INSIGHT REPORT

How to Ensure Effective Systems and Processes Are in Place

to Assess, Monitor and Improve the Quality and Safety of Your Care Home Service

A practical governance guide for providers, registered managers, quality leads, commissioners, stakeholders, purchasers and investors

SAFE	WELL-LED	REGULATION 17

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Safe and Well-led: What this Insight Covers

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This insight focuses on CQC's Safe and Well-led key questions, including the quality statements linked to risk, safeguarding, medicines, staffing, governance, leadership, learning, culture and improvement.

Safe and Well-led are closely connected and together they demonstrate good quality care. Providers should be able to evidence strong systems, effective processes and confident oversight that drive safer practice, promote a positive culture and deliver better outcomes for people in the homes they manage.

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

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

Safe & Well-led Quality Statement Checklist

A practical self-assessment tool for care home providers

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Use this checklist to test whether your service can evidence the Safe and Well-led quality statements in practice. Tick each statement where evidence is in place and use the gaps to inform your service improvement plan.

Safe

- ☐ **1.** We learn from incidents, safeguarding, complaints and near misses.
- ☐ **2.** We manage transitions and care pathways safely.
- ☐ **3.** We recognise, report and act on safeguarding concerns.
- ☐ **4.** We involve people in positive risk management and choice.
- ☐ **5.** We maintain safe environments, equipment and premises.
- ☐ **6.** We deploy enough skilled staff to meet people's needs safely.
- ☐ **7.** We prevent and control infection effectively.
- ☐ **8.** We manage, review and audit medicines safely.

Well-led

- ☐ **1.** We have a shared direction, values and positive culture.
- ☐ **2.** Our leaders are capable, compassionate and inclusive.
- ☐ **3.** Staff feel safe to speak up and concerns are acted on.
- ☐ **4.** We promote workforce equality, diversity and inclusion.
- ☐ **5.** We have effective governance, management and sustainability systems.
- ☐ **6.** We work well with partners, professionals and communities.
- ☐ **7.** We focus on learning, improvement and innovation.
- ☐ **8.** We consider environmental sustainability in our planning and practice.

Quick RAG review	● Green - clearly evidenced and embedded	● Amber - partially evidenced or inconsistent	● Red - not evidenced or requires urgent action

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1. Executive summary

For care home providers, effective governance is not simply about having policies, audits, meetings, dashboards and action plans in place. It is about being able to evidence that those systems are active, accurate, understood, monitored and leading to safer, better outcomes for people living in the service.

This is where CQC's key questions of Safe and Well-led become closely connected. A service cannot be safely delivered if risks are not known, monitored or acted upon. Equally, a service cannot be well-led if leaders do not have clear oversight of quality, safety, staffing, culture, risk and improvement.

> **Core provider question**
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> Can we evidence that our systems and processes identify risk, drive action, improve care and protect people from avoidable harm?

CQC Regulation 17 requires providers to have effective governance, including assurance and auditing systems or processes. These systems must assess, monitor and drive improvement in the quality and safety of services and must assess, monitor and mitigate risks to people's health, safety and welfare.

This report sets out what this means in practice, how CQC triangulates evidence, how different roles should read CQC findings alongside the quality statements, and what may happen when providers cannot evidence effective systems and processes.

2. Why this matters

Good governance is not a paperwork exercise. It is the mechanism that allows a provider to know whether people are safe, whether staff are delivering care in line with assessed needs, and whether leaders have enough oversight to identify and reduce risk.

Recent inspection learning across adult social care continues to show repeated concerns where providers had audits, meetings and action plans, but these systems did not always identify the risks later found during inspection. PGQ Solutions has deliberately anonymised the examples below because the learning is sector-wide, not service-specific.

- medicines audits not identifying unsafe or inconsistent practice;
- care plans containing conflicting, incomplete or outdated information;
- risk assessments not reflecting people's current needs;
- specific risks not being consistently understood by staff;
- incidents, safeguarding concerns and complaints recorded but not analysed for themes;
- staffing systems not evidencing that staffing levels are linked to dependency and risk;
- actions recorded as complete without evidence that practice improved;
- provider oversight not identifying repeated or escalating shortfalls;
- leaders unable to clearly explain what had improved or how they knew people were safer.

