The King's Fund

Bold thinking for better health

What makes care outstanding?

The King's Fund's report on principles for outstanding care for the Care Quality Commission

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This independent report was commissioned by the Care Quality Commission under its research partnership with The King's Fund to support the development of its future regulatory model. The views in the report are those of the authors and all conclusions are the authors' own.

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Executive summary

In 2021, the Care Quality Commission (CQC) – the independent regulator of health and social care in England – started a major programme of change. Three independent reviews in 2024 and 2025 found serious problems with the way CQC put the changes into practice (Care Provider Alliance 2025; Dash 2024; Richards 2024). As a result, CQC is now rebuilding its approach to regulation (Care Quality Commission 2025f). This includes developing four sector specific assessment frameworks.

Currently, CQC is using the Single Assessment Framework (SAF), introduced in 2023. The SAF applies to all health and social care services. It is based on five key questions that check whether services are:

- safe
- effective
- caring
- responsive
- well led.

Under each question, there are quality statements. The quality statements show what is needed from providers, commissioners and system leaders for the delivery of high-quality care.

For the services CQC rates, it gives one of four ratings:

- outstanding
- good
- requires improvement
- inadequate.

CQC gives ratings for each of the five key questions. Depending on the type of service, CQC then combines the ratings at the service, location and/or trust level.

Our project

The King's Fund has a research partnership with CQC. As part of this partnership, we were asked to do some work focused on what makes care outstanding.

Providers and inspectors often say it is hard to tell the difference between good care and outstanding care. Our research aimed to develop principles that explain what outstanding care looks like and how it is different from good care. We wanted to:

- identify the areas the principles should cover
- consider whether they should vary across the different sectors that CQC's assessment framework covers
- consider whether they should vary across the five key questions in CQC's assessment framework
- explore how the principles could be used in practice
- explore whether principles designed for providers could also help with local authority assessments.

To do this, we reviewed existing literature and interviewed a range of stakeholders. We then refined the principles through stakeholder workshops (see below for more information). We also gathered views on how these principles might be applied. For more information on this, see the section below on '**How the principles might be used'.**

The principles are not a description of CQC's current 'outstanding' rating. Instead, they provide insights into what outstanding care looks like. This can support CQC's ongoing work on its assessment approach. They are also intended to help provider organisations understand what outstanding care means. As CQC develops its assessment framework, it can decide how and when to use the principles and supporting research. For example, it could explore which regulatory processes or functions they are most relevant to.

This project started in March 2025, and we shared our findings with CQC in July 2025.

Our approach

The project had two phases.

Phase one

In phase one we reviewed the literature on outstanding care. We also carried out 21 semi-structured interviews with stakeholders (between April and May 2025). Interview participants included:

- CQC staff
- a small number of staff from provider organisations (primary and secondary care)
- experts by experience (people with lived experience who join CQC inspection teams. For more information, see Care Quality Commission 2025d).

The interviews explored:

- what outstanding care looks like
- how it differs from good care
- how principles could help identify outstanding care.

From our analysis of the literature and interviews, we developed five draft principles for outstanding care.

Phase two

In phase two we ran 6 workshops with a total of 48 participants:

- three workshops with providers. These included participants from different sectors (community services, hospitals, mental health care and adult social care). Participants were also from a mix of NHS, independent and voluntary organisations. Most had services that CQC had rated outstanding or good
- two workshops with experts by experience
- one workshop with CQC operational staff, including current or former inspectors.

The workshops tested, revised and refined the principles. We also asked participants how they might use the principles.

Finally, we held an engagement workshop with CQC's policy leads for local authority assessment. This was to share our findings and discuss whether the principles could apply to their work.

What is outstanding care?

We used our literature review, interviews and workshops, to explore the question: What does outstanding care look like?

We found that it varies across different settings. However, there is broad agreement on its key features. People described outstanding care in three main ways.

- **In comparison with other care, services or organisations.**
  Many people explained outstanding care by comparing it to **good** care. They described it as care where staff go 'the extra mile' or do something 'above and beyond'.
- **It is something you can feel.**
  Others said that outstanding care is something you know when you experience it or see it. However, it can be hard to define or measure.
- **It is a different way of delivering care.**
  People also saw outstanding care as care delivered consistently well. It also involves a strong commitment to learning, innovation and continuous improvement.

From the literature review and our discussions, we identified the key features of outstanding care. We outline these below.

Person-centred care

For people using services, care feels outstanding when it is tailored to their individual needs and preferences. It recognises their strengths and treats them as a ‘whole person’.

Person-centred care looks different in different settings. For some, continuity of care is most important. Across all sectors, however, our findings highlighted two essential features:

- a strong focus on the needs and wishes of the individual
- active involvement of people in decisions about their care.

Many stakeholders described this relational approach as key to outstanding care. This was particularly true for experts by experience. They emphasised the importance of staff making genuine connections with the people they care for. They also thought it was about staff being curious about their lives. This means understanding their needs. It also means giving them the power to influence their care, where that is what they want.

Leadership

Our research highlighted the critical role of excellent leadership in delivering outstanding care. CQC has long recognised this link.

Leadership influences care in many ways. The literature and our interviews focused on how leaders shape organisational culture. It also considers how they support staff wellbeing. These in turn affect the quality of care.

Outstanding care happens when staff feel engaged, motivated and empowered to take ownership of their work. This environment encourages innovation and continuous service improvement.

Participants described different leadership styles. A common theme was leadership that is flexible, collaborative and shared – that is, it is not always ‘top-down’.

Equity and inclusion

Outstanding care prioritises equity and makes sure everyone is treated fairly and included. This applies to both people using services and staff. The literature shows that organisations with an inclusive culture usually provide better care. Meanwhile, ignoring diverse needs can lead to poor experiences and outcomes.

Although this came up less often in interviews, some people linked equity and inclusion to person-centred care. They also linked it to creating a welcoming environment and focusing on those with the worst health outcomes.

Learning and improvement

Making learning and improvement part of everyday practice is key to high-quality care. This came up in our interviews and workshops. We heard that outstanding care comes from a commitment to continuous reflection and improvement. This means regularly using data and feedback from staff and people who use services, to spot areas for change and make things better.

This theme is closely linked to leadership. This is emphasised in the literature. It highlights the link between a learning culture and a form of leadership that creates a ‘learning organisation’.

Innovation

Innovation plays a key role in improving care for people who use services. In our interviews and workshops, many people said that innovation is what sets outstanding care apart from good care. They stressed that innovation should be an ongoing process, shaped by staff and user feedback and by looking at outcomes. It is not just about having one clever feature or a new piece of technology.

Innovation works best when combined with continuous learning and inclusive leadership. Together, these help to create an environment where staff feel able to find new and better ways of doing things.

Principles for outstanding care

Based on our literature review and interviews, we developed five principles for outstanding care. We refined them through stakeholder workshops.

There is a lot of overlap between the principles and the features of outstanding care set out above. But there are two key differences, because the focus of the principles is on outstanding care **in practice**.

- First, we brought together two connected themes from the literature and interviews. Learning and innovation are grouped into a single principle.
- Second, we also grouped some related ideas that came up across the themes into a single principle. This is focused on a ‘framework’ for outstanding care. This is the principle of having a purposeful approach to making a positive difference.

The principles are:

- interlinked and reinforcing – they should be considered together
- high-level descriptions – they give a sense of what outstanding care looks like for CQC and providers
- universal – they are designed to apply across all sectors that CQC regulates. However, they also recognise that outstanding care varies by context.

We now set out each principle, with a definition and illustrations of how the principle could look in practice. Together, they reflect common features of outstanding care across different settings.

Principle 1: Delivering truly person-centred care

Definition: Outstanding care is always highly responsive to individuals' needs, preferences and aspirations, recognising what is important to people who use services, their strengths, cultures and histories.

Below are some illustrations of what it could look like.

- Staff establish a genuine and deep connection with those they care for and demonstrate real curiosity about what matters to them and how to meet their needs.
- Kindness and dignity are central to every interaction between staff and those they care for.
- People using services have autonomy and the power to have their needs and wishes communicated and to influence their care.
- Families, carers and people who use services are encouraged and actively supported to be active partners in their care, leading to exceptional levels of satisfaction.
- Care goes beyond meeting clinical or personal care needs. It also supports and empowers people to achieve what is important to them.
- Care that is joined up for each individual along their care 'pathway', within and between services, is prioritised.

Principle 2: Embedding a culture of compassionate and inclusive leadership

Definition: Outstanding care happens when leaders foster an open, psychologically safe, inclusive and values-driven culture that is focused on people who use services and empowers staff.

Below are illustrations of what it could look like.

- Leadership is distributed, supportive and inclusive.
- Leaders are visible, accessible and responsive to staff and people who use services.
- Values, including expectations for high-quality care, are truly people focused and consistently lived throughout the organisation.
- Staff are highly engaged, respected and supported to learn and develop.
- Staff have a clear sense of belonging, feel safe and are encouraged to speak up and are empowered to make decisions in response to the preferences of people who use services.
- Leaders consistently embrace opportunities available to their service or organisation to make a positive, tangible difference to the local community, economy and environment.

Principle 3: Prioritising equity and inclusion

Definition: Outstanding care happens in an environment that is inclusive, prioritises equity and actively embraces diversity among people who use services and staff.

Below are some illustrations of what it could look like.

- Care environments are welcoming and actively value and respect all people.
- Diverse perspectives are sought and celebrated.
- Partnerships with communities and community organisations are actively developed, to co-design and co-deliver services.
- Organisations and services challenge themselves about the particular contribution they can make to tackling health and care inequalities.
- Organisations and services promote equity and proactively respect human rights.
- There is clear accountability for equality and inclusion, with measurable goals and regular reporting.

Principle 4: Continuously integrating learning into practice to drive improvement and innovation

Definition: Outstanding care happens when a learning mindset is embedded in teams and organisations, with a focus on evolving practice and continuously sharing knowledge.

Below are some illustrations of what it could look like.

- Continuous reflection, learning and improvement are part of regular practice.
- There is an open culture that is honest about challenges and mistakes, and values these as opportunities for learning.
- Innovation is contextual, purposeful and enables consistently better outcomes for staff and people who use services.
- Quantitative and qualitative data is used meaningfully to drive improvement.
- Learning is systematically shared internally and with other organisations to support system integration and improvement.
- Relevant learning from beyond the organisation and from other sectors is integrated to consistently improve care.

Principle 5: Having a purposeful approach to making a positive difference for people who use services

Definition: Outstanding care comes from a clear and deliberate focus on making a positive difference for people who use services, staff and the wider system and is evidenced in key outcome measures and feedback from people who use services and staff.

Below are some illustrations of what it could look like.

