Homecare Association submission to the Care Quality Commission consultation on the draft sector-specific assessment framework for Adult social care.

Submitted via the CQC website on 11th June 2026

The Homecare Association welcomes the opportunity to comment on the draft adult social care assessment framework. Homecare (domiciliary care) plays a central role in helping people drawing on care and support to live safely and independently at home, avoid unnecessary hospital admissions, and maintain control over their daily lives. The framework includes many positive features, particularly its stronger emphasis on outcomes, equity, human rights, and lived experience.

Our response makes four core points. First, the framework needs stronger homecare-specific application. Second, it must distinguish provider control, provider influence and wider system constraints. Third, it should reduce overlap between KLOEs. Fourth, it should define rating thresholds and evidence expectations more clearly, especially for small and medium-sized providers.

How we developed our response

This response draws on extensive evidence from the Association's policy work, including information from the Association's Quality and Compliance Specialist Interest Group and feedback from individual members from both small and large homecare providers. It also integrates insights from our response to last year's CQC consultation and from four key Homecare Association reports: *Care Quality Commission: Regulatory Performance in Homecare One Year On* (September 2025), *What is the CQC Looking For? Insights for Providers from Analysis of 1,052 CQC Homecare Inspection Reports 2024–2025*, and the *Care Provider Alliance CQC Single Assessment Framework Review – Final Report*.

We have also drawn on our latest published analysis of CQC assessment activity to 5 May 2026, *Unseen & Unrated: The widening CQC assurance gap in community social care, two years on (June 2026)* which shows that the position for community adult social care has deteriorated further since our September 2025 report. As detailed in this report the Association recommends the following:

1. Deploy surge capacity to clear the community backlog.
2. Ring-fence and rebalance assessment effort towards community social care in proportion to its share of the market.
3. Introduce a risk-based two-tier system so that never-assessed services receive a timely first assessment.

4. Publish monthly, sector-specific data on assessment completions and backlog reduction.

5. Commission an independent assessment of the resources required to maintain a three-year cycle across the expanded community market.

6. Protect inspection throughput during the transition to the new frameworks.

We have also considered CQC's 2017 adult social care KLOE framework. We are not arguing for a return to that model, but it provides a useful benchmark because it contained clearer applicability markers, including what applied to all services, what applied only where relevant, and what applied to services delivered in premises the provider did not control.

Question 1: Do you agree that the draft assessment framework(s) will support CQC to make clearer, more transparent judgements about quality?

Strongly agree / Agree / Neither agree nor disagree / Disagree / Strongly disagree

The Homecare Association agrees in part. The draft framework gives CQC a clearer structure for describing quality than high-level key questions alone. The expanded KLOEs and rating characteristics should help CQC explain the basis for its judgements more clearly and show more explicitly what sits behind each rating. The stronger emphasis on outcomes, equity, safety culture and lived experience also moves in the right direction. Providers across both our specialist groups also welcomed the overall streamlining, including fewer statements and less duplication than the Single Assessment Framework. They saw the return to KLOEs as a positive step because it gives the framework a clearer structure and makes it more recognisable for adult social care.

Comments from members:

"The move back to sector-specific KLOEs is an improvement because it is clearer and more recognisable for adult social care than the recent single-framework approach."

"My concern is not so much the headings themselves, but that many of them are still too high-level to show exactly what standards will be applied in practice."

However, the framework will not support sufficiently clear judgements for homecare unless CQC anchors it more explicitly in the realities of care delivered in people's own homes. Providers in both specialist groups raised strong concerns about how the framework will work, particularly around evidence expectations, inspector consistency and the lack of detailed guidance. Much of the draft still reads as though it has been designed for services that control a building, supervise staff on site and

manage care within a single location. Homecare operates differently. Care and support workers deliver support in people's own homes, often work alone, travel between visits, and rely on coordination from the registered manager, office team and, where relevant, the clinical lead. Unless CQC reflects that model more explicitly, inspectors and providers will continue to interpret the same wording in different ways. That will weaken consistency and reduce confidence in ratings.