> **PGQ Solutions view**
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> Having paperwork is not the same as having assurance. A service may look organised on paper but still be unsafe if the systems do not identify, escalate and resolve risk.

3. Why Safe and Well-led must be read together

CQC's assessment framework is made up of five key questions: Safe, Effective, Caring, Responsive and Well-led. Under each key question sit quality statements that describe what providers should live up to when delivering high-quality, person-centred care.

Safe

Safe asks whether people are protected from avoidable harm, abuse, neglect and discrimination; whether risks are identified and acted upon; whether there are enough skilled staff; whether medicines and infection prevention are managed safely; and whether learning happens when things go wrong.

Well-led

Well-led asks whether leaders understand the service, whether governance systems are effective, whether information about risk and performance is used to improve care, and whether there are clear responsibilities, roles, accountability and oversight.

Finding	Governance interpretation
Medicines error	May indicate a Safe issue. Repeated errors without trend analysis may indicate a Well-led issue.
Falls risk	May indicate a Safe issue. Failure to update care plans, review staffing and monitor outcomes may indicate a Well-led issue.
Poor care records	May create Safe risks. Repeated poor recording despite audits may indicate ineffective oversight.
Environmental hazard	May be a Safe concern. Poor escalation and unresolved maintenance actions may indicate governance failure.

Self-reflection

Is this an isolated practice issue, or does it show that our systems failed to identify, escalate or resolve the risk?

4. What effective systems and processes look like in practice

Effective governance should create a clear line of sight from the person receiving care to the provider, nominated individual, director or board. A strong governance system should not sit in a folder. It should be visible in daily practice.

- what the current risks are;
- how those risks were identified;
- who is responsible for managing them;
- what action has been taken;
- whether the action has reduced the risk;
- how learning has been shared;
- how residents, relatives and staff have been involved;
- how the provider knows improvement has been embedded.

Governance component	What it should evidence
Structured audit programme	Audits should cover medicines, care plans, IPC, safeguarding, incidents, staffing, training, supervision, the environment, nutrition, hydration, falls, pressure care and governance. They should identify risk, actions, responsible leads, deadlines, evidence and learning.
Live service improvement plan	The SIP should include clear actions, named owners, target dates, risk ratings, progress updates, evidence of completion, management review and provider oversight.
Current risk register	The risk register should capture service-level risks including medicines, staffing, safeguarding, care planning, IPC, environment, leadership capacity, training, complaints, culture and repeated incidents.
Clear provider oversight	Provider visits should test whether risks are known, whether actions are completed, whether staff understand changes, and whether people experience improvement.
Evidence of learning	The service should show how it learns from incidents, complaints, safeguarding, feedback, audits, provider visits, professional feedback and CQC findings.
Confirmation that actions worked	Closing an action is not enough. Providers should check whether the issue improved, the risk reduced, staff practice changed and outcomes for people improved.

The governance loop

Governance component	What it should evidence
	Risk identified -> action taken -> evidence gathered -> outcome reviewed -> learning embedded.

5. How CQC triangulates evidence

CQC does not look at one document in isolation. It triangulates evidence. This means that CQC may compare what the provider says with what staff say, what residents and relatives say, what professionals say, what records show, what audits show and what inspectors observe.

CQC may compare

- provider and Registered Manager explanations;
- staff and leader feedback;
- people's experience and relative feedback;
- partner, commissioner and professional feedback;
- care plans, risk assessments and daily notes;
- audits, incident logs, safeguarding records and complaints;
- observation of care, medicines, environment and staff practice;
- outcomes being achieved for people.

Example: medicines assurance

If a provider states that medicines are well managed, CQC may review the medicines audit, MAR charts, stock balances, PRN protocols, medicines care plans, staff competency records, medicines incidents, staff knowledge, people's experience and management oversight.

