How CQC monitors, inspects and regulates NHS trusts

Updated November 2022

Updates to this guidance since August 2021:

- Updated information about the Use of Resources assessments to reflect their current status

Always check CQC's bulletins and website for the most up-to-date guidance

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MONITORING AND INFORMATION SHARING

How we monitor and inspect NHS trusts

CQC Insight

We use CQC Insight to monitor potential changes to the quality of care that you provide. CQC Insight brings together in one place the information we hold about your services, and analyses it to monitor your service at provider, location, or core service level. This will help us to decide what, where and when to inspect and provide analysis to support the evidence in our inspection reports.

Sharing CQC Insight with you

CQC Insight produces monitoring reports, which we will share with your trust. This will enable us to have an ongoing conversation about quality during your regular relationship management meetings with your local CQC relationship holder. We will also share the reports with other key partners including NHS England and NHS Improvement, clinical commissioning groups and Healthwatch. You will receive access rights to see your reports when the Insight product for your sector is ready.

Changes in the quality of care

Our inspectors will check CQC Insight regularly. If it suggests an improvement or decline in the quality of care for a service, we may follow this up between inspections, or ask you for further information or explain the reasons during our regular relationship management meetings. We may also decide at our internal planning meeting to re-inspect that service. If there are significant concerns we may carry out a focused inspection.

What CQC Insight shows us

For all NHS trusts, CQC Insight gives inspectors:

- Facts and figures: contextual and descriptive information such as levels of activity, staffing and financial information.
- A ratings overview: the trust's latest CQC ratings with information about the direction of potential change suggested by the performance monitoring indicators.
- Intelligence overview: a summary of the analysis of the indicators selected to monitor performance. It is presented at provider, key question and, where available, core service level.
- Performance monitoring indicators: show a trust's performance compared with national standards or with other providers. They also indicate changes in a trust's performance over time, and whether its latest performance is an improvement, decline or about the same as the equivalent period 12 months before. All indicators are mapped to CQC's five key questions and key lines of enquiry (KLOEs).
- Featured data sources: for example, the findings from national surveys, incident reports, mortality ratios and outliers.

We will coordinate our monitoring activities for complex providers that operate across sectors and, where possible, combine information about each of their services within our Insight model.

Sources of information

CQC Insight analyses information from a range of sources and uses common indicators to monitor performance across all types of NHS trusts. This is also tailored to each sector or type of service. For example, CQC Insight for acute hospitals presents findings from relevant national clinical audits and our analysis and follow-up of mortality outliers. CQC Insight for providers of specialist mental health services includes analysis of the findings of our visits to people detained under the Mental Health Act 1983 and relevant notifications under the Act. Where possible, we will present analysis relating to the core services and KLOEs.

When new data becomes available, we will refresh the data in our Insight products as soon as possible.

The content of all our Insight products initially focuses on existing data collections. We are continuing to develop indicators, particularly in relation to the core services and from national clinical audit programmes. We are also looking at ways to improve how we use qualitative information, including views from the public, staff and people who use services. As we develop CQC Insight, we will ask you for feedback so that we can improve it.

How we work with national partners

We work in partnership with many national organisations to share information about services and people's experiences of them. These closer working relationships will increase efficiency by reducing duplication and making the best use of shared information and resources. Our inspectors and inspection managers have an ongoing relationship with organisations including:

- NHS England and Improvement
- Healthwatch England
- National Guardian Freedom to Speak Up
- National Data Guardian.

We also engage with other partner organisations, such as the Parliamentary and Health Service Ombudsman, professional regulators such as the Nursing and Midwifery Council, the Health and Care Professions Council and the General Medical Council, and royal colleges. We will work with these bodies and gather different types of information regularly, as well as in the lead-up to an inspection.