Clarity matters even more because regulatory coverage in community social care, including homecare, has weakened further. Our August 2025 analysis found that only 29.7% of homecare locations had up-to-date ratings, while 70.3% were either unrated or had ratings over four years old. Our latest analysis, using CQC data downloaded on 5 May 2026, shows further deterioration: 36.9% of community social care locations were unassessed and 46.6% had ratings over four years old. In that context, CQC needs a framework that is simple, service-specific and fast to apply. A complex or repetitive framework will slow inspectors and providers down when the system already lacks capacity to maintain current ratings. It will also make it harder for CQC to restore public confidence and provide commissioners and families with ratings that reflect the current reality of care.

The framework also needs to distinguish much more clearly between what the provider controls directly, what the provider can influence, and what the provider should escalate but cannot resolve alone. That distinction matters particularly in homecare, where providers often work within fixed commissioned care packages, short commissioned call lengths, incomplete referral information, housing conditions they do not control and limited access to wider NHS support. The draft introduction recognises this issue, but the detailed KLOEs and rating characteristics do not yet apply that principle consistently.

Members also continue to raise concerns about inconsistent inspection practice, with different inspectors expecting the same issue to be evidenced in different ways. That inconsistency undermines confidence that the framework alone will deliver clearer and more transparent judgements. Members also report that some inspectors still do not adequately understand the difference between a care home and a homecare service, which creates a significant risk of inappropriate expectations and inconsistent ratings in homecare.

CQC should strengthen the framework by:

- Creating homecare-specific guidance within the adult social care framework, or a distinct homecare guidance document, rather than relying on generic wording alone.
- Adding homecare-specific descriptors and examples under every KLOE.

- Defining how inspectors should judge homecare-specific issues such as continuity, missed and late visits, travel time, lone working, delegated healthcare activities, and changes in need between visits.
- Distinguishing clearly between provider failure and wider system constraints that the provider has identified, escalated and tried to mitigate.

Overall, the framework points in the right direction, but CQC needs to anchor it much more firmly in the realities of homecare if it wants judgements to feel consistently clear, fair and transparent.

Question 2: Do you agree that the draft assessment framework for your sector will help providers to understand what CQC will look at in an assessment?

Strongly agree / Agree / Neither agree nor disagree / Disagree / Strongly disagree

The Homecare Association agrees in part. The draft gives providers more detail than a broad, principle-based framework alone and shows the direction of travel across safety, effectiveness, person-centred care, equity, responsiveness and leadership. Providers can see the broad domains that CQC intends to assess.

However, the framework still does not help homecare providers understand clearly enough what CQC will look at in practice. In homecare, quality depends heavily on assessment, care planning, rota design, continuity of care, support of workers, visit timing, communication between the office team and frontline staff, escalation of deterioration, safe medicines support, record quality and coordination with families and community professionals. The draft touches on many of these issues, but it spreads them across multiple KLOEs in a way that does not reflect how homecare actually operates.

Providers in our specialist groups echoed that concern. They said the framework still feels too generic and does not fully reflect homecare realities, including limited control over the care environment. They also raised strong concerns about unclear evidence expectations, inconsistent inspector approaches, and the lack of detailed guidance. Taken together, those points suggest providers still will not understand clearly enough what CQC will look at in a homecare assessment unless CQC publishes more specific guidance and practical examples.

Comments from members:

“As a homecare provider, I feel it still lacks clarity on evidence expectations, consistency, and inspector approach without detailed guidance.”

“It still does not give enough operational detail on what inspectors will actually test, what evidence they will prioritise, and how they will apply the framework consistently.”

“Until the detailed guidance and provider handbook are published, it is hard to say that it is fully practical.”

The evidence from the Homecare Association’s 2025 analysis of 1,052 inspection reports shows that Good homecare services show reliable person-centred delivery, visible leadership, effective risk management and positive feedback. It describes Requires Improvement services as showing variable reliability and communication and weak governance follow-through, and Inadequate services as showing serious failures in medicines, risk, records and governance. CQC should use those real homecare markers to shape the framework more explicitly.