> **Triangulation risk**
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> If the audit score says medicines are safe, but MAR charts, stock checks, staff knowledge or incidents show otherwise, the evidence does not triangulate. That is where providers become exposed.

6. What good evidence looks like

Good evidence should be clear, current and connected. It should show that the service identified the risk, understood the cause, acted proportionately, reviewed whether the action worked and embedded the learning.

Example 1: falls risk

Risk identified	Increase in falls during the evening period.

Evidence reviewed	Incident forms, falls log, care plans, risk assessments, dependency tool, staffing rota, sensor mat checks, staff feedback and family feedback.
Action taken	Falls risk assessments updated, care plans amended, evening staff deployment reviewed, equipment checked, referral made to falls team, family informed and staff reminded through handover and supervision.
Oversight	Reviewed by the Registered Manager and provider.
Outcome	Reduction in evening falls, improved staff awareness, updated records and evidence of ongoing monitoring.

Example 2: medicines risk

Risk identified	Repeated gaps in topical medicines records.
Evidence reviewed	MAR charts, body maps, medicines audit, staff competency, care notes, resident feedback and stock checks.
Action taken	Body maps updated, competency refreshed, daily senior checks introduced, audit frequency increased and errors reviewed in team meeting.
Oversight	Manager reviewed weekly for four weeks; provider reviewed through quality report.
Outcome	Improved recording, no repeated gaps and staff able to explain the process.

7. Warning signs of weak governance

Weak governance is not always obvious at first. The service may appear organised, but the evidence does not demonstrate control. The risk is that leaders believe assurance is in place while the system is not detecting deterioration.

- audits scoring highly despite known concerns;
- repeated actions appearing month after month;
- action plans with no named owner or deadline;

- actions marked complete without evidence;
- care plans reviewed with "no change" but no meaningful evaluation;
- risk registers not updated after incidents;
- provider visits that do not test quality and safety;
- staff unaware of current risks or improvement priorities;
- residents and relatives not involved in improvement;
- governance meetings without clear actions;
- no analysis of themes from complaints, safeguarding or incidents;
- dependency tools not linked to staffing decisions;
- no evidence that learning changed practice.

8. Reading a CQC report through the quality statements

A CQC report should not be treated as a document for the Registered Manager alone. It should be used as a whole-service learning and governance tool. Each finding should be translated into responsibilities, evidence and improvement measures.

1. What did CQC find?
2. Which key question does this relate to?
3. Which quality statement does this sit under?
4. Which regulation may be affected?
5. Who owns this area?
6. What does this mean in daily practice?
7. What evidence would show improvement?
8. How will the provider know the improvement is embedded?

> **Central role-based question**
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> What does this finding mean for my role, and what evidence should I be producing to show improvement?

9. Role-based responsibilities across the service and organisation

A CQC report should be broken down by role. This makes improvement practical and prevents all accountability being placed on one person. The table below can be used by providers to translate CQC findings into operational ownership.

