather than implying a single model.

Assessing Needs - Outstanding

> *A consistent, holistic approach to assessing, planning and delivering care means that people's quality of life, outcomes and independence are maximised and often exceed expectations.*

'Exceed expectations' is particularly difficult to evidence consistently or fairly. Whose expectations are the benchmark? The person's own? The commissioners? The GPs? The families? For people with progressive or life-limiting conditions, exceeding expectations may be clinically impossible even with excellent care. This characteristic conflates quality of practice (which can be Outstanding) with outcome (which may be constrained by factors entirely outside the provider's control).

Supporting People to Live Healthier Lives - Outstanding

> *Links with health and social care services are excellent, encouraging other providers to follow this partnership model.*

This requires the provider to be both demonstrably excellent in its partnerships and to have a documented influence on other providers' behaviour - an evidential bar that may be more accessible to larger, higher-profile providers and effectively out of reach for smaller, specialist, or rural services operating with limited infrastructure for sector leadership activity. Outstanding should not systematically advantage scale.

Evidence-Based Care - Outstanding

> *People's outcomes, including their quality of life, are consistently good and regularly exceed expectations.*

As above. 'Regularly exceed expectations' is not a consistent standard. Excellent palliative care, excellent support for people living with progressive neurological conditions, and excellent dementia care may all result in decline - but can still

constitute outstanding practice. Outcome language needs to be framed relative to the person's trajectory and condition, not against an unspecified baseline.

Improvement, Innovation and Learning - Outstanding

> *The service is a recognised leader and exemplar in its field, and its innovative approaches are sought out, adopted and adapted by others.*

This is not a standard that can be assessed on inspection - it describes a sector reputation that develops over time through channels entirely outside the provider's control. It may systematically advantage services with established academic or policy connections. Outstanding should describe what happens within the service, not how it is perceived externally.

B. Characteristics across rating levels that require clarification

Consistency of language around 'innovative' and 'creative'

Terms such as 'innovative', 'creative', and 'novel' appear extensively in Outstanding characteristics across multiple KLOEs, often without definition. Innovation is not a quality standard in itself - a provider that delivers consistently excellent, evidence-based, well-governed care using established methods is delivering outstanding care. The framework risks implying that repetition of established good practice is inherently insufficient for Outstanding. This should be addressed by reframing innovation-related language as one possible route to Outstanding, not a requirement.

Requires Improvement characteristics that describe inadequacy

In several sections - Safe Medicines, Governance, and Listening to Feedback in particular - some Requires Improvement characteristics describe practice that would, in most clinical or legal frameworks, constitute inadequacy: for example, controlled drugs not consistently stored in line with legislation, or consent not consistently obtained. There should be a more principled distinction between the two levels, with Requires Improvement describing practice that is inconsistent or developing, and Inadequate reserved for practice that is unsafe, unlawful, or persistently harmful.

Kindness, Compassion and Dignity - Outstanding

> *Staff in all roles are highly motivated and enabled to offer care and support that is genuinely compassionate and kind and is evident through strong communication and connections. Staff care for individual people and each other in a way that exceeds expectations.*

'Exceeds expectations' applied to compassion is not an evidencable standard. Inspectors cannot reliably operationalise 'exceeds expectations' as a threshold for Outstanding compassion - and there is a risk that this characteristic defaults to subjective impression rather than observable evidence.

6. Clarity of the Draft Framework

The language of the framework is, for the most part, clear and accessible. The decision to frame KLOEs as questions and to provide scope listings is helpful. The 'I statements' continue to be a useful anchor for person-centred inspection.

However, the overall document is very long, and the four-level structure for each KLOE makes cross-referencing extremely cumbersome. A provider seeking to understand where their practice sits on the rating scale for a given KLOE must compare four separate sections of text. We would recommend:

- A tabular or matrix presentation for each KLOE, showing how the characteristics differ across rating levels side by side.
- A summary overview table mapping each KLOE to its key evidential themes, to support providers in self-assessment and inspection preparation.
- Core standard statements per KLOE (as recommended above), which acts as the primary reference point.

7. Do the Four Frameworks Represent the Sectors Appropriately?

We confine our view here to the adult social care framework. We note that adult social care encompasses an exceptionally diverse range of service types - from large residential and nursing homes to sole-trader domiciliary services, from highly specialist acquired brain injury rehabilitation to light-touch sheltered housing support. The framework has made reasonable efforts to accommodate this diversity, and we recognise that the alternative - multiple sub-sector frameworks - brings its own complexity.

We would, however, note the following concerns about sector fit:

- The framework implicitly assumes a level of organisational infrastructure (governance boards, workforce leads, partnership managers) that is not present in many smaller providers. Some Outstanding characteristics are structurally more accessible to larger organisations.
- The framework's treatment of the commissioning relationship is welcome in principle but insufficient in practice. Several areas - staffing levels, continuity of care, environmental standards - are directly shaped by commissioning decisions, and providers should not bear the full evidential burden for outcomes determined elsewhere.
- The framework could more explicitly acknowledge the distinct operating context of micro-providers and sole traders, who now constitute a significant and growing part of the market in many areas, including Norfolk.