NHS Improvement

When working together, CQC and NHS Improvement follow these principles:

- We work together to carry out our respective functions effectively, while recognising that each organisation is legally and operationally independent.
- Our organisations are more closely aligned so that our definitions, measurement and operations are based on a single shared view of quality.
- We work to remove duplication between our organisations.
- We focus on quality and show that it should, and can, be maintained and improved alongside financial sustainability.

We work together across all aspects of our regulatory/oversight model, by:

- sharing data and aiming to use a single, shared standard of measurement, both to review performance and to decide where to target support or oversight
- coordinating how we gather evidence to plan site visits, using information from NHS Improvement as evidence to inform our judgements on inspections and improvement activities
- sharing information on the results of our inspections and regulation/oversight, including enforcement actions, and areas of good practice

- coordinating how we engage with individual providers as well as with wider health care systems.

Well-led

The well-led framework for healthcare providers has a strong focus on financial and resource governance, and was developed jointly by CQC and NHS Improvement. It provides a single structure to enable us to assess and review the leadership, management and governance of an organisation (including self-review).

CQC uses the well-led framework in our inspections and regulatory activity, and NHS Improvement uses it in its oversight/regulation and to support improvements in trusts. Trusts themselves are encouraged to use the framework to carry out developmental reviews as part of their efforts for continuous improvement.

When CQC inspects the well-led key question at the trust level we take into account NHS Improvement's assessment of a trust's performance and leadership.

Before an inspection, NHS Improvement will provide information on trusts' financial and resource governance to CQC's inspection teams, which is drawn from its regular oversight and improvement work. Members of staff from NHS Improvement may also carry out a detailed assessment of financial and resource governance for a particular trust in a joint team with CQC inspectors, when inspecting the well-led key question at the trust-wide level. NHS Improvement will assess the risks in each trust and use the information it already holds to determine its involvement.

Use of resources

CQC and NHS Improvement recognise that effective use of resources is fundamental to enable health and care providers to deliver and sustain high-quality care for patients. We are committed to working together to assess, rate and report on NHS trusts' use of resources.

Use of resources assessments also form part of NHS Improvement's approach to trust oversight and improvement through the Single Oversight Framework. This identifies the support that trusts need and provides good practice to help drive improvement and give patients consistently safe, high-quality, compassionate care within financially sustainable local health systems.

The use of resources framework was jointly developed with CQC. NHS Improvement started to use this to assess non-specialist acute trusts' use of resources in October 2017. The use of resources assessment results in a rating and report, which helps patients, providers and regulators to understand how effectively trusts are using their resources to provide high-quality, efficient and sustainable care.

See the section on use of resources.

Fit and proper persons requirement: directors

NOTE: this does not apply to providers that are individuals or partnerships.

Providers are responsible for appointing, managing and dismissing directors and board members (or their equivalents). People who have director-level responsibility for the quality and safety of care, treatment and support must meet the fit and proper persons regulation (FPPR) (Regulation 5 of the Health and Social Care Act 2008). This aims to make sure that directors are fit and proper to carry out their role.

You must carry out appropriate checks to make sure that directors are suitable for their role. Our role is to make sure that you have a proper process to make robust assessments to satisfy the FPPR.

Information of concern

CQC may intervene where there is evidence that you have not followed, or you do not have, proper processes for FPPR. Although we do not investigate individual directors, if we receive information of concern about the fitness of a director, we will pass this on to you as the provider.

We will tell you about all concerns relating to your directors and ask you to assess all the information we send. We will have the consent of the third party referrer to do this, and will protect their anonymity wherever possible. However, there may be occasions when we are concerned about the potential risk to people using services, so we will need to progress without consent. We will also inform the director to whom the case refers, but we will not ask for their consent.

You must detail the steps that you have taken to assure the fitness of the director and provide a full response to CQC.

We will carefully review and consider all information. Where we find that your processes are not robust, or you have made an unreasonable decision, we will either:

- contact you to discuss further
- schedule a focused inspection
- take regulatory action in line with our enforcement policy and decision tree if we identify a clear breach of the regulation.