- Outcomes and experiences for people who use services are excellent and there is a constant drive to improve them.
- There is a clear vision for outstanding care and how all those responsible for care delivery can provide it.
- Providers are outward looking and work in partnership to meet the needs of those in their care and, where appropriate, the needs of the wider community.
- Effective governance, processes and systems are in place to identify and drive positive outcomes.

How the principles might be used

Our research explored not only what the principles for outstanding care should look like, but also how they could be applied. Overall, experts by experience and provider organisations saw value in the principles. Views from CQC staff were mixed.

Possible uses include:

- informing CQC's revised assessment framework
- supporting judgements on outstanding care in quality panels. However, some felt that sector-specific detail would be needed
- having them included in training and induction for CQC inspectors and experts by experience
- helping provider organisations identify areas for development and shape improvement plans
- communicating what outstanding care looks like across provider organisations.

However, some participants questioned their usefulness without sector-specific detail. They also raised concerns about how the achievement of broad principles could be evidenced.

Considerations for using the principles

To make the principles effective, several factors need attention.

- **Clarify their purpose.** The principles are high-level guides, not checklists or performance criteria. Clear framing and design will help avoid confusion.
- **Ensure alignment.** The principles must fit with CQC's wider work on assessment. This will require an iterative process and further engagement with staff and stakeholders.
- **Confirm the sector approach.** Most of our participants agreed on a single set of universal principles. However, views were mixed on whether they should apply across all sectors. CQC will need to decide how the principles link to sector-specific frameworks.

Usefulness of the principles for local authority assessments

CQC introduced local authority assessments at the end of 2023. These assessments check whether authorities are meeting their duties under Part 1 of the *Care Act 2014*. Our research explored whether our principles could help with these assessments.

CQC's policy leads for local authority assessment are responsible for the approach to local authority assessments. Team members reviewed our principles for outstanding care and gave some positive feedback. They suggested the principles might help in calibration (quality assurance) panels.

However, they agreed that the principles only cover a small part of what local authority assessments involve. They felt that significant extra work, or a different set of principles, would be needed for them to be fully useful.

Limitations of this work

It is important to note some limitations of this work.

- **Focus of the research.** We looked at what principles for outstanding care should be. We did not look at whether principles are the best way to define outstanding care compared to other approaches. Exploring alternative methods could be valuable.
- **Purpose of CQC's outstanding rating.** The purpose of CQC's outstanding rating was not included in the scope of our work. However, it came up during review. This suggests CQC should clarify the intended purpose of the rating.
- **Alignment with wider work.** Our research ran alongside CQC's broader work on revising its assessment approach. We did not have enough detail on that work to frame our workshops. This may have affected how the principles for outstanding care that we developed were received. CQC needs to do further work to decide how the principles align with its wider work.
- **Workshop recruitment challenges**.
    - Some sectors were underrepresented in the workshops. This was due to the timing of the workshops and individuals' availability. A key example is primary care.
    - Provider workshops were aimed at those rated outstanding or good. This was so they could describe the difference between the two. However, recruitment difficulties meant we decided to include providers with other ratings. This meant some lacked direct experience of outstanding care. However, their perspectives were still useful, given the principles could support improvement work.
    - More engagement will be important as CQC continues its work on the assessment framework. This should include a wider set of providers.

01 Structure of this report

This report sets out the findings of The King's Fund's work to develop a set of principles for outstanding care.

Section 1 sets out the context for this work, including CQC's current assessment approach and its ongoing improvement work. It also sets out the aims and objectives of this project, a methodology summary and key limitations of the work.

Section 2 sets out the findings of our research (from our literature review, interviews and workshops) on the question: What is outstanding care? It outlines the key features of outstanding care that we identified through this part of the work.

Section 3 sets out the five principles for outstanding care. We drew on the evidence set out in section 2 to develop them and we refined them through a series of stakeholder workshops.

Section 4 discusses whether and how the principles might be used. It sets out views from interviewees and workshop participants on this question and highlights some key considerations that we identified during the project.

Section 5 draws together the key themes from our work and suggests some key areas for focus for CQC in the future.

02 Introduction

Context

In 2021, the Care Quality Commission (CQC) – the independent regulator of health and social care in England – introduced a new strategy leading to a far-reaching programme of change. CQC intended for this to simplify the assessment process for providers and make better use of insight from a range of data sources to help prioritise assessments. The change programme included the introduction of new information technology systems, some internal restructuring and the introduction of a new Single Assessment Framework (see the boxes below).

However, in 2024 and 2025, a series of independent reviews into CQC's effectiveness identified significant internal failings associated with the implementation of the changes it had been carrying out (Dash 2024; Richards 2024; Care Provider Alliance 2025). The changes were found to have severely reduced CQC's ability to identify poor performance and support improvement, leading to a loss of credibility in the health and social care sectors.

Challenges that the reviews identified included significant problems with CQC's provider portal – part of the information technology changes that CQC had introduced – which were preventing CQC from rolling out the new assessment framework effectively and from managing concerns raised. The reviews also highlighted challenges arising from changes to the organisation of inspection teams, resulting in a loss of sector expertise and a reduction of seniority within teams.

A number of concerns were also raised in relation to the Single Assessment Framework itself, such as the way it was communicated and the language used. The reviews also identified problems with the way the framework was being applied (Dash 2024) and concerns among providers about the way in which ratings were being calculated (Bliss and Jones 2024).

In response to the reviews' findings, CQC is now in the process of rebuilding its approach to regulation. Under the leadership of a largely refreshed executive team and board, CQC is working to address concerns that the reviews raised through some immediate operational actions, as well as a number of 'foundational improvements' (Hartley 2025). CQC has acknowledged that the current assessment approach is too complicated. It is now in the process of updating the assessment framework, as well as the way that it is applied and how judgements are made. The aim is to have a tailored assessment framework for each sector it regulates, and a set of 'ratings characteristics', which will describe what each rating looks like for each key question (Care Quality Commission 2025f).

CQC has been working in partnership with stakeholders on this process, engaging with staff, providers, the public and wider stakeholders to develop changes to the content and use of the assessment framework and characteristics. CQC is currently consulting on its revised approach.

CQC's assessment framework for providers

The Single Assessment Framework was introduced in November 2023 to cover all health and social care services. This retained some elements of the previous framework but was intended to simplify the regulatory process, better reflect care delivery across different services, and focus on outcomes rather than just procedural compliance.

The Single Assessment Framework is made up of five key questions, retained from the previous framework, which ask whether health and care services are safe, effective, caring, responsive and well led (see (Care Quality Commission 2025b).

Under each of the key questions there is a set of quality statements (replacing 'key lines of enquiry' under the previous framework), of which there are 34 across the five key questions. The quality statements are articulated as:

- 'we statements' – describing what is required of providers for the delivery of high-quality care
- 'I statements' – describing what people who use services should experience.

CQC awards most health and social care services with a rating. For those it rates, the four quality ratings are outstanding, good, requires improvement and inadequate. Ratings are given against each of the five key questions.

Depending on the type of service, these can be aggregated at service, location and/or trust level, according to a set of rules. (Care Quality Commission 2025a).

Outstanding care under the current CQC assessment framework

To assess specific quality statements, inspectors look at different types of evidence and use their professional judgement to assign a score. Scores given at quality statement level are used to calculate a percentage score at key question level.

The percentage score is translated into one of four quality ratings, based on a set of thresholds. A score of 88% and above is considered outstanding.

The outstanding rating is typically awarded to only a small proportion of providers.

In CQC's most recent report on the state of health care and adult social care in England (Care Quality Commission 2025d), the latest overall ratings (rather than ratings by key question) for outstanding care in 2025 were as follows:

- hospice services – 32% were rated outstanding
- community health services – 17% were rated outstanding

- independent acute hospitals – 4% were rated outstanding
- independent ambulance services – 4% were rated outstanding
- adult social care services – 2% were rated outstanding
- GP services – 2% were rated outstanding
- NHS acute hospitals – 1% were rated outstanding
- NHS and independent mental health services – none were rated outstanding
- NHS ambulance services – there were no published ratings under the Single Assessment Framework.

Aims and objectives of this project

One issue highlighted in feedback from providers during our engagement exercises on the assessment approach was the challenge of distinguishing between good and outstanding care. The descriptions provided in CQC's existing assessment framework reflect the 'good' rating, and currently there is little guidance for providers or regulators as to what 'outstanding' care looks like. Inspectors are also raising the difficulty of distinguishing between good and outstanding care (Richards 2025).

Within the context of its broader work to develop its assessment approach, CQC commissioned The King's Fund to undertake some work focused on outstanding care, as part of a broader research partnership between the two organisations.

The purpose of the project was to develop a set of a principles that describe outstanding care. The aim was not to develop principles that were simply a description of the outstanding rating in CQC's current assessment framework, but rather to develop principles that could inform and sit alongside the CQC's updated ratings characteristics and framework – offering CQC and providers a high-level articulation of what outstanding care looks like and helping them distinguish between care that is outstanding and care that is good.

Our research aimed to explore what the principles should cover and how they might be used. We considered whether it was possible to develop a single set of principles that applies across all the key questions in CQC's assessment framework and each of the sectors that CQC regulates. We also considered the extent to which the principles might be applicable to CQC's local authority assessments, which, as noted above, were introduced in November 2023. These assessments consider how local authorities are meeting their duties under Part 1 of the *Care Act 2014*.

Our key research questions were as follows.

- What does outstanding care look like?
- How does outstanding care differ from good care?
- What should principles for outstanding care look like?
- What role could the principles play in identifying outstanding care?

- How might CQC and providers use the principles?
- To what extent do the principles need to differ by sector?
- How might the principles be used as part of local authority inspections?
- How can we ensure the principles stand the test of time?

Methodology summary

We carried out our research in two phases between March and July 2025. Phase one involved a rapid literature review and stakeholder interviews. We then used the insights drawn from these activities to inform the design of draft principles for outstanding care. Phase two involved workshops to test and refine these principles and further engagement activities with CQC.

We set out what the two phases involved in more detail below but please also see the appendix.

Phase one

Literature review
We carried out a literature review including UK and international sources, focusing on what constitutes high-quality care outcomes and experiences. We also reviewed key CQC reports and guidance. We extracted key themes used to describe excellent care and supplemented this with targeted reviews on topics such as leadership.

Stakeholder interviews
Alongside the review of the literature, we conducted 21 interviews in April and May 2025 with people who had insight into outstanding or high-quality care and/or experience of working in regulation, primarily at CQC.

The majority of the interviewees were people working in or with CQC in different roles, but we also spoke to:

- a small number of representatives from provider organisations (general practice, an acute trust and a hospice)
- experts by experience (for more information, see Care Quality Commission 2025d)
- someone with experience of regulation in a different sector
- two people from an international health service improvement organisation.