The system context within which providers operate

A sector-specific assessment framework is appropriate and necessary. However, care quality for any individual does not depend solely on the provider delivering their direct care - it depends on the whole system functioning effectively. The quality of local authority adult social care commissioning and care management, the degree of integration between health and social care locally, the responsiveness of NHS community and specialist services, and the effectiveness of local safeguarding boards and quality assurance arrangements all have a direct and material bearing on the outcomes that providers can achieve.

We ask that CQC gives explicit recognition to this system dependency both within the framework and in its wider regulatory communications. Where CQC's inspection activity identifies patterns of concern that point to systemic rather than provider-level failure - for example, where multiple providers in an area are encountering the same difficulties at the health-social care interface, or where care plan quality reflects local authority practice rather than provider deficiencies - this intelligence should actively inform CQC's system oversight function. The adult social care provider framework cannot be read in isolation from the performance of the commissioners, health partners, and local systems within which providers operate.

8. Overall Comments - What Is Missing or Overlapping?

The commissioning context requires stronger, more consistent recognition

The framework's preamble acknowledges the commissioning landscape, following CPA feedback. However, this acknowledgement does not translate consistently into the rating characteristics. We would recommend that:

- A standing contextual note is included within the framework - and embedded in inspector guidance - making explicit that where a provider demonstrates that practice is constrained by commissioning arrangements, resourcing decisions, or system factors, this context will be weighed in the assessment.
- Outstanding characteristics in areas such as staffing, environment, and continuity of care do not implicitly require resourcing levels that are not available in the commissioned market.

The framework is silent on provider-commissioner relationships as a quality lever

The Well-Led sections Partnerships and Communities KLOE focus on community and external relationships but does not explicitly address the quality of the provider-commissioner relationship. Given that commissioning decisions are one of the most significant determinants of care quality - shaping staffing ratios, care package hours, and admissions policies - the framework misses an opportunity to assess whether providers are engaging constructively with commissioners, raising concerns about

care quality through appropriate channels, and working collaboratively to manage quality risks at the interface between the two organisations.

Health delegation deserves more explicit treatment

The growing complexity of healthcare delegation in care home and domiciliary care settings - including insulin administration, PEG feeding, complex wound care, and catheter management - is acknowledged in the Safe Systems KLOE but not developed into sufficiently detailed rating characteristics. Given the patient safety implications and the legal and governance complexity of this area, we would recommend dedicated and more granular rating characteristics for healthcare delegation, potentially as a distinct KLOE within Safe.

Workforce sustainability should be addressed explicitly

The framework addresses workforce equity, culture, and safe staffing but does not explicitly address workforce sustainability - the long-term capacity of providers to recruit and retain a workforce sufficient to deliver safe, high-quality care. In the current context of structural workforce shortages, significant numbers of providers are operating under sustained pressure in this area. The framework should assess the quality of providers' strategies for workforce sustainability, rather than implicitly treating workforce gaps as evidence of inadequate leadership.

Cyber security and digital systems need fuller treatment

Cyber security and the Data Security and Protection Toolkit (DSPT) are listed within the Governance KLOE scope but are not developed into meaningful rating characteristics in the draft. This is a growing area of risk for adult social care providers. We recommend that the final framework provides clearer evidential expectations around digital governance, the DSPT, and cyber security, proportionate to provider size and context.

Implementation: the framework must be effectively delivered to be effective

A well-designed framework will only achieve its purpose if it is implemented well. We wish to draw CQC's attention to a set of concerns about implementation that are distinct from the framework's content but equally important to its impact in practice.

Providers across our membership consistently report that the quality of their relationship with their CQC inspector is one of the most significant factors in whether regulatory engagement supports or hinders quality improvement. An inspector who knows a service, understands its history, and engages with its leadership in a professional and constructive manner enables providers to be genuinely open about emerging concerns and to use regulatory oversight as a quality lever. Where that relationship is absent - where assessors have no prior knowledge of the service, where there is high turnover of named contacts, or where engagement

is experienced as adversarial - the framework's aspiration to support transparency and learning cannot be realised.

We therefore ask that CQC gives explicit attention to the following implementation conditions:

- Assessor knowledge and continuity: providers should, where operationally possible, have consistency of named assessor contact, with assessors who have sufficient knowledge of the service and its context to make well-informed judgements.
- Assessor training and calibration: the subjectivity risks identified in this response - particularly around Outstanding characteristics - make robust assessor calibration essential. Providers need confidence that the framework is applied consistently across the sector.
- A genuinely supportive regulatory posture: CQC has an opportunity to position itself as a partner in quality improvement as well as a regulator of quality failures. The framework should be accompanied by clear commitments about how CQC will engage with providers who are working constructively to address concerns, and how inspection activity will recognise improvement trajectories rather than only point-in-time performance.
- Regular inspection: the value of a new framework depends on it being applied. Providers who have not been inspected under the new framework for extended periods will be unable to benefit from the transparency and clarity it offers. CQC should publish its intentions around inspection frequency and ensure that the resource is in place to implement them.

The framework represents a significant investment by CQC and the sector. The conditions for its effective implementation deserve the same attention as its content.