Some KLOEs also fit homecare only partially. Sections on safe environments, access, and some aspects of medicines and treatment assume a level of provider control that many homecare providers do not have. In people’s own homes, providers assess, mitigate, communicate and escalate risks, but they do not control the premises in the same way as a residential service. The Homecare Association’s submission to the 2025 CQC consultation made this point clearly in relation to care environment requirements and on-site models of evidence, and the same issue remains in this draft.

The 2017 KLOE framework made this distinction more explicitly than the current draft. It described premises management as relevant to care homes, equipment as relevant to all services, and premises risks as relevant to all services, including the question of how the provider manages risks where support is delivered in premises for which it is not responsible. CQC should preserve and strengthen that practical distinction in the new framework.

For example, the draft ‘Safe environments and infection prevention and control’ KLOE covers premises, equipment, IPC, environmental risks and digital systems (draft framework pp. 14-16), while ‘Timely and equitable access’ and ‘Equity in experiences’ cover access, reasonable adjustments, digital exclusion, interpreting and communication barriers (pp. 46-50). These are important issues, but the final framework should state explicitly how they apply when support is delivered in a person’s own home rather than in premises controlled by the provider.

The framework also needs to work for SMEs. The CPA review notes that 85% of adult social care providers are SMEs with fewer than 50 employees and that many do not have dedicated quality improvement staff. A framework that depends on repeated evidence mapping, overlapping KLOEs, or heavy narrative self-assessment will advantage larger providers and reduce fairness for smaller homecare services. Members also say providers will not understand clearly enough what CQC will look for unless inspector training becomes more thorough and more consistent. Some of our members reported that inspectors still do not fully appreciate the difference between a care home and a homecare service, and this affects how they interpret standards in practice. They add that inconsistent advice from CQC and inconsistent

interpretation during assessment make it harder for providers to know what good looks like.

Providers will understand assessments better if CQC:

- Adds service-type guidance at KLOE level, with clear homecare examples of what Good and Outstanding look like.
- Sets out the primary sources of evidence for homecare, such as care plans, call monitoring, rota data, continuity data, escalation records, complaints analysis, medicines competency checks, and out-of-hours logs.
- Shows where a KLOE or descriptor does not apply to homecare, rather than expecting providers to interpret that alone.
- Designs evidence requests and assessment expectations so they remain proportionate for SMEs.

Question 3: Do you agree that the draft assessment framework(s) will help CQC and providers to identify and address inequalities in care?

Strongly agree / Agree / Neither agree nor disagree / Disagree / Strongly disagree

The Homecare Association broadly agrees with the intention behind the draft. The framework gives much stronger prominence to equity, protected equality characteristics, communication needs, reasonable adjustments, access and people's experiences than previous approaches. That stronger emphasis is welcome. Including specific KLOEs on timely and equitable access, equity in experiences, and workforce equity and culture should help focus attention on issues that providers and inspectors have not always addressed consistently in the past.

This focus matters in homecare. Homecare providers often support people with needs the wider system has underserved for long periods, including people with dementia, learning disabilities, sensory loss, mental health needs, end-of-life, communication barriers, and complex combinations of health and social care needs. A stronger equity focus should help providers and inspectors examine who experiences poorer continuity, weaker communication, reduced access to reviews, poorer coordination, or less personalised support.

However, the framework does not yet define clearly enough what inequalities mean in practice for homecare providers. Participants in our specialist groups said this creates confusion about expectations and accountability. They highlighted that homecare organisations have limited control over wider social, economic and environmental inequalities, and that equity and access can be difficult to evidence where services accept referrals widely and where funding and commissioning contexts shape what providers can realistically deliver. As one contributor put it:

"A service can provide nominal access while still producing unequal experiences or outcomes."