How we work with local and regional partners and the public

We use people's experiences of care to help decide when, where and what we inspect.

We encourage people to share their experience with us so that we can understand and act on them. This includes through our national Tell us about your care partner charities.

We also work in partnership with a range of local and regional groups. We share publicly available information with these groups and ask them to share information with us.

As well as your clinical commissioning groups, our Inspectors and Inspection Managers will be in regular contact with people from the relevant:

- local Healthwatch
- overview and scrutiny committees
- foundation trust councils of governors
- independent NHS complaints advocacy
- voluntary and community sector organisations (particularly those representing people whose voices are seldom heard)
- local authorities
- GP patient participation groups
- independent mental health advocacy
- independent Mental Capacity Act advocacy.

We also work with:

- parliamentarians
- schools
- police, fire services and local medical committees
- coroners
- environmental health teams.

How we manage our relationship with you

Ongoing contact with CQC

One of your local CQC Inspectors or Inspection Managers will be designated as your relationship holder. Your relationship holder is key in developing a consistent understanding of your organisation.

The main way for you and your relationship holder to maintain regular contact will be through relationship management meetings. These allow you to discuss important matters about your services.

We will strengthen alignment with other national bodies such as NHS Improvement, to reduce any duplication in ongoing contact with providers.

Frequency of meetings

Face-to-face relationship management meetings will usually happen at least every three months. Your relationship holder may also stay in contact with you more regularly, for example through teleconferences.

Who should attend

Your relationship holder will usually meet with senior and/or executive members of the trust's management team, together with any other member of staff the trust wishes to bring to discuss a particular issue. In some circumstances, senior staff from CQC will attend.

As part of the relationship management meeting, we may ask to meet staff or patient groups to establish a broader view of the trust's culture and quality performance and help us decide on priorities for inspection.

What we discuss

Before a face-to-face relationship management meeting, your relationship holder will fill in a template to inform the discussion, based on the information we hold. This may include information such as details about changes in practice, serious incidents or complaints or concerns they have received about the trust's services. We will share the template with you before the meeting and you will be able to comment on it or add to it.

If a trust has any significant concerns about quality, we expect you to raise them with the relationship holder, together with the action the trust is taking to address them. If the trust has commissioned any external reviews, you should also disclose these as a matter of course.

Other opportunities for contact

Your relationship holder will normally attend two of the trust's board meetings in a year (to be confirmed). This enables them to observe how the board is run, and to meet its members.

CQC will also liaise regularly with other local and regional organisations and the public, and with national partner organisations.

We welcome your feedback to help us improve our services. If you have any concerns, please contact your relationship holder and we will respond as quickly as we can.

INSPECTION

The inspection team

Each inspection team is led by a member of CQC's staff and includes specialist professional advisors such as clinicians and pharmacists. Where appropriate, an inspection team will also include Experts by Experience. These are people who have experienced care personally or experience of caring for someone who has received a particular type of care.

The experts who join the team reflect the type of services being inspected, the areas that we want to focus on and the nature of any concerns identified before inspection. This will also influence the size of the inspection team. An inspection team may include:

- A CQC Head of Inspection.
- CQC inspectors and inspection managers.
- Specialist professional advisors. These are clinical and other experts such as nurses, doctors, psychiatrists, psychologists, social workers, GPs, physiotherapists, occupational therapists, or health service managers.
- Mental Health Act Reviewers.
- Experts by Experience.
- CQC inspection team support staff (where appropriate).

Where we are carrying out the trust-level inspection of the well-led key question, we will also include:

- Specialist professional advisors with appropriate experience of organisational leadership, governance and finance, such as relevant directors and heads of governance.
- Staff from NHS Improvement, to assess financial and resource governance in the trust.

We will only carry out a comprehensive inspection of all core services in exceptional circumstances, but for larger inspections, an inspection team may also include an Inspection Chair (a senior clinician, or director level leader).