Participants included representatives from a mix of sectors and organisations, and varied in terms of experience and seniority.

In the interviews, we asked stakeholders what outstanding care looks and feels like to them. We also asked them to share an example of a time they felt they had seen outstanding care, and what it was that made them describe it as outstanding. We probed them on how, in their view, outstanding care differs from good care and, where relevant, how they currently identify outstanding care. We also asked interviewees whether and how, in theory, they might use a set of principles for outstanding care once developed.

The interviews were semi-structured and lasted between 30 minutes and an hour. They were conducted online over Microsoft Teams with consented audio recordings.

We conducted thematic analysis of the features of outstanding care that interviewees raised and of their views on how a set of principles for outstanding care might be used. We tested and refined our thinking through team analysis sessions and regular meetings with CQC.

Developing the draft principles for outstanding care
To develop the principles for outstanding care, we first synthesised the key themes identified in the literature with those that that we drew from the stakeholder interviews, with the aim of capturing what we had gathered from these activities and to reflect the key features of outstanding care.

We shared the draft principles and our initial findings on how the principles might be used with CQC, which helped us develop our approach to the workshops.

Phase two

Workshops
In phase two, we tested and refined the draft principles through a series of six stakeholder workshops (in June and July 2025):

- three workshops with health and care providers
- two workshops with experts by experience
- one workshop with CQC operational staff, including current or former inspectors.

We worked closely with CQC to identify participants for all the workshops.

Participants for the provider workshops were selected to represent a mix of sectors, services and organisational size and the majority had been awarded either an outstanding or a good rating by CQC. The range of sectors and services represented included adult social care, children's public health, air ambulance, hospices, acute and mental health hospitals and drug and alcohol services. Availability to participate in the research was also a key factor in identifying workshop participants and, given the workshops fell in the summer months, we decided to take a pragmatic approach to recruitment.

During the workshops, we first asked participants to share their views on what outstanding care looks like to them. We then presented the draft principles produced at the end of phase one, first as a set and then individually. We asked participants for feedback on the content of the principles and whether and how they might be used.

The workshops were semi-structured and lasted up to two hours. They were conducted online over Microsoft Teams, with consented audio recordings.

We conducted a thematic analysis of the discussions in the workshops. We then synthesised the themes with our analysis of the literature and interviews in phase one and used feedback on the principles to further refine the content and the language used.

Additional engagement workshop focused on local authority assessments
One of the aims of our project was to consider the applicability of the principles for outstanding care to the local authority assessment process. Once the principles were refined following the workshops, we facilitated an engagement session with CQC's policy leads for local authority assessment. We used the session to share the findings from our work and explore whether and how the principles might be applicable to local authority assessments.

Limitations of this work

It is important to note some limitations of our work.

- The aim of our work was to develop a set of principles that describe outstanding care, and therefore the focus of our literature review and interviews was on understanding the main features of outstanding care to inform what the principles should look like. However, throughout the project, including at report review stage, a number of other associated questions and issues were raised, which fell outside of the scope of our research. These may warrant further exploration from CQC as part of its wider work on the assessment framework (see below).
    - Some stakeholders in our interviews and workshops questioned **the usefulness of principles as an approach or tool for distinguishing between good and outstanding care**. Our literature review did not examine the concept of principles or seek to compare this with other approaches, but there may be value in exploring the range of approaches to identifying outstanding care.
    - At report review stage, one reviewer highlighted **the need to set out clearly the purpose of CQC's outstanding rating** – for example, indicating whether this is for encouraging improvement, informing service users about the quality of a service or setting aspirational standards only a few will achieve. Exploring views on this question was not within the scope of our research, but it suggests it would be helpful for CQC to set out explicitly the rating's intended purpose.
- Our work on the principles was conducted concurrently with CQC's work to develop its assessment framework, which is subject to a public consultation. Although we shared our findings regularly with CQC as the project developed, and we were kept informed of CQC's work on the assessment framework, further work is likely to be required to ensure the two are aligned.
- Linked to this, because CQC's work is ongoing, we were unable to present our principles for outstanding care alongside the broader assessment framework, which may have a bearing on how they were received. Again, this may point to the need for further work to refine the principles as the framework is further developed.
- The research was conducted over a relatively short period (the end of March to the beginning of July, 2025), with our engagement workshops falling in the summer. This affected participant availability, which required us to take a pragmatic approach to recruitment. It also meant that some views (most notably, primary care) were not reflected in our workshops.

- We focused our provider engagement on those who had received a rating of good or outstanding from CQC (although our pragmatic approach to participant recruitment meant that, in practice, this was not always the case). We had this focus on the basis that the organisations and services with these ratings were likely to have more insight into outstanding care and were a more likely audience for the developed principles. However, given the role the principles could play in supporting improvement work, engagement with a wider set of organisations is likely to be helpful as part of CQC's broader engagement work on the assessment framework.

03 What is outstanding care?

Before considering how to articulate outstanding care as a set of principles, we wanted to understand how those within CQC, providers, experts by experience and the literature describe and understand it. Through our literature review, interviews and workshops, we explored the fundamental question: What is outstanding care?

In this section, we set out our findings on this question. We outline three main ways in which participants in our interviews and workshops talked about outstanding care. We then set out the themes – or features – that came through in the descriptions of outstanding care that our interviewees and workshop participants gave, and that are present in the literature. Drawing on this evidence base, in the next section, we set out the principles for outstanding care that we developed and which we refined through a set of workshops.

Overall, we discovered that there is broad consensus about what makes care outstanding, with some of the overarching features of outstanding care coming up time and time again throughout the project. However, there were different views about what constitutes outstanding care in practice, especially in terms of what this looks like in different settings.

Three ways in which stakeholders described outstanding care

Across the interviews and workshops, outstanding care was broadly talked about in three ways.

In comparison with other care, services or organisations

Outstanding care was often described in relation to good care, with outstanding care being that which goes the ‘extra mile’ or ‘above and beyond’ good care. In the interviews and workshops, different views were expressed about what ‘above and beyond’ might look like. However, it was generally described as involving additional effort or devotion to colleagues and people using services.

> *To me outstanding care is... going above and beyond to promote independence whilst managing risk.*
> **(Expert by experience – interview participant)**

Outstanding care was also often described in relation to the outcomes of past assessments – as a sign of progress – or in relation to other organisations and services to demonstrate exceptional quality. Some suggested that an outstanding rating should be significantly better than a good rating and therefore only awarded very exceptionally in order for it to maintain its value.

> *My definition of outstanding is that not everyone can be outstanding. You have to be differentiated. And you can be differentiated by how well you are doing in comparison to others.*
> **(CQC stakeholder – interview participant)**

However, others argued that an outstanding rating should be achievable for all, and that the principles should reflect this by outlining ways in which all organisations can deliver outstanding care. Similarly, some stakeholders suggested that the principles should not reference ways of working that are difficult to achieve in the context of a health and care system under pressure – for example, the genuine integration of services.

> Nothing is joined up… that's an area that fails over and over again… [so including it in our definition of outstanding is] setting them up to fail.
> **(Expert by experience – workshop participant)**

This raises fundamental questions about the extent to which the principles should be aspirational, or reflective of reality. Some stakeholders felt strongly that our collective expectations around what outstanding care looks like should to some extent be fixed and not lowered to account for the current challenges that the health and care system faces. Others felt that the principles would need to be adapted over time and reflect the changing nature of our expectations and the state of the system in order to remain relevant, useable and stand the test of time. This is discussed further in section 3.

It is something you can feel

When asked what outstanding care looks like, stakeholders commonly described it as something you can feel. They suggested that while outstanding care is extremely difficult to define or measure, people know when they have received or witnessed it.

> *You can feel it, but [it can be] difficult to define.*
> **(Expert by experience – workshop participant)**

Stakeholders suggested that you can feel when care is outstanding primarily because a key aspect of it is genuine human connection. It means going beyond caring for people to demonstrating a kind of selflessness in doing the very best for them.

> *Outstanding care is understanding and knowing the person as an individual and tailoring services to them, but also supporting those important to the person…*
> **(Expert by experience – workshop participant)**

It is a different way of delivering care

People in our interviews and workshops commonly described outstanding care as a way of doing things – that is, focusing less on **what** is involved in delivering outstanding care, and more on **how** care is delivered in an outstanding way. For example, some suggested that outstanding

care is about fully embedding all aspects of good care at every level, and in every interaction, within a service or organisation, as well as continuously learning and seeking to improve.

> *Outstanding would be [if an organisation is]… consistently good and exceptional.*
> **(CQC stakeholder – interview participant)**

Stakeholders also identified working in partnership with others as key to delivering outstanding care.

> *The reality of being outstanding in today's world is that no one organisation can deliver that for their patients. They have to work in partnership with a multiplicity of different organisations.*
> **(CQC stakeholder – interview participant)**

The key features of outstanding care

As outlined above, interviewees and workshop participants described outstanding care in a range of ways. Their professional backgrounds, their personal experiences and their interaction with different sectors often influenced these descriptions.

However, looking across all of the strands of our research – our review of the literature on outstanding care and our interviews and workshops – there was broad consensus about some of the key features of outstanding care. We found that the same themes were discussed in relation to care in different sectors, and that there was little change in how outstanding care was discussed in the literature over the period that we looked at (2010–25).

The main features are discussed below. Although they are set out as separate themes, in practice they are connected and overlap.

Person-centred care

For people receiving care services, care feels outstanding when it is responsive to their individual needs and preferences and when it recognises their assets – when it is focused on them as a 'whole person'.

While there is no agreed definition of person-centred care, there were some common themes in the way that it was described in the literature and in our interviews and workshops. Various frameworks have been developed to encapsulate the spirit of person-centred care, such as the 'four principles of person-centred care' model. This shifts the focus from the traditional 'What is the matter with you?' model to a collaborative 'What matters to you?' approach (Skills for Health 2025) and the notion that person-centred care needs to be done **with** the person, rather than **to** or **for** them (The Health Foundation 2014).

The four principles, which The Health Foundation (2014, p 6) has developed, are as follows.

- ‘Affording people dignity, compassion and respect.
- Offering coordinated care, support or treatment.
- Offering personalised care, support or treatment.
- Supporting people to recognise and develop their own strengths and abilities to enable them to live an independent and fulfilling life.’

At its heart, person-centred care is holistic and truly responsive to the individual, taking into account ‘individual expression, preferences and beliefs’ (Santana *et al* 2018).