The framework also risks treating inequality too much as a documentation issue and not enough as a delivery issue. In homecare, inequalities often arise through digital exclusion, cultural and linguistic barriers, poor access to interpreters, hidden disabilities, rural travel constraints, fragmented coordination across services, and short commissioned visits that do not allow personalised support. The Homecare Association's submission to the 2025 CQC consultation highlighted these risks specifically, including digital exclusion, communication inequalities, rural inequalities, and the risk of inspector bias. CQC should reflect those delivery realities more clearly in the framework.

CQC should not hold providers responsible for structural inequalities they do not control where they have identified the issue, taken reasonable action and escalated appropriately. As one member put it:

"…regarding the wider social determinants of health (e.g., inadequate housing, fuel poverty, or neighbourhood safety)…we can signpost and report these issues, we cannot be held accountable for the local authority's failure to provide adequate housing or social funding."

Inspectors also need homecare-specific equality competence, not just equality language, in the framework. The CPA review found that inspectors do not always understand the diversity of service types or apply the framework consistently. That risk directly affects how fairly CQC will judge action on inequality in homecare. Evidence expectations must also remain proportionate. For small and private-pay services in particular, CQC should focus on qualitative evidence of how providers adapted care to meet a person's protected characteristics or communication needs, rather than rely on complex demographic data that may add burden without improving assurance.

CQC should strengthen the framework by:

- Clarifying how inspectors will assess action on inequalities within the provider's control.
- Distinguishing clearly between provider actions and wider system failings.
- Strengthening expectations on accessible information, language support, cultural competence, and support for people whose voices are seldom heard.
- Training inspectors in homecare-specific equality issues, including digital exclusion, communication differences, rurality, and intersectionality.

Overall, the framework has the right ambition on inequalities, but CQC needs to make the expectations more practical and more clearly linked to what homecare providers can reasonably deliver and influence.

Question 4: Do you have any comments about the new key lines of enquiry (KLOEs)? For example, do they prioritise the aspects that are most important for delivering good quality care in the sector? Do any areas need a separate KLOE? Or can any KLOEs be combined?

The Homecare Association considers that the KLOEs cover many of the right themes, but they do not yet prioritise the issues that matter most in homecare strongly enough. Several KLOEs are relevant and useful, particularly those on managing risks during care and treatment, safe staffing, assessing needs, consent, person-centred care, independence, continuity, feedback, governance and leadership. These areas align well with the core features of safe and effective homecare.

However, the framework still feels too generic and, in places, too residential-centric. Participants in our specialist groups said the KLOEs do not yet reflect core homecare realities strongly enough, particularly around premises, environment, physical safety, and the delivery of care in people's own homes. One member noted:

"The 'Safe' KLOEs regarding premises and environment are still too focused on buildings the provider controls. In homecare, we cannot 'fix' a client's steep stairs or narrow doorway; we can only manage the risk within them."

In homecare, providers assess risk, adjust care delivery, support the person, use equipment where appropriate and escalate concerns, but they rarely control the physical environment. The framework should reflect that distinction more consistently.

Specialist group members also highlighted the under-representation of lone worker safety and dispersed workforce management. As one member put it:

"There is an under-representation of lone worker safety. The 'Well-Led' KLOE often misses the complexity of managing a workforce that rarely meets in person."

In homecare, care and support workers usually work alone and rarely meet managers or colleagues face to face. Effective leadership therefore depends on strong remote supervision, communication, lone-working safeguards, rota oversight, escalation systems and practical support for staff who deliver care in isolation. The KLOEs should recognise those realities more explicitly.

The framework also gives insufficient prominence to the practical delivery challenges that most affect quality in homecare. These include continuity of care and support

workers, visit timing, missed and late visits, rushed calls, travel time, communication between the office team and care and support workers, escalation of deterioration, and coordination with unpaid carers and community professionals. These issues sit at the heart of people's experience of homecare and often determine whether care feels safe, dignified, and responsive. Some members also noted that dignity, risk, safety, hydration, end-of-life care, and outcomes are present in the draft, but not prominent enough.