Role	What this means	Evidence to produce	Practical test
Frontline care staff	Understand what the finding means for the people they support; know current risks; follow updated care plans; record accurately; escalate concerns promptly.	Daily notes, charts, incident reports, escalation records, handover attendance, learning session records.	Would staff knowledge, care records and CQC observation all tell the same story?
Senior carers / shift leaders	Check that staff follow current care plans; monitor risks each shift; support accurate records; brief agency/new staff; escalate unresolved risk.	Shift handovers, walkaround checks, escalation records, medicines checks, spot checks, incident follow-up.	If the manager was not in the building, would senior staff still know current risks and act on them?
Nurses / clinical leads	Review clinical risk; update clinical care plans; ensure medicines, wounds, deterioration and referrals are safely managed.	Clinical risk reviews, wound records, medicines audits, competencies, GP/SALT/falls/dietitian referrals, clinical supervision.	Can the service evidence that clinical risks are known, reviewed, escalated and safely managed?
Ancillary teams	Maintain a safe environment; escalate repairs; evidence IPC, food safety, equipment and premises checks.	Cleaning schedules, IPC audits, maintenance logs, fire checks, equipment servicing, water temperatures, kitchen and allergen records.	Would CQC observation of the environment match audit scores and maintenance records?
Registered Manager	Lead improvement; identify immediate risk; link findings to quality statements/regulations; evidence progress and embed change.	SIP, risk register, audits, action evidence, supervision, governance minutes, feedback, incident/safeguarding/complaint analysis, provider reports.	Can the manager explain what has improved in the last 30, 60 and 90 days, and evidence it?
Provider / NI / directors	Ensure oversight is active; test assurance; ask why systems did or did not identify risk; allocate resources; challenge and support the manager.	Provider visit reports, director/board minutes, risk escalation records, resource decisions, staffing oversight, quality assurance reports.	Could the provider explain the service's top risks without relying solely on the Registered Manager?
Quality manager / governance lead	Identify themes and system failure; check whether actions are closing the issue or only closing the task; share learning across the organisation.	Thematic analysis, audit trends, SIP oversight, risk register review, dashboards, lessons learned reports, action verification.	Can the organisation show that it learns from one report and prevents the same issue happening again?
Commissioners / LA / ICB	Assess safety, transparency, improvement progress, placement risk, safeguarding risk and contract confidence.	Immediate risk controls, provider updates, timescales, assurance reports, evidence of improvement.	Would a commissioner feel confident that the provider knows the risk, owns the risk and is reducing the risk?

Role	What this means	Evidence to produce	Practical test
Residents and relatives	Understand whether people are safe, listened to and experiencing visible improvement.	Resident/relative meetings, accessible updates, "you said, we did", complaints learning, evidence that feedback changed practice.	Would residents and relatives recognise the improvements being described by the provider?
Lenders, purchasers and investors	Consider regulatory, operational, workforce, environmental and governance risk; assess whether risk is understood and manageable.	Due diligence reports, CQC action plans, risk registers, staffing evidence, capex requirements, governance assurance, improvement trajectory.	Does the report show manageable improvement actions, or a provider that does not yet understand its own risk?

10. Self-reflection questions for providers

Safe: provider reflection

- Do we know who is currently at highest risk?
- Are care plans and risk assessments accurate and current?
- Can staff explain the risks for the people they support?
- Are falls, choking, pressure damage, nutrition, hydration, medicines, diabetes, constipation, infection prevention and distressed behaviour reviewed consistently?
- Are safeguarding concerns analysed for patterns?
- Are medicines errors reviewed for themes?
- Are environmental risks identified and acted upon quickly?
- Are staffing levels linked to people's dependency and risk?
- Are agency and night staff aware of current risks?
- Can we evidence that lessons from incidents have changed practice?

Safe practical test

If CQC asked a member of staff about a resident's current risk, would their answer match the care plan, the risk assessment, the daily notes and what CQC observes?

Well-led: provider reflection

- Do we have a clear governance structure from staff level to provider level?
- Are audits completed honestly?
- Do audits identify the same issues that CQC, commissioners, residents or relatives would identify?
- Are findings analysed for themes and trends?
- Are actions allocated to named people with deadlines?
- Are overdue actions escalated?
- Does the provider receive regular quality and safety information?
- Does the Registered Manager receive support and challenge?
- Do staff feel able to raise concerns?

- Is feedback used to improve care?
- Can we evidence what has improved in the last 30, 60 and 90 days?

> **Well-led practical test**
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> If the provider was asked today, "What are your top five risks and what are you doing about them?", could they answer clearly and evidence it?

11. What happens when providers cannot evidence this

If a provider cannot evidence effective systems and processes, the concern is not simply administrative. It may indicate that the service cannot demonstrate safe and well-led care. The real issue is not whether the provider had an audit. The issue is whether the audit worked.