While person-centred care looks different in different care settings, as CQC’s 2014 ‘Defining good’ series demonstrates, this focus on the needs and wishes of the individual is seen as a fundamental feature of outstanding care across a range of sectors (Care Quality Commission 2014). A focus on personalised care and understanding the needs of people at an **individual** level were common features of outstanding adult social care provision that CQC identified in its *State of health care and adult social care in England* report for 2023/24 (Care Quality Commission 2024). As well as highlighting the importance of meeting people’s needs, there is an emphasis on actively encouraging people to be involved in decisions about their care, and a holistic approach that recognises people’s goals and interests, as well as their basic needs (Care Quality Commission 2024).

Person-centred care is often connected with the concept of ‘continuity of care’. This can take different forms, including:

- ‘relational continuity’, where a service user has a continuous therapeutic relationship with one or more clinicians
- ‘managerial continuity’, where the sharing of information and communication between teams or organisations are consistent and timely and take account of the service users preferences.

There is evidence that continuity of care leads to positive outcomes and an improved experience for people using services. In general practice, for example, continuity of care has been linked to fewer avoidable hospital admissions and urgent care visits, as well as higher levels of satisfaction. (Fraser and Clarke 2023)

The themes around person-centred care in the literature resonate strongly with what we heard in our interviews and workshops. Stakeholders spoke about the importance of recognising the assets of a person being cared for – what they need, what they want, what they can do for themselves and what they need help with – and how responsiveness to all of this improves quality of care and outcomes. Considering all aspects of a person receiving care, beyond their clinical or basic needs, enables them to live a better and fuller life.

> *To me, outstanding care is understanding and knowing the person as an individual and tailoring services to them but also supporting those important to the person*.
> **(Expert by experience – interview participant)**

There is a clear connection in the literature – and in what we heard in our interviews and workshops – between person-centred care and staff who show compassion and empathy. Where care is outstanding, this approach is nurtured through training and is part of a broader culture that is focused on care and compassion (Van Lieshout *et al* 2015). Delivering this kind of care also requires staff to make genuine connections with – and maintain a sense of curiosity about – the people they care for (Dewar and MacBride 2017).

In our interviews and workshops, many stakeholders, particularly experts by experience, described this relational approach as key to delivering outstanding care, where the focus is not limited to the tasks undertaken, or the equipment used, but also includes **how** the care is delivered.

> *Caring is a vocation, not a job… compassion and empathy, building relationships, is the foundation***.**
> **(Expert by experience – interview participant)**

Other themes in the literature about aspects of person-centred care include a focus on the physical environment and designing this in a way that aligns with people's preferences (Care Quality Commission 2024) and provides an appropriately supportive environment (Paes *et al* 2018).

Leadership

Excellent leadership, which is inclusive, flexible, values driven and people focused, fosters a rewarding organisational culture where staff are highly engaged, feel motivated to innovate and take ownership of their work. This in turn leads to a culture of excellence in care delivery.

The importance of excellent leadership featured prominently throughout our research, and there is a large body of evidence on the link between leadership and the quality of care (Barr and Dowding 2025; West 2021; Senge and Hamilton 2015). Leaders and their style of leadership can influence care in many ways, but in the literature and our interviews the emphasis was placed on the impact leaders have on organisational culture, staff wellbeing and engagement and, through these, the quality of care.

CQC and others, such as Skills for Care and The King's Fund, have long recognised the link between excellent care and excellent leadership and there has been a correlation between organisations rated outstanding for their leadership and outstanding overall (Care Quality Commission 2016). A number of CQC's guidance and summary documents on outstanding care highlight the role of leaders in fostering a culture that is open, supportive and 'positive' (Care Quality Commission 2017a.2015). CQC defines well-led care as happening when the 'leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture' (Care Quality Commission 2022). A CQC report on quality improvement in hospital trusts further notes how the quality of leadership influences the quality of care and level of

improvement within an organisation, and consequently their CQC rating (Care Quality Commission 2018b).

This is partly about the visibility of leadership and clear communication from senior leaders, which in turn supports engagement and ownership among staff. In 2015, CQC noted that the success of Frimley Park Hospital – the first acute hospital to be awarded an outstanding rating – was partly due to a focus on staff engagement, including working with staff to develop a set of organisational values (Care Quality Commission 2015).

This theme also came through in our interviews. Participants told us that excellent leadership helps to create an environment in which organisational values are shared among staff, fully embedded and continually enacted. In this way, an organisation or service is united and resilient, with staff able to work together to deliver outstanding care.

> *[An example that I saw of outstanding was a trust in which] everybody was pointing in the same direction. You don't see that in many places*.
> **(CQC stakeholder – interview participant)**

The importance of creating an 'open' culture also contributes to staff feeling:

- supported to deliver the best possible care for people who use services
- safe to raise challenges and their 'own' their mistakes
- empowered to make changes where necessary (West *et al* 2015).

A shift to a culture in which staff felt supported, safe and able to own their mistakes was one factor that enabled Morecambe Bay NHS Foundation Trust to move from special measures to being rated outstanding (Trueland 2017). Excellent leadership helps to maintain staff satisfaction and wellbeing and ultimately deliver high-quality care for people who use services. Again, this is something that our interviewees highlighted.

> *If you've not got the leadership right, everything else falls down. If you have a culture of fear, it's never going to work, it's not a safe place to be for staff or patients… [you have to] allow people to own and share their mistakes.*
> **(Provider – interview participant)**

People talked about different leadership styles and approaches, but common to them all was a form of leadership that is flexible and distributed and not always hierarchical. What we heard aligns with some of the literature on leadership approaches and the way in which they can help to create the right culture for excellent quality of care and staff wellbeing (Elkomy *et al* 2023; (Walsh and de Sarandy 2023).

One of the largest studies on the role of leadership in organisational culture and high-quality care in the NHS (Dixon-Woods *et al* 2014) found that leadership that was operationalised at every level of the organisation, with clear objectives and focused on learning and improvement, was crucial to maintaining a culture that valued high-quality, compassionate care for people who use services.

Equity and inclusion

Outstanding care is care that focuses proactively on equity and inclusion for people who use services, and for those who deliver them.

The link between equity and inclusion and delivering high-quality care is well documented. CQC's *State of health care and adult social care in England* reports for 2016/17, 2017/18 and 2020/21 (Care Quality Commission 2021b, 2018c, 2017b) all reflect on the links between:

- organisations that embed a culture of equity and inclusion
- leaders who honour these values in decision-making
- organisations that achieve good or outstanding assessment ratings from CQC.

> *We found that services that did well had leaders who were enthusiastic and committed to equality, a culture of equality and human rights, and applied 'equality and human rights thinking' to quality improvement*.
> **(Care Quality Commission 2017b)**

Health and care organisations that recognise and value the diversity of the population groups they serve are better able to deliver fair and equitable support. Conversely, a lack of consideration of these differences and related needs can result in poor experiences and outcomes for certain groups of people (Imtiaz-Umer and Frain 2023; (LewisDave Buck*et al* 2022). Evidence shows that a focus on equity and inclusion can also have positive impacts for staff: it helps to create a culture in which everyone feels safe, valued and well supported.

> *There is an association between good and outstanding practice and a focus on equality and inclusion for both people using services and for staff. Equality and inclusion is often embedded into the culture of organisations where good practice is found. Where this happens, leadership teams make considerable efforts to support staff in areas such as training, health and wellbeing, and welfare. And a focus on equality and inclusion for people using the service often goes hand-in-hand with a focus on equality and inclusion for staff.*
> **(Care Quality Commission 2018c)**

CQC has reviewed case studies of services that have used equality and human rights approaches to improve care. Through this work, it has identified nine factors that have been crucial in developing outstanding care, including committed leadership, staff equality and involving others. These do not require significant amounts of resources to implement, but rather shifts in thinking and behaviour about equality, and an understanding of the contribution it can make to delivering outstanding care (Care Quality Commission 2018a).

While equity and inclusion were identified in the literature as key elements of outstanding care, overall participants in our interviews and workshops mentioned them less often. However, some people did describe equity and inclusion as central to delivering outstanding care. This was mentioned in three different ways:

- as an extension of person-centred care, ensuring the backgrounds, cultures, preferences and individual needs of people who use services are taken into account in the way that they are cared for

> *[Outstanding requires us] to think about how care fits with patients and not the other way around.*
> **(Provider – interview participant)**

- in relation to ensuring that care environments are actively welcoming and respectful of all identities and that there is a culture of genuinely valuing a diversity of perspectives

> *If you do not feel included or respected, you will not feel safe to speak up and nor will you feel comfortable working and so on.*
> **(CQC stakeholder – interview participant)**

- in relation to having a strong focus on supporting populations that experience the worst health outcomes, as a way to help address health inequalities through health provision – this could involve, for example, assessing unmet needs or access issues among local populations and designing interventions to help reduce this inequity and promote improved outcomes.

The last point was made more often in relation to health services (as opposed to social care) and NHS services (as opposed to private care organisations). There was also discussion among participants in the workshops about how far this broader focus on addressing health inequalities is an appropriate consideration for private care organisations, given that their model means care is delivered to those who pay for it.

Learning and improvement

Embedding learning and improvement is crucial to the delivery of high-quality, safe care (National Advisory Group on the Safety of Patients in England 2013). Outstanding care happens where there is a culture of learning, supported by clear processes and practices, which in turn drives improvement. Organisations must be able to implement learning and demonstrate its effectiveness in improving care quality. There are various frameworks and guides that have been published to support care providers to improve the quality of care (see, for example, Skills for Care 2024; Care Quality Commission 2020). The Institute for Healthcare Improvement has also developed a framework (Frankel *et al* 2017) and this identifies four key components of a learning system that contribute to safe, reliable, high-quality care:

- transparency
- reliability
- improvement and measurement
- continuous learning.

Learning and improvement are closely connected to the theme of leadership. The literature emphasises the link between a learning culture and a form of leadership that creates a 'learning organisation' (see, for example, West *et al* 2015). The key question on leadership within CQC's assessment framework emphasises the importance of providers being able to evidence learning, its application and its contribution to improvement. It is important therefore that leaders and staff pay attention to how learning is implemented and its effectiveness (Care Quality Commission 2025b).

A SQW independent rapid literature review for CQC on improvement cultures in health and adult social care settings found that organisations do not have a single culture, rather there are subcultures within teams, wards and groups (SQW 2023). Creating a culture of learning and improvement therefore needs to recognise these different subcultures and embed processes and practices of learning and improvement that work for everyone.

Many people in our interviews and workshops described a continuous focus on reflection and improvement as a key feature of delivering outstanding care.

> *Outstanding is continuing to evolve… and everyone needs to be signed up to it. It's about fostering learning and [an] open culture to develop staff, reflect and continually move forward.*
> **(CQC stakeholder – interview participant)**

This could involve systematically using a range of data from staff and people who use services, to identify issues and gaps in delivery, and to drive positive change. This approach puts people who use services and their families at the centre of service design and delivery.