The previous 2017 KLOE framework was clearer on this point. Its safe staffing rating characteristics specifically recognised that services providing care and support in people's own homes should have enough staff cover across the geographical area, consider travel time, deliver a consistent and reliable service, and avoid short calls unless the assessed care can be delivered safely without being rushed. CQC should retain this practical homecare-specific wording in the new framework.

This is visible in the draft framework itself: 'Safe systems, pathways and transitions' already include care co-ordination, information sharing, continuity, referrals and delegation (pp. 8-10), while 'Care provision, integration and continuity' again covers collaborative working, continuity and service provision (pp. 42-43). Similarly, 'Timely and equitable access' (pp. 46-48) and 'Equity in experiences' (pp. 48-50) both cover barriers, reasonable adjustments and communication needs.

There is also significant overlap between several KLOEs. The main areas for review are:

- Safe systems, pathways and transitions, and Care provision, integration and continuity, which both cover coordination, handover, continuity and joined-up working.
- Timely and equitable access and Equity in experiences, which both cover barriers, communication, reasonable adjustments, and unequal experiences.
- Safety culture, Listening to and responding to feedback, and Improvement, innovation and learning, which all revisit concerns, challenge, feedback and improvement.
- Assessing needs, Managing risks during care and treatment, and Supporting people to live healthier lives, which all touch on assessment, monitoring, changing needs, and risk.
- Person-centred care, Independence, choice and control, and consent to care and treatment, which all revisit choice, rights, involvement and control.

As one contributor observed, "*There is a risk of overlap. I understand why CQC separates culture from day-to-day risk management, but the boundary will need to be very clearly explained, or similar evidence could be used under both headings.*" Another noted, "*These are all legitimate themes, but they sit close together and may*

help further streamline this section and be very clear about the same operational reality from slightly different angles." A third commented, *"Well-led often becomes the place where governance, leadership, culture, improvement and partnership issues all accumulate."* These observations reflect a broader concern that overlap is not a minor drafting issue. It increases burden, scatters evidence, makes self-assessment harder and gives inspectors too much room to interpret the same issue in different ways.

The evidence base supports a stronger and more standardised structure. The CPA review found that overlapping statements create administrative burden and inconsistent interpretation, while flexible sampling can miss key areas, including previous weak points and aspects of care providers want to show. Providers in the CPA work wanted a reduced core set of statements, applied consistently at routine inspections. That logic applies equally here.

CQC could also reintroduce an explicit 'applies to' discipline within the new framework. The 2017 document used this approach to show where a prompt applied to all services, only to specific regulated activities, or only where the provider had responsibility. A similar device would reduce ambiguity in the current draft and help inspectors apply the framework proportionately across homecare, residential care and supported living.

CQC should therefore:

- Merge overlapping KLOEs into a smaller core set for homecare.
- Assess a standard set of core evidence areas at each routine assessment, while allowing proportionate risk-based lines of enquiry where there are specific concerns.
- Create a stronger and more explicit line on continuity and reliability of care delivery in homecare, because missed visits, late visits, poor continuity, rushed support, and weak communication cause direct harm.

Overall, the KLOEs cover many important themes, but CQC needs to make them more clearly applicable to homecare, more focused on the realities of care delivered at home, and less duplicative if they are to support consistent and meaningful assessment.

Question 5: Do you have any comments about the rating characteristics that describe quality under each key line of enquiry (KLOE) for each rating level?

The Homecare Association welcomes the move towards clearer rating characteristics. This approach should help CQC move away from over-complex scoring systems and support more transparent judgements. The Homecare

Homecare Association

Association's submission to the 2025 CQC consultation supported a return to ratings at key question level with clear rating characteristics because providers need to understand what Good, Outstanding and Requires Improvement look like in practice.