- CQC may identify a breach of Regulation 17 Good governance;
- related concerns may be linked to Regulation 12 Safe care and treatment where people are exposed to avoidable harm or risk of harm;
- staffing concerns may be linked to Regulation 18 where staffing levels, skills or deployment do not meet people's needs;
- the provider may be required to produce an action plan or written report;
- warning notices or other enforcement action may be considered where risk is significant;
- ratings may be affected, including Requires Improvement or Inadequate outcomes;
- commissioner scrutiny may increase;
- families and professionals may lose confidence;
- lenders, purchasers or investors may reduce confidence or seek additional assurance;
- people may be exposed to avoidable harm because risks are not identified or acted upon quickly enough.

12. The PGQ Solutions provider assurance test

Providers should regularly ask the following questions and ensure the answers can be evidenced through records, observation, staff knowledge, feedback and outcomes.

9. What are our top five risks today?
10. How do we know these are the top risks?
11. Where is this evidenced?
12. Who owns each risk?
13. What action is being taken?
14. What is overdue?
15. What has been escalated?
16. What has improved?
17. What has not improved?
18. How do we know people are safer as a result?

PGQ Solutions assurance statement

If these questions cannot be answered clearly, the governance system may not be providing effective assurance.

13. Minimum evidence checklist

At minimum, a care home should be able to produce the following evidence. The presence of these documents alone is not enough; the provider must evidence that they are used, understood and making a difference.

[ ] Structured audit programme	[ ] Live service improvement plan
[ ] Current service risk register	[ ] Provider oversight reports
[ ] Governance meeting minutes with actions	[ ] Incident, accident and safeguarding analysis
[ ] Complaints and feedback analysis	[ ] Care plan and risk assessment review system
[ ] Staffing and dependency oversight	[ ] Training, supervision and competency records
[ ] Resident and relative feedback	[ ] Staff feedback and freedom-to-speak-up evidence
[ ] Learning alerts or team briefings	[ ] Evidence of action closure
[ ] Evidence that improvements were checked and embedded	[ ] Clear escalation routes to provider/director level

14. Closing statement from PGQ Solutions

Safe and Well-led services do not wait for CQC to identify risk. They know their own service. They can evidence what is working, what is not working, what action is being taken and what outcomes are improving.

Good governance protects people, supports staff, strengthens leadership and gives providers confidence that quality and safety are being actively monitored.

Final reflection

If CQC entered your service tomorrow, would your audits, risk register, care records, staff feedback, resident experience, incident analysis and provider oversight all tell the same story?

The strongest providers can evidence:

- We knew the risk.
- We acted on it.
- We monitored it.
- We involved people.

- We learned from it.
- We improved the outcome.

That is what effective systems and processes should look like in practice: not just a completed action plan, not just an audit score, and not just a provider visit, but a clear, triangulated line of evidence showing that risk was known, action was taken, practice changed and people experienced safer, better care.

15. References

The regulatory references below were checked against official CQC guidance before finalising this website-ready insight report.

CQC Assessment framework: https://www.cqc.org.uk/guidance-regulation/providers/assessment/assessment-framework

CQC Assessing quality and performance: https://www.cqc.org.uk/guidance-regulation/providers/assessment/assessing-quality-and-performance

CQC Regulation 17: Good governance: https://www.cqc.org.uk/guidance-regulation/providers/regulations-service-providers-and-managers/health-social-care-act/regulation-17

CQC Safe assessment framework: https://www.cqc.org.uk/guidance-regulation/providers/assessment/single-assessment-framework/safe

CQC Governance, management and sustainability quality statement: https://www.cqc.org.uk/guidance-regulation/providers/assessment/single-assessment-framework/well-led/governance-management-sustainability

CQC Regulation 12: Safe care and treatment: https://www.cqc.org.uk/guidance-regulation/providers/regulations-service-providers-and-managers/health-social-care-act/regulation-12

CQC Regulation 18: Staffing: https://www.cqc.org.uk/guidance-regulation/providers/regulations-service-providers-and-managers/health-social-care-act/regulation-18