> *If you've not based [decisions] on effective data analysis, if you cannot understand who your population is (both your staff and patients) and you cannot understand how to respond to [them], and you don't know what the barriers are, then you cannot be outstanding. It's impossible.*
> **(CQC stakeholder – interview participant)**

Participants suggested that when fully embedded, this approach enables an organisation to be adaptable in the face of change and challenge, while ensuring that leaders maintain their focus in the face of external pressures such as political changes. In this way, the approach helps to ensure the sustainability of organisations and the delivery of outstanding care.

Participants were also clear that when it comes to outstanding care, a culture of learning and improvement must extend beyond organisational boundaries to include sharing best practice with, and learning from, other organisations.

> *[Outstanding care is thinking about] how all providers can work together to make a better place for us all.*
> **(CQC stakeholder – interview participant)**

Innovation

The literature sets out the role of innovation in driving high-quality care for people who use services. It describes the range of forms that innovation in health and care can take, including new products, services, care pathways or technologies, which are implemented to improve the quality of care and service users' experiences and outcomes (Kelly and Young 2017).

CQC makes the distinction between two types of innovation: one that involves invention (creating new ideas, products, services and so on); and one that involves adoption (implementing what has worked well elsewhere) (Care Quality Commission 2021). One theme in the literature is the role that innovation can play in transforming care in ways that result in positive outcomes for people receiving care. For example, the *State of health care and adult social care in England* reports for 2018/19 and 2023/24 (Care Quality Commission 2024, 2019) discuss the importance of innovations in delivering joined-up care and improving quality of care for those who providers serve. The reports note that outstanding care happens when innovation is embedded at a strategic level rather than individual leaders driving it.

The literature also discusses innovation within the context of workforce and the role of leadership and organisational culture in its development and implementation (Care Quality Commission 2025c, 2021a, 2017a), linking in with the themes in relation to learning and leadership. Previous work from The King's Fund has explored the role of compassionate leadership in creating a working environment that encourages people to find new and improved ways of doing things (Collins *et al* 2017). Working cultures where clinicians are encouraged to be 'research aware' and 'research active' can support the development of new ideas, leading to benefits for people who use care services, teams and organisations, as well as staff themselves. This means a culture where clinician engagement in research opportunities is normalised, and clinicians have protected time to do this (General Medical Council undated).

There is also evidence on the value of engaging more broadly with people who use services in order to innovate. The Accelerated Access Collaborative report, *Enabling innovation and adoption in health and social care* (Care Quality Commission 2021), further notes the importance of providers working with the people they care for and support when it comes to thinking about innovations and their implementation.

Participants in our interviews and workshops frequently cited innovation as a key feature of delivering outstanding care, and as a mark of difference between outstanding care and good care. While some participants highlighted the use of technology in this regard, innovation was more commonly mentioned in relation to finding new ways to provide care and to carry out existing tasks – for example, recruiting different roles to help engage with and support people who use services who experience barriers to accessing care.

Some stakeholders suggested that an important part of delivering outstanding care is having a sustained and consistent approach within an organisation or across services. That is, something innovative is not outstanding in and of itself; rather, using innovation to support the consistent delivery of good-quality care across every part of an organisation is what merits an outstanding rating. Innovation – and learning and improvement, as discussed above – should be systematic,

driven by service user and staff feedback and backed up by the assessment of outcomes, with a focus on making a positive difference for people using services. It can be ‘high tech’ or ‘low tech’ and it does not need to cost a lot.

> *Innovation is important but… it’s not about the odd thing being done in an outstanding way – outstanding should be across the board, not just one ‘whizzy’ element.*
> **(CQC stakeholder – interview participant)**

04 Principles for outstanding care

The aim of this project was to develop a set of high-level principles that help providers and regulators to identify and articulate outstanding care. The five principles we developed drew on the key features of outstanding care identified in our literature review and interviews (set out in section 2) and they were further shaped through a series of stakeholder workshops.

There is a lot of overlap between the principles and the features of outstanding care set out in section 2. But there are two key differences because the focus of the principles is on outstanding care **in practice**. First, we grouped two connected themes from the literature and interviews – learning and improvement, and innovation – into a single principle. Second, through our analysis we identified points raised in relation to different themes that could be helpfully grouped together into a single principle, focused on a 'framework' for outstanding care – that is, the principle of having a purposeful approach to making a positive difference. Further details on these decisions are given below.

In this section we set out the final set of principles for outstanding care, indicating how they relate to the evidence base set out in section 2 and the themes in our interviews and workshops. In section 4 we consider how the principles might be used, as well as the steps CQC may want to take in order to make use of the principles.

What the principles are and what they are not

As noted above, the overall purpose of the principles we developed is to offer a high-level description of what outstanding care looks like – for CQC and for providers – and in particular to help differentiate between good care and outstanding care. They are intended to conjure up a 'sense' of what outstanding care is; they do not offer an exhaustive list of all the elements of outstanding care, nor are they a checklist for achieving an outstanding rating from CQC.

The five principles are interlinked and it is important that they are considered together. The principles incorporate the features of outstanding care, and overlap and reinforce one another. We see outstanding care as care that reflects all five principles. They incorporate both features of outstanding care, as well as some of the 'drivers' of outstanding care.

While we acknowledge that exactly what outstanding looks like varies between sectors and settings, our evidence review shows that there are some clearly identifiable features common to outstanding care across a range of contexts (this is also something we explored with our interview and workshop participants, as set out in section 2). We therefore designed the principles to be sufficiently high level that they can inform understanding of outstanding care across all the sectors that CQC regulates.

For each principle, we developed a high-level definition. To further articulate what the principle is focused on – and recognising that it will manifest differently in different settings – we also produced a small number of illustrations of what that aspect of outstanding care might look like in practice.

While they are rooted partly in the findings of our literature review, to help ensure the principles felt meaningful to CQC and providers, as far as possible we reflected the language and descriptions that stakeholders had used in the interviews and workshops.

We expect that providers and CQC staff will be the primary audience for the principles, rather than people who use services and the public. However, people who use services (via the involvement of experts by experience) have informed them.

Five principles for outstanding care

1. Delivering truly person-centred care
2. Embedding a culture of compassionate and inclusive leadership
3. Prioritising equity and inclusion
4. Continuously integrating learning into practice to drive improvement and innovation.
5. Having a purposeful approach to making a positive difference for people who use services, staff and the wider system

Below we have set out each principle, including a definition and some illustrations of what it could look like, recognising it will manifest differently in different settings. We also highlight the key themes and feedback that informed them.

Principle 1: Delivering truly person-centred care

Definition: Outstanding care is always highly responsive to individuals' needs, preferences and aspirations, recognising what is important to people who use services, their strengths, cultures and histories.

Below are some illustrations of what it could look like.

- Staff establish a genuine and deep connection with those they care for and demonstrate real curiosity about what matters to them and how to meet their needs.
- Kindness and dignity are central to every interaction between staff and those they care for.
- People using services have autonomy and the power to have their needs and wishes communicated and to influence their care.

- Families, carers and people who use services are encouraged and actively supported to be active partners in their care, leading to exceptional levels of satisfaction.
- Care goes beyond meeting clinical or personal care needs. It also supports and empowers people to achieve what is important to them.
- Care that is joined up for each individual along their care 'pathway', within and between services, is prioritised.

This principle draws on themes that came out clearly in the literature review and in our interviews, as set out in section 3, around the importance of a human connection between people receiving care and care givers, and the need for a 'holistic' approach that recognises the needs and preferences of the person receiving care. It emphasises the importance of staff showing a genuine 'curiosity' – a term used in the literature and in our interviews – about the people they care for. In some settings, continuity of care or consistency in teams caring for an individual will be a key part of achieving this.

Conversations in our workshops emphasised the importance of consistently putting the needs of people first at all levels of care, highlighting this as a key distinction between outstanding care and good care. Workshop participants put an emphasis on being **proactive** in some of these areas – for example, actively supporting and encouraging families and carers to engage in the care of the individual, where this is what the individual wants, rather than simply enabling this. This principle and the emphasis on recognising the particular needs and preferences of people who use services are closely linked to the principle on equity and inclusion set out below. However, the latter goes beyond individual needs to look at broader issues related to health inequalities and engagement with communities.

Principle 2: Embedding a culture of compassionate and inclusive leadership

Definition: Outstanding care happens when leaders foster an open, psychologically safe, inclusive and values-driven culture that is focused on people who use services and empowers staff.

Below are illustrations of what it could look like.

- Leadership is distributed, supportive and inclusive.
- Leaders are visible, accessible and responsive to staff and people who use services.
- Values, including expectations for high-quality care, are truly people focused and consistently lived throughout the organisation.
- Staff are highly engaged, respected and supported to learn and develop.
- Staff have a clear sense of belonging, feel safe and are encouraged to speak up and are empowered to make decisions in response to the preferences of people who use services.
- Leaders consistently embrace opportunities available to their service or organisation to make a positive, tangible difference to the local community, economy and environment.

The critical role of inclusive and compassionate leadership in outstanding care came through clearly in our literature review. Participants in our workshops, particularly those from provider organisations, felt that this principle articulated a fundamental component of outstanding care.

The principle highlights the role of leaders in creating an environment that enables staff to deliver outstanding care. Themes that informed the development of the principle are:

- the importance of distributed and inclusive leadership, where staff at all levels are enabled and supported to lead in different ways
- the relationship between leadership, staff and service users' outcomes – workshop participants emphasised that distributed, inclusive leadership that is people focused in turn has a positive effect on the quality of care.

Principle 3: Prioritising equity and inclusion

Definition: Outstanding care happens in an environment that is inclusive, prioritises equity and actively embraces diversity among people who use services and staff.

Below are some illustrations of what it could look like.

- Care environments are welcoming and actively value and respect all people.
- Diverse perspectives are sought and celebrated.
- Partnerships with communities and community organisations are actively developed, to co-design and co-deliver services.
- Organisations and services challenge themselves about the particular contribution they can make to tackling health and care inequalities.
- Organisations and services promote equity and proactively respect human rights.
- There is clear accountability for equality and inclusion, with measurable goals and regular reporting.

Our literature review highlighted the link between a focus on equality and inclusion and the delivery of high-quality care. This is not only about valuing the diversity of people who use services, but also about fostering a culture where staff feel safe, included and enabled to deliver the best care.

While participants in our interviews and workshops did not identify the prioritisation of equity and inclusion as a key feature of outstanding care explicitly, many people alluded to aspects of this, which we have brought together into a broad principle. This includes a focus on tackling health and care inequalities and working with diverse communities and community groups to understand people's needs and inform the design and delivery of services. This aligns well with some of the themes in the literature.