However, the draft rating characteristics still need more precision and much stronger sector fit for homecare. Many descriptors remain broad, aspirational, or generic. They express the right intention, but they do not always tell providers or inspectors clearly how one rating level differs from another in real-world homecare practice. CQC itself recognises in the draft introduction that stakeholders asked for clearer boundaries between rating levels and clearer links with compliance. That issue remains unresolved.

Participants in our specialist groups questioned the unclear distinction between Good and Outstanding and raised major concerns about the return of professional judgement without safeguards. They felt that vague language, for example references to visible commitment or meaningfully, risks inconsistent inspection judgements unless CQC provides much clearer criteria, practical examples and homecare-specific case studies. Unless CQC improves inspectors' knowledge of the Fundamental Standards and associated regulations, including Regulations 9 to 20, members also questioned the consistent application of the characteristics. Several members reported examples where inspectors appeared to apply different expectations to the same issue. In that context, clearer wording alone will not be enough unless CQC also delivers more thorough and credible inspector training.

As set out in response to Question 2, our analysis of homecare inspection reports identifies practical markers that differentiate quality in homecare, including reliability, continuity, communication, medicines support, escalation, operational grip and governance follow-through. The rating characteristics should translate those markers into clearer thresholds between Outstanding, Good, Requires Improvement and Inadequate, rather than repeating broad or aspirational language. Our new report, 'Unseen and unrated' found 24% of community ratings published in the past year were Requires Improvement or Inadequate (versus 12% historically), with Inadequate up from 0.5% to 3.6%.

The 2017 rating characteristics also provide a useful comparison point. They gave more concrete homecare examples under safe staffing, including travel time, staff cover, short calls, familiar staff, changes at short notice, and whether people feel rushed or unsafe. These are practical markers that help distinguish Good, Requires Improvement and Inadequate homecare. The new rating characteristics should be at least as clear on these operational thresholds.

The Homecare Association has five main concerns.

1. The boundaries between rating levels remain unclear, especially between Good and Requires Improvement. Homecare providers need to understand

what moves a service from Good to Requires Improvement when concerns arise around continuity, visit reliability, medicines support, staffing pressures, complaints handling or escalation. Without clearer thresholds, providers and inspectors will continue to rely too heavily on individual interpretation.

2. Some Outstanding descriptors rely too heavily on terms such as “innovative”, “creative”, “exceptional” or “benchmark” without explaining what evidence inspectors should use in homecare or how smaller providers can meet those expectations proportionately.

3. Some descriptors assume provider control over premises, food, equipment, environmental design, or access arrangements that many homecare providers do not have. As already mentioned, homecare providers assess risk, support the person, communicate concerns and escalate appropriately, but they do not own or control the home.

4. The framework does not yet describe the key markers between good or poor homecare sharply enough, including missed visits, late visits, rushed support, weak continuity, unsafe travel planning, poor office-to-field communication, and failures to escalate changing needs.

5. The framework should distinguish more clearly between isolated shortfalls, repeated concerns and systemic failure, because that is how actual risk usually presents in homecare.

CQC should revise the rating characteristics so that they:

- Reflect the actual markers found in homecare inspection reports.
- Define thresholds more clearly between Good, Requires Improvement, and Inadequate.
- Explain how inspectors should assess Outstanding proportionately for smaller providers.
- Include homecare-specific examples under each rating level.

Overall, the Homecare Association supports the principle of clear rating characteristics, but CQC should tighten the wording, define the thresholds more clearly and add homecare-specific examples before final publication. Without that added clarity, the framework will not give providers or inspectors a dependable basis for consistent ratings.

Question 6: Overall, how clear do you find this draft assessment framework(s), for example is the language clear and understandable?

Very clear / Somewhat clear / Neutral / Somewhat unclear / Very unclear

The Homecare Association finds the framework moderately clear in structure but not consistently clear in application. The overall layout is logical, and the headings and KLOEs make the document easier to navigate than a purely narrative framework. CQC has also clearly tried to respond to earlier feedback about language and structure. Providers in our specialist groups similarly welcomed the clearer overall structure.