One theme in our workshop discussions was the extent to which the principle of equality and inclusion would apply to all care settings or all types of providers. For example, some participants in our provider workshops found it difficult to envision how they could partner with communities and community organisations or tackle wider health inequalities. Particularly some independent and specialist providers noted that because their service users came from specific populations (that is, those with private insurance or those referred for specialist care), they felt it would be difficult for them to tackle broader health inequalities.

As with each of the five principles we developed, the principle of equality and inclusion is intended to capture a high-level 'approach' associated with outstanding care and the illustrations given above demonstrate what the principle might look like in practice. It is not expected that all illustrations (of which addressing broader health inequalities is one) will be relevant in all settings. Nonetheless, in response to the above feedback, the principle was amended to emphasise the importance of providers challenging themselves to think about their

particular contribution to reducing health inequalities, and their willingness to think creatively and embrace a more stretching goal (appropriate to the service provider's particular circumstances), as the differentiator between good and outstanding care. In addition, while we would expect good care to be equitable, we have highlighted the **prioritisation** of equity as a feature of care that is outstanding.

Although a small number of workshop participants questioned whether the principle was better incorporated into the first principle set out above on person-centred care, it has been kept as it is because the principle goes beyond individual needs and considers the diversity of needs, to include collaboration with communities and community groups and wider issues. It also addresses institutional factors that can lead to inequalities within a provider organisation, rather than focusing on individuals.

Principle 4: Continuously integrating learning into practice to drive improvement and innovation

Definition: Outstanding care happens when a learning mindset is embedded in teams and organisations, with a focus on evolving practice and continuously sharing knowledge.

Below are some illustrations of what it could look like.

- Continuous reflection, learning and improvement are part of regular practice.
- There is an open culture that is honest about challenges and mistakes, and values these as opportunities for learning.
- Innovation is contextual, purposeful and enables consistently better outcomes for staff and people who use services.
- Quantitative and qualitative data is used meaningfully to drive improvement.
- Learning is systematically shared internally and with other organisations to support system integration and improvement.
- Relevant learning from beyond the organisation and from other sectors is integrated to consistently improve care.

The principle of continuing to integrate learning into practice to drive improvement and innovation brings together learning and innovation, which were two core themes from our literature review. We combined these features within a single principle to emphasise the interconnected nature of learning and innovation when it comes to outstanding care. The focus is on continuous learning, and a form of innovation that is contextual and purposeful – avoiding the characterisation of innovation as, for example, the adoption of a new piece of technology or improved processes in an isolated part of the service. This emphasis on continuous learning and innovation is also important in ensuring that the principle 'stands the test of time',

recognising that adopting an innovation tool or practice at a certain point in time does not in itself make a service innovative, unless embedded within this longer-term approach.

The principle was developed based on themes that came through in our literature review, interviews and workshops about improvement, innovation and how organisations ensure that they create a culture of learning. It also considers how services harness learning and innovation to improve care and support for people who use services.

The principle is also closely linked to the principle focused on compassionate and inclusive leadership. An open culture of acknowledging mistakes and learning from them – key to embedding learning in practice and using this to innovate – are contingent on the right leadership.

Principle 5: Having a purposeful approach to making a positive difference for people who use

Definition: Outstanding care comes from a clear and deliberate focus on making a positive difference for people who use services, staff and the wider system and is evidenced in key outcome measures and feedback from people who use services and staff.

Below are some illustrations of what it could look like.

- Outcomes and experiences for people who use services are excellent and there is a constant drive to improve them.
- There is a clear vision for outstanding care and how all those responsible for care delivery can provide it.
- Providers are outward looking and work in partnership to meet the needs of those in their care and, where appropriate, the needs of the wider community.
- Effective governance, processes and systems are in place to identify and drive positive outcomes.

This final principle on making a positive difference sets out the importance of having an overall, deliberate ‘framework’ for outstanding care. Although this was not an explicit theme in our literature review or interviews, it brings together some specific points that were raised in relation to the other themes. Often these were talked about as ‘enablers’. This includes an emphasis on the critical role of infrastructure, governance and systems in ensuring high-quality care. It also connects to the idea of a focus on – or vision for – outstanding care that staff across an organisation share.

More fundamentally, it is about the clear pursuit of a positive impact on people who use services, and the ability to demonstrate this. A theme that came through in a number of our

workshops was the critical importance of the link between the first four principles set out above and this final principle of making a positive difference for people who use services. Many felt that without this clear, deliberate focus, matched by evidence of impact, care cannot be considered outstanding.

The principles as a group of five

As set out earlier in this section, the five principles are interlinked, overlap and reinforce one another. For example, if care is truly person centred, responding to the needs and preferences of each individual, it must also be inclusive. Similarly, a culture that encourages learning and improvement is most likely where there is an inclusive form of leadership, with staff feeling engaged and enabled to take risks.

There are also themes that cut across all five principles, most notably the importance of a community-focused or 'outward-looking' approach, whether that takes the form of sharing learning with other services and organisations, or identifying opportunities for working with local community organisations to develop services.

The interconnectedness of the principles reflects their 'high-level' nature, and also the complexity of defining outstanding care, which, as discussed in the previous section, is often described as something 'that is felt'. Outstanding care is care that reflects all five principles – excellence in only one or two of the areas identified is not sufficient.

Testing and refining the principles through the workshops

We used six workshops with a range of people, including experts by experience, CQC staff and staff in provider organisations, to refine the principles (see the methodology in the appendix for more details on the workshop participants). The workshops were an opportunity to share and test the first iteration of the principles and collect views on whether they covered the right areas and how they might be used.

The principles were presented first as a high-level set of five to get initial reflections from participants and then individually, along with their more detailed definitions and illustrations, allowing participants to give specific feedback on each one.

As well as the specific points highlighted above in relation to individual principles, the feedback collected across our workshops shaped the final principles in the following ways.

- It confirmed the broad content of the principles.
- It led to the 'strengthening' of the principles' definitions and illustrations to help ensure they reflected outstanding rather than good care.
- It resulted in changes in language.

The broad content of the principles

Nearly all workshop participants were positive about the high-level principles when presented as a set of five (that is, without their more detailed definition and illustrations). Participants felt that they were broadly successful in capturing key elements of outstanding care, and there was little challenge on the areas they covered.

> *I think these are great high-level concepts and I do think that they will resonate as being great points, but again it [is what] hangs underneath them [that will be key].*
> **(Provider – workshop participant)**

Some participants did highlight additional features that they thought should be included within the high-level principles, and there were several comments on the need to make safety more explicit in particular. While we would, of course, expect outstanding care to be safe – no service with safety concerns could be considered outstanding – we did not see this as a defining feature of care that is outstanding. But the principles are intended to be relevant across the five key questions within CQC's assessment framework, one of which relates to safety. In addition, the approach the principles capture, such as patient-centredness or continuous learning and innovation, could make that safety outstanding.

However, these questions highlight the importance of thinking carefully about how the principles are framed and communicated. This is discussed in more detail in section 4.

'Strengthening' of the principles' definitions and illustrations to help ensure they reflected outstanding rather than good care

A recurring question in our workshops was whether the draft principles described good care rather than outstanding care, with many suggesting that they reflected what was expected as standard practice. As far as possible, we strengthened the language used to address this point – for example, making clear that outstanding care happens when certain practices or approaches are embedded and applied consistently and proactively, rather than when they happen on a one-off basis. The interconnected nature of the principles is also key; as noted earlier, we consider outstanding care to be care that reflects all five of the principles.

However, our discussions highlighted a fundamental question about outstanding care, which came up at several points during the research: Is outstanding care tangibly different from good care, or does the cumulative effect of consistently and comprehensively delivering all aspects of good care, make it outstanding? Different views on this point were expressed during the research, and this question may be something for CQC to consider as part of its broader work on the assessment framework.

Changes to language

Workshop participants made a range of comments on specific terminology and phrasing used in the principles' definitions and accompanying illustrations. For example, we received feedback that the principles needed to consistently use the language of 'people who use services' rather than referring to patients only – a change that is reflected in the final set of principles. There were also suggestions about language that could be added to the descriptions to make them more inclusive or to improve clarity. For example, in relation to the principle of providing truly person-centred care, instead of one of the illustrations referring to 'different voices' being sought and celebrated – which excludes people who are non-speaking – the illustration was amended to refer to 'diverse perspectives'.

In terms of the presentation of the principles as a high-level set of five (that is, without the more detailed definition and illustrations – see the first box in this section), views were mixed. Some people liked the simplicity of the principles and could see a use for them in this form, but others found it difficult to engage with the principles without further details. For the most part, workshop participants felt comfortable with the level of detail provided when we shared the principles in full, although some felt that additional, sector-specific information was required, as discussed in section 4.

05 Putting the principles into practice

As well as considering what the principles for outstanding care should look like, our research looked at how they might be used. This section sets out views from our interviewees and workshop participants on whether and how they would use the principles. It also highlights some key considerations that CQC will need to address if the principles are to help inform understanding of outstanding care.

A universal set of principles?

One of our key research questions was the extent to which it is possible to have a single set of principles for all of the sectors that CQC regulates. Stakeholders in our interviews and workshops had mixed opinions on this question and different views were also put forward during the report review stage.

Some of those taking part in our interviews and workshops felt that, to be meaningful, the principles would need to be tailored to different sectors. These participants suggested that the significant variation in the nature of care delivered – for example, in a residential care home compared with an air ambulance service – meant that outstanding care would look too different in these settings to be reflected in a shared set of principles.

However, others felt that if the principles captured the overarching characteristics of outstanding care as intended, they should be capable of being used to inform understanding of outstanding care across all sectors.

Our research questions also included the extent to which it is possible to have a single set of principles across all key questions in CQC's assessment framework. Most felt comfortable with this approach:

> *[High-level principles are] almost like the pillars, aren't they? They should be the pillars with which you build stuff around.*
> **(Provider – interview participant)**

While we acknowledge that exactly what outstanding looks like varies between sectors and settings, we found that the literature on high-quality care in different sectors shared similar themes, suggesting that there are some features common to outstanding care across a range of contexts. Similarly, when asked to describe outstanding care, interview and workshop participants with experience working in different sectors referenced similar features, even when they were drawing on very different examples, and often used the same language.

On this basis, we designed the principles to be applicable to all the sectors that CQC regulates. However, as set out in section 3, to help with usability across different sectors and

organisations, we included additional detail – some 'illustrations' – to indicate what each principle *might* look like in practice, depending on the setting.

Stakeholders' views on using the principles

In our interviews, we asked people if, in principle, they would make use of a set of principles for outstanding care. During our workshops, we asked participants if they would use the draft principles we had shared, and if so, how. We heard different views on this, but many people involved in our research did see a use for the principles.