However, the draft remains too long, too repetitive, and too conceptually dense in places. The same themes recur across multiple KLOEs, as mentioned above. This repetition makes the framework harder to use and increases the risk that inspectors and providers will duplicate evidence or interpret similar wording differently across different sections. The CPA review raised the same concerns about overlapping statements, unclear guidance and administrative burden, and the Homecare Association's submission to the 2025 consultation made the same point in relation to the existing framework.

The draft also uses broad terms such as "visible commitment", "meaningful involvement", "equitable", "inclusive", "accessible", "innovative", "trauma-informed", "psychological safety" and "co-production". These terms have value, but CQC should define them in plain language and illustrate them with acceptable homecare evidence, such as care records, call monitoring data, rota and continuity reports, staff supervision records, complaints analysis, safeguarding logs, medicines competency checks and escalation records.

Clarity is also limited by the wider inspection system, not just by the wording of the framework itself. Members reported that advice from CQC head office is of variable quality and sometimes inadequate or incorrect. They also described inconsistent interpretation between inspectors. That creates confusion even where the written framework appears clearer, and it reinforces concerns that inconsistency will continue unless CQC improves internal consistency and the wording of the framework.

Adding more detail will not help if it slows the system down. In a sector where 46.6% of community social care locations had ratings more than four years old as of 5 May 2026, CQC should avoid changes that make assessments slower without making them fairer. Throughput of inspections continues to be a constraint. A more complex framework risks making an already weak regulatory position worse.

CQC can improve clarity by:

- Shortening and simplifying repeated descriptors.

- Removing duplication across KLOEs.
- Defining key terms more operationally so providers understand what evidence inspectors will expect in practice.
- Including service-type examples alongside the generic framework and showing where wording applies only where relevant.
- Setting out clearer examples of evidence for homecare and publishing a provider-facing self-audit tool aligned to the framework, especially to support smaller providers.

Overall, the framework is clear in intent, but not yet clear enough in practical application for homecare.

Question 7: We are keen to know whether these 4 assessment frameworks represent the sectors we regulate appropriately, or if they need to be separated in a different way, and if so, how?

The move back to sector-specific KLOEs is a step in the right direction because it is clearer and more recognisable for adult social care than the recent single-framework approach. However, it does not go far enough. The Homecare Association does not believe that a broad adult social care framework can represent all adult social care sectors equally well without much stronger tailoring. Homecare differs materially from residential and supported living models. In homecare, outcomes depend on coordination, reliability, communication, responsiveness, and safe support in a person's own home rather than on a provider-controlled environment. For that reason, the Homecare Association has argued for frameworks designed by service type rather than broad sector, and the CPA review similarly supported service-type guidance at statement level.

Providers in our specialist groups repeated the view that the framework still feels too generic and does not fully reflect homecare realities. They also said that some KLOEs remain too residential-centric, especially around premises, environment, and physical safety. That evidence supports the case for stronger service-type separation, or at minimum a more explicit homecare-specific module, because a broad adult social care framework still risks applying inappropriate assumptions to care delivered in people's own homes.

Provider evidence, inspection analysis and the CPA review all support stronger service-type tailoring. Members continue to report that some inspectors do not sufficiently distinguish between care home and homecare expectations. A generic adult social care framework will therefore continue to risk inappropriate assumptions unless it contains mandatory homecare-specific guidance and clear "where relevant" boundaries.

The 2017 framework shows that even when CQC used a combined adult social care framework, it still needed clear relevance markers to avoid inappropriate application across unlike services. The issue is therefore not simply whether there is one framework or several; it is whether the final framework contains mandatory homecare-specific guidance and clear 'where relevant' boundaries.

The Homecare Association therefore recommends that CQC take one of two approaches:

1. Create a dedicated framework or guidance document for homecare within adult social care.
2. Use a shared core framework, supported by mandatory service-specific sections for homecare, residential care, supported living, live-in care, and other service models. These should include tailored KLOE prompts, evidence sources, examples, and rating descriptors.