Potential uses of principles for outstanding care

We heard that principles for outstanding care could be used in a number of ways, including:

- to inform CQC's ongoing work on the assessment framework
- to inform CQC's judgements on outstanding care in quality panels – although this may depend on having additional, sector-specific detail alongside the principles
- in training and induction materials for CQC inspectors and experts by experience who are involved in inspections
- to support improvement work in provider organisations by helping them to identify areas for development and to inform their improvement plans
- to help communicate what outstanding care looks like across provider organisations.

Overall, the experts by experience and people from provider organisations who were involved in our research were positive about the principles. Experts by experience suggested that they could be valuable in inspections by offering guidance on what outstanding care looks like. Staff from provider organisations identified two broad areas where the principles would be helpful. First, they could help with sharing a high-level description of outstanding care across their organisation to help build understanding of what this looks like and what to aim for.

> *We could use the principles to communicate outstanding [care] in a non-complicated way… what we are aiming for… empowering staff to know what they are doing is great.*
> **(Provider – workshop participant)**

Second, some people from provider organisations felt that the principles could support internal improvement efforts by helping identify development areas and informing improvement strategies. One workshop participant described the value the principles could bring in helping to generate broader insights on their organisation's performance:

> *… instead of, you know, how long did it take him to receive a phone call? …, that sort of data is completely different. [The principles are] simple and it works, and it really gives me in my own organisation an idea of what actually, you know, what data [we have]. Because of course we've got to collect other data, and I understand that. But in regards to some [aspects] of person-centred care and how we improved it, this is a starting point for us.*
> **(Provider – workshop participant)**

Another participant talked about using the principles to support their work to understand performance levels and identify areas for improvement.

> *We could do a peer review process… get a peer to simulate an inspection… this would help.*
> **(Provider – workshop participant)**

However, as set out above, some of those from provider organisations felt that additional, sector-specific detail was needed to make the principles useful in practice. There were also concerns from some about how they would be able to evidence 'achievement' of such broadly defined principles. These were recurring themes across our workshops and are discussed in more detail below.

Views among CQC staff on whether and how the principles might be used were mixed. In our interviews, a number of CQC staff in policy and strategy roles told us that the principles could help ensure consistency in inspection ratings, acting as a 'thinking tool' internally and, for example, supporting decision-making in quality panels for services or organisations on the cusp of being awarded an outstanding or good rating. As alluded to in the box above, interviewees also talked about the potential for the principles to support ongoing work on the assessment framework and quality statements, with the principles providing overarching guidelines on outstanding care. They said that there may also be a use for the principles in training and induction for inspectors and other CQC staff.

However, others felt that principles were not necessarily the right tool for addressing the issue around consistency, and there was concern from one CQC interviewee that the principles would be too vague, leading to more inconsistency.

Overall, participants in our workshop with CQC operational staff – including inspectors – were sceptical about the principles' usability in their current form, picking up on two themes that some participants in our provider workshops and interviews had mentioned. A key concern was around the use of a single set of principles across all sectors, with most indicating that unless they were tailored to individual sectors, they would be too generic. Another theme focused on the challenges in quantifying and demonstrating impact against the areas the principles identified.

> *Principles are unable to measure impact, which is the ultimate goal.*
> **(CQC stakeholder – workshop participant)**

Each of these concerns is discussed further in the next subsection.

Considerations for using the principles

While there was support for the principles from many of the people we engaged with, our work also highlighted some key considerations that will need to be resolved if the principles are to be of use to CQC and providers:

- clarifying the purpose of the principles
- ensuring coherence between the principles and CQC's wider work
- confirming the approach to sectors
- getting the design right.

We provide further details on these considerations below.

It is important to note the broader point that while the principles are intended to offer a high-level articulation of what outstanding care looks like, they were developed concurrently with CQC's work on the assessment framework, rather than helping to shape it. This means that future work is likely to be required to test the coherence of the principles and CQC's broader assessment approach and, for example, specific ratings characteristics.

Clarifying the purpose of the principles

Clearly articulating the purpose of the principles – when they could be used, how and by whom – will be critical. As set out in section 2, we developed a set of principles that could sit above the detail of CQC's assessment framework, capturing between them a sense of what outstanding care looks like. However, in discussions across all workshops, many participants interpreted the principles as a checklist or a set of criteria against which performance would be measured. This led to questions from providers and, in particular, CQC operational staff about how 'meeting' the principles would be evidenced.

> *But they [the principles] are really difficult to quantify and in most baseline good services, I'd expect families to be encouraged to be active partners in their care. I'd expect staff to support people, and I would say services need to be prioritised. I don't think that gives a really sort of a concrete viewpoint to measure anything against it.*
> **(CQC stakeholder – workshop participant)**

This highlights the importance of being explicit about the way in which the principles could be used. For example, the principles could offer insight to inform decision-making in CQC's quality panels where care is considered to be 'on the cusp' between good and outstanding, although this may rely on supporting, sector-specific material.

There is also an opportunity to address some of the more fundamental questions relating to CQC's approach to scoring – which fell outside of the scope of our work – which were put

forward during our project (see below). These were raised both during the research and at report review stage in particular.

- The first one relates to the extent to which outstanding care is aspirational or something that everyone can achieve. Some felt that, to be meaningful, the outstanding rating should be limited to a small minority of services and organisations, while others felt that it should be possible for all services to be outstanding.

> *Would it be possible, then, in a group in 100 hospitals, everyone could be outstanding? The answer is yes and any CQC approach that insists on a distribution is missing the point.*
> **(Other expert – interview participant)**

- Second, linked to this, on the specific question of the difference between good and outstanding care, there was some discussion about whether or not the cumulative effect of care being good in all areas and over a period of time is sufficient to make care outstanding. This question came up time and time again during our research, including at report review stage, with different views put forward. One reviewer suggested that if comprehensively delivering all aspects of good care made a service or organisation outstanding, the purpose of the outstanding rating should be called into question.

As discussed below, the framing and design of the principles may also help with clarifying their purpose. However, our research makes clear that without this clarification, providers and CQC operational staff will feel unsure as to how and when to make use of the principles.

Ensuring coherence between the principles and CQC's wider work

A key part of defining the purpose of the principles will be deciding how and where they fit with or inform CQC's assessment framework and approach. This theme came up in our interviews and across all of our workshops, with participants suggesting that without clear guidance on this point, the principles were likely to cause confusion.

> *It's [set of principles] helpful, but I guess my only caution is how does this tie in with the quality statements? Because what we don't need is another thing to utilise. I keep telling people: 'Forget the old KLOE [Key Lines of Enquiry assessments]. Forget it. I want you to focus on the quality statements.' So, if we can embed these somehow or align them really clearly, that would be really helpful.*
> **(Provider – workshop participant)**

As CQC takes forward its work on the assessment approach, it will need to consider alignment between the principles, the revised assessment framework(s) and ratings characteristics. This is likely to involve an iterative process to ensure that the overall approach is coherent.

This process could involve further engagement work within CQC and with stakeholders, alongside work to develop the content of a revised provider assessment framework.

Consideration should also be given to what is needed to support assessments of outstanding local authorities (*see* below).

More broadly, it is also important to note that some of the participants in our research questioned the value of principles altogether. As indicated in section 1, our research did not consider principles alongside other tools for identifying outstanding care and therefore there may be some value in exploring the range of alternative approaches that could be used.

Confirming the approach to sectors

CQC has indicated that it will be developing sector-specific assessment frameworks. Within this context, and again, linked to the point on overall coherence, the CQC will need to clarify whether and how the principles for outstanding care could be used to inform the understanding of outstanding care across different sectors.

As set out above, there were mixed views in our interviews and workshops about whether having a single set of principles for outstanding care, to be applied across all of the sectors CQC regulates, would be workable in practice. These contrasting views came through again at report review stage, with one reviewer suggesting that, without bespoke approaches to different sectors, the ratings would lack credibility.

This may be a question of design: one suggestion put forward in different forms in both the interviews and workshops was that the principles could be a useful starting point for some 'translation work', which would consider more specifically what outstanding care looks like in different settings. For example, one participant in a provider workshop, previously an inspector, spoke about the importance of consistency and clarity when communicating the ratings to the public:

> *So, I think being very clear about where these will be applied potentially and consistently to what they say will be really important. Because if we are going to go to hold certain sectors to different standards, then we need to be very clear about what that baseline is… but I think we have to be incredibly clear about, actually the independent sector is being held to this standard that is slightly different to the NHS, or hospices are being held to this standard and that is different. And when you get an outstanding [rating], what that really means. So, I think that's just a piece for translation into the future.*
> **(Provider – workshop participant)**

Similarly, at report review stage it was suggested that the principles – while not sufficient for quality review panels in their current form – could be used as a basis from which sector- and service-specific 'criteria' could be developed, with the principles helping to ensure some consistency.

As part of its work on the assessment approach, CQC will need to determine whether the principles in their current form can inform work across its sector-specific frameworks, or whether further work is needed. This could include work to 'translate' them into sector-specific principles,

or to supplement them with sector-specific guidance, for example in the form of case studies (*see* below).

Getting the design right

Part of the answer to the issues identified above may lie in the way in which the principles are presented, further developed and shared. While this was not a key focus of our research, during our interviews and workshops a number of suggestions were made about how the principles could most helpfully be presented. Bringing these together with our analysis of the key issues above, should the CQC wish to make use of the principles, we suggest that the following factors should be taken into account.

- Avoid presenting the principles as a list or set of bullet points, as this may undermine the intended purpose of the principles as a high-level articulation of outstanding care and risks reinforcing the idea that they are a checklist or set of features to be 'ticked off'. A list approach may also fail to convey the extent to which the principles are interlinked and the idea captured by the fifth principle of an overarching framework for outstanding care, which draws on each of the others. For example, if CQC does want to share the principles, a diagram or presentation of the principles in concentric circles is likely to be more effective in conveying the intended purpose of the principles.
- If CQC uses the set of five universal principles for outstanding care to inform assessment frameworks for all of the sectors it regulates, it would be helpful to provide these alongside some examples or case studies of what this looks like in practice, in different settings. Even where interviewees and workshop participants supported the idea of a single set of principles, they often indicated that they would be most useful if supported by some guidance as to how they might manifest in different sectors.
- In line with its approach to work on the assessment approach more broadly, CQC should engage further on whether and how the principles could be used. In particular, it would be helpful to explore how the principles could inform characteristics of ratings and assessment methods for outstanding care with those stakeholders likely to use the principles. This would build on the work we undertook to engage with a range of CQC staff and provider representatives in developing and refining the principles.

Applying the principles to local authority assessments

One of our specific research questions was the extent to which the principles developed for providers might be applicable to CQC's local authority assessments. Once the principles had been finalised, we held an engagement workshop with CQC's policy leads for local authority assessment to explore this question specifically.