For homecare, any service-specific module should address:

- care delivered in people's own homes, including limited provider control over premises;
- lone working, out-of-hours support, travel time and scheduling;
- continuity, missed, late and rushed visits;
- delegation, clinical oversight, medicines support and escalation of changing needs;
- communication with care workers, families, unpaid carers, advocates and health professionals;
- digital systems, including electronic care records, call monitoring and eMAR;
- direct payment, privately funded and self-funded care; and
- business continuity and end-of-life care delivered at home.

Overall, without clearer separation or a more explicit modular approach, CQC risks applying generic wording to unlike services and creating avoidable inconsistency in inspection and rating. Homecare should not sit simply as a broad subset of adult social care without stronger service-type separation.

Question 8: The content of the assessment frameworks is still in draft; do you have any overall comments that would help us to improve them, for example is anything missing, or is there any overlap?

The Homecare Association supports the direction of travel in the draft framework, but CQC should make targeted improvements before publication. The framework includes important strengths, including its stronger emphasis on outcomes, quality of life, equity, human rights, culture, leadership, and learning. However, CQC now needs to improve sector fit, reduce duplication and strengthen the link between the framework and what people drawing on care and support actually experience in homecare.

CQC should not add complexity to a system that is already failing to maintain current ratings in homecare. The regulator is currently assessing too few homecare services to provide adequate assurance across the market, and too many ratings remain out of date. Any final framework must therefore be practical enough to support faster, fairer, and more current ratings.

Providers must understand CQC's evidence standards, what good looks like in practice, and how CQC will apply structured professional judgement consistently and transparently

Overall, the draft would improve more through operational clarity than through adding more topics. Providers need to understand CQC's evidence standards, what good looks like in practice, and how CQC will apply structured professional judgement consistently and transparently. The final framework should draw a clear line between provider control, shared responsibility and wider system failure.

Providers in our specialist groups stressed that consistency, clarity, and proportionality are essential if the new framework is to be credible and workable for homecare services. They also asked CQC to pilot the framework transparently, publish a clear roadmap for learning, include small providers and self-funders in the pilot, and avoid a rushed rollout. Members continue to report that some inspectors do not sufficiently distinguish between the expectations that apply in a care home and those that apply in homecare. That reinforces the need for stronger service-type tailoring and for CQC to improve not only the framework itself but also the practical delivery model around it.

The final framework should not lose practical specificity that existed in earlier CQC frameworks. In particular, CQC should retain explicit references to provider responsibility, premises not controlled by the provider, travel time, reliable staff cover, short calls, continuity, and people feeling rushed or unsafe. These are not new sector asks; they have appeared before in CQC's own adult social care assessment materials.

Before publication, the CQC should:

- Design by service type, with mandatory homecare-specific guidance or a dedicated homecare module.
- Reduce and merge overlapping KLOEs so providers and inspectors can apply the framework consistently and proportionately.
- Define provider control, shared responsibility and wider system failure, especially where commissioning constraints affect safe delivery.
- Add homecare-specific examples, evidence sources and “where relevant” markers under KLOEs and rating levels.
- Make continuity, reliability and operational grip central markers of homecare quality, including visit timing, safe medicines support, escalation, rota design and communication between office teams and frontline staff.
- Tighten rating thresholds so they distinguish clearly between isolated shortfalls, repeated concerns and systemic failure.
- Improve the inspection process around the framework, including service-type expertise, proportionate evidence requests, advance planning, timely reports, factual accuracy and meaningful routes to challenge judgements.

Overall, the Homecare Association welcomes the intent behind the draft, but CQC now needs to make the framework more specific, less repetitive and more obviously workable in homecare. With stronger tailoring for homecare, clearer boundaries of responsibility, fewer overlaps and more precise rating characteristics, CQC can produce a framework that supports fairer judgements, clearer expectations and more meaningful improvement across the homecare sector.

The test of the final framework should be whether a person receiving support at home, a family member, a provider and an inspector would all understand what good homecare looks like and how CQC will judge it fairly.