Feedback from the team on the principles broadly echoed what we heard from CQC's operational staff. There were some positive reflections on the overall principles, and a suggestion that they could be useful in calibration panels. However, many participants felt that the principles in their present form captured good care rather than outstanding care, again

leading to a discussion about the extent to which consistently delivering all aspects of good care makes it outstanding.

Much of the conversation focused on whether and how it was possible to map the principles onto the approach for local authority assessments, given how this differs from the approach for providers. There was a suggestion that the principles might need to map more directly to assessments at the level of individual quality statements to reflect the approach used in local authority assessments. Overall, the view was that more detailed work would be required before the principles could support the process in a meaningful way.

06 Conclusion

At the heart of our research was the question of what outstanding care looks like, and how principles might help to distinguish between good care and outstanding care. Our interviews and workshops confirmed that this is an ongoing challenge for both providers and regulators and reinforced the value of developing a clear and shared articulation of what outstanding care looks like.

Through our research we found that outstanding care is in some ways easy to define, with broad consensus on its key features across the literature and a broadly shared understanding of what this looks like among regulators, people using services and providers of different types.

However, clearly articulating outstanding care as a set of principles – which feel meaningful and useful across a range of stakeholders – has been less straightforward. While most people in our workshops received the broad areas that the principles covered well, capturing the distinction between good care and outstanding care was an ongoing challenge. This reflects the widely held idea that outstanding care is something 'that is felt' and can be hard to describe. But it also connects with the following fundamental questions about the nature of outstanding care, and CQC's outstanding rating, which we came back to time and time again in our discussions and at report review stage.

- Is outstanding care tangibly different from good care, or does consistently delivering on all aspects of good care make it outstanding?
- To what extent should outstanding care be 'aspirational'? Should it be possible for all providers to achieve an outstanding rating or is outstanding care only ever delivered by a few?

We heard different views on these questions across all of the groups we spoke to, and therefore these may be helpful questions for CQC to consider as part of its ongoing work on the assessment approach. They also connect with a key question about the underlying purpose of CQC's outstanding rating, and the value of CQC setting this out explicitly.

There was also a lot less consensus on the question of whether and how a set of principles would be helpful in practice. This suggests that the challenge may lie less in agreeing on what outstanding care looks like, and more in determining how it is identified, which tool or approach is most useful and for whom. While our key research questions included examining the role that principles could play in identifying outstanding care and how they might be used, a key limitation of our work was that we did not explore alternative approaches to identifying or articulating outstanding care.

As our conversations in the interviews and workshops made clear, the question as to how a set of principles might help with identifying outstanding care cannot be separated from the broader

questions around CQC's assessment approach and the work it is currently undertaking to improve.

For the principles to meaningfully support CQC's work on its assessment approach, further testing and refinement will be required to ensure that they align with the revised assessment framework and approach to scoring. Overall, our research suggests that a broad set of principles for outstanding care could be valuable, and that some providers in particular might use them to support their work to improve. The principles may also have a key role to play in CQC's internal quality panels when making judgements on outstanding ratings, although this may depend on them being accompanied by more detailed, sector-specific guidance. Clearly, framing them as a high-level set of universal principles to inform the more detailed assessment framework and methods would help to clarify their purpose and help avoid confusion. Our work has also underlined the value of engaging widely as this work is taken forward, in the line with the approach CQC is taking in its wider improvement work.

07 Appendix: Methodology

We carried out our research for this project between March and July 2025. The project had two phases: phase one included a review of relevant literature and some in-depth interviews to produce a draft set of principles for outstanding care; and phase two included a series of workshops to test and refine the principles. Each of these activities is set out in more detail below.

Phase one – literature review and stakeholder interviews

Literature review
We carried out a rapid literature review using The King's Fund Library to identify available peer-reviewed and 'grey' literature on outstanding care and principles for outstanding care, as well as articles and case studies on specific services or organisations considered to be outstanding. The search focused on care that was considered to be excellent in terms of outcomes and experience, including but not limited to care that CQC had rated as outstanding. We also drew on CQC's own reports and guidance, which describe some of the factors that drive high-quality care, including features of outstanding care.

Search terms included good and outstanding ratings, and principles for and assessments of excellent care. We used a number of databases and sources*:*

- the Health Management Information Consortium (HMIC) database – a combination of databases from the Department of Health and Social Care and The King's Fund
- the King's Fund's database
- MEDLINE
- the Social Policy and Practice database
- Google Scholar
- international websites.

The inclusion criteria for the literature review were that the literature had to be from the United Kingdom and elsewhere but in the English language only, and published between 2010 and the current day. The search yielded a total of 107 articles, which we sifted for relevance.

The bulk of the literature from the United Kingdom relevant to the broad topic of excellent or outstanding care involved CQC reports and examples of providers who had been rated good or outstanding. Some literature focused on the impact of ratings on different aspects of care, staff and workforce issues in different sectors. Others compared the use of CQC's assessment framework with other sectoral guidance/tools. There was a limited amount of relevant literature from outside of the United Kingdom, which included some case studies of high-quality care. Our search did not identify any literature that considered or evaluated the use of principles as an approach to identifying outstanding care.

We used the literature review to:

- identify the themes most frequently cited in relation to the best or outstanding care
- understand the relationship between these features and high-quality care
- look at the way in which they are described.

Given that the wider literature on outstanding care was limited, once we had identified the broad features of outstanding care, we supplemented this with a targeted literature review focused on specific themes, such as leadership.

Stakeholder interviews

Alongside the review of the literature, we conducted 21 interviews in April and May 2025 with people who had insight on outstanding or high-quality care, and/or experience of working in regulation, primarily at CQC. The majority of interviewees were people working in or with CQC in different roles, but we also spoke to a small number of representatives from provider organisations, experts by experience for more information, see Care Quality Commission (2025d), someone with experience of regulation in a different sector and two people from an international health service improvement organisation. Participants included representatives from a mix of sectors and organisations, and with varying lengths of experience and seniority. Across all the stakeholder groups, the types of roles participants held included the following:

- CQC inspectors and assessors
- CQC sector directors and deputy directors
- CQC national advisers
- medical director
- chief nurse, acute trust
- GP
- consultant
- operational manager in a hospice
- vice president of an international health service improvement organisation.

Table A1 displays the types of stakeholders involved in the interviews, the number of interviews we carried out with each type and the number of participants involved in these interviews.

Table A1: Stakeholder interview details

Type of stakeholder	Number of interviews	Number of participants
CQC senior management and operational staff	13	14
Experts by experience	2	2
Providers	4	5
External organisations	2	2
Total	21	23

In the interviews, we asked stakeholders what outstanding care looks and feels like to them. We also asked them to share an example of a time when they felt they had seen outstanding care,

and what it was that made them describe it as outstanding. We probed them on how, in their view, it differs from good care.

Specific areas covered included the following.

- What does outstanding care look like in practice? (For this question there was a particular focus on the differences between good and outstanding care.)
- What current approaches are used to identify outstanding care?
- How might providers and inspectors make use of principles for outstanding care?
- Could there be a universal set of principles that articulate outstanding care, or might the principles differ by sector and/or key question?

Interviews were semi-structured and lasted between 30 minutes and an hour. They were conducted online over Microsoft Teams with consented audio recordings. Most of the interviews involved just one participant, but two interviews involved two participants.

We used a custom Excel spreadsheet to conduct thematic analysis of the features of outstanding care that interviewees mentioned and of interviewees' views on how a set of principles for outstanding care might be used. We tested and refined our thinking through team analysis sessions and tested this through our regular meetings with CQC.

Developing the draft principles
The output of phase one was the development of a draft set of principles for outstanding care, based on our analysis of the themes in the literature and interviews. These principles were designed through an iterative process, and arranged to be read as five interlinking principles that are not mutually exclusive.

To help ensure that the principles felt meaningful to CQC and providers and are widely accessible, as far as possible we reflected the language and descriptions that stakeholders used in their interviews.

We shared the draft principles and our initial findings on how the principles might be used with CQC. This helped us develop our approach to the workshops, which we held during phase two.

Phase two – workshops, analysis and engagement

The workshops
In phase two, we tested the draft principles for outstanding care through a series of workshops with a range of stakeholders:

- three workshops with health and care providers
- two workshops with experts by experience
- one workshop with CQC operational staff, including a number of people who were or had previously been in inspector roles.

We worked closely with CQC to identify participants for all workshops.

We selected participants for the provider workshops to represent a mix of sectors, services and organisational size and CQC had rated the majority of the providers as either outstanding or good. The range of sectors and services represented included adult social care, children's public health, air ambulance, hospices, acute and mental health hospitals and drug and alcohol services.

Availability to participate in the research was also a key factor in identifying workshop participants and, given the workshops fell in the summer months, we were required to take a pragmatic approach. This meant that not all providers in our workshops had been awarded either a good or outstanding rating. In addition, while we did identify a participant from a primary care provider, they were unable to attend at short notice and therefore this perspective was missing from our workshops.

Table A2 displays the types of stakeholders involved in the workshops, the number of workshops we conducted with each type and the number of participants attending these workshops.

Table A2 Workshop details

Type of stakeholder	Number of workshops	Number of participants
Providers	3	26
Experts by experience	2	14
CQC operational staff	1	8
Total	6	48

In the workshops, we first asked participants to share their views on what outstanding care looks like to them, with prompts on differences between outstanding and good care. Following this we presented the draft principles for outstanding care that we produced at the end of phase one, first as a set and then individually. We asked participants for feedback on the content of the principles and about whether and how they might be used. We carried out the workshops over Microsoft Teams and recorded them. Members of the research team also took notes of the discussions, which were subsequently written up.

Analysis
We conducted a thematic analysis of the discussions in the workshops. We synthesised the themes with our analysis of the literature and interviews in phase one and used feedback on the principles to further refine the content and the language used.

Additional engagement workshop focused on local authority assessments
In December 2023, CQC introduced a programme of formal assessments for local authorities, which consider how they are meeting their duties under Part 1 of the *Care Act 2014*. The expectation is that CQC's initial round of assessments for all 153 local authorities will have been completed by the end of March 2026. At the same time, CQC will be working to 'develop and refine' its approach to local authority assessments, as part of its wider improvement work (Care Quality Commission 2025a).

The approach used for assessing local authorities is different from the one used for assessing providers. Rather than using the five key questions set out in CQC's assessment framework for providers — it is focused on a subset of nine quality statements. It also draws on only five of the six evidence categories used in provider assessments, with the observation evidence category not used (Care Quality Commission 2025e).

One of the aims of our research was to consider the applicability of the principles for outstanding care we developed to the local authority assessment process. Once we had refined the principles following the workshops, we facilitated an engagement session with CQC's policy leads for local authority assessment. We used this session to share the findings from our work and explore whether and how the principles might be applicable to local authority assessments.

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