What we will inspect

Our main approach is to carry out inspections of certain core services followed by an inspection of the well-led key question at trust level. But we will sometimes look at all core services (a comprehensive inspection) and sometimes just look at specific areas of concern (a focused inspection).

Types of inspection

Core service with well-led

These involve inspecting the five key questions in at least one core service, followed by an inspection of how well-led a provider is. We may also include an inspection of an additional service. The number of services that we inspect will therefore vary for each organisation. Most core (and additional) service inspections will normally be unannounced to enable us to observe routine activity. In some cases we may give a short notice period, for example when the service is delivered over a large geographical area or where we are inspecting a significant number of core services simultaneously.

The inspection of the well-led key question at trust level will follow the core service(s) inspection. This will be announced on the first day of the core service(s) inspections to give us time to schedule the appropriate interviews. On-site activity will take up to three days. This assessment focuses on the well-led key question at trust level, and draws on our wider knowledge of quality in the trust at all levels.

Our assessment of trust-wide leadership, governance, management and culture will be the starting point for the trust-level rating for well-led. We also consider improvements and changes since the last inspection.

A small team of inspectors and specialist advisors with appropriate experience will look at a range of evidence applicable at the overall trust board level. This includes interviews with board members and senior staff, focus groups, analysis of data, strategic and trust-level policy documents, and information from external partners. The scope and depth of our assessment of the well-led question varies for each provider. Our approach depends on factors such as the size of the trust, the findings of previous inspections, and information gathered from the provider, external partners and other sources on performance and risks in the trust across our five key questions.

Comprehensive

A comprehensive inspection is when we inspect all core services and all five key questions for each core service followed by an inspection of how well-led a provider is. The visit is announced and will usually last between one and four days.

Comprehensive inspections will only be triggered where we have significant concerns, for example if a trust is receiving mandated intensive support or where there has been significant change in the provision of services.

There will also be an unannounced visit(s) following the main announced inspection. This may be during the day or out of normal working hours and will often involve a smaller inspection team. We may re-visit areas we have already inspected. As with other inspections, at the start of the visit, the team will meet with the provider's senior operations lead on duty at the time and we will feed back if there are any immediate safety concerns.

Focused

We may carry out a focused inspection when we need to respond to information about a concern or to follow up on the findings of a previous inspection. The inspection doesn't always look at all five key questions, but is focused on specific areas of concern.

Focused inspections may also happen when we have taken enforcement action. They are therefore smaller than comprehensive inspections, although they follow a similar process.

Focused inspections will normally be unannounced.

Inspecting complex providers and combined trusts

Where possible, we align our inspection process to minimise the complexity and increase efficiency for providers that deliver services across more than one sector for example, mental health, community health and care homes. We will use teams of specialists to inspect each of the services. For example, some trusts may provide a combination of acute hospital, mental health care, community health services and ambulance services, and may also run care homes or provide primary health care services. Also see how we rate services.

Use of resources

NHS Improvement carries out use of resources assessments for non-specialist NHS acute trusts. The assessment is of the provider's overall use of resources, and is assessed only at the trust level (not for each core service or hospital location).

It includes an announced site visit by a team from NHS Improvement. These will be planned with the trust in advance and normally scheduled to take place before the corresponding CQC on-site inspection of the well-led key question at the trust level.

Use of resources assessments result in a formal rating for the trust's use of resources and a report, which CQC reviews, approves and publishes on our website.

These assessments initially apply to non-specialist acute trusts, but NHS Improvement is exploring how it could also apply to specialist acute trusts and mental health, ambulance and community care trusts.

For more information about the approach, see the section on use of resources and the joint use of resources assessment framework.

Core services

Core services are the ones that most trusts provide. They are typically services that people use the most, or in some cases, the ones that may carry the greatest risk.

We will not always inspect every ward or part of a core service in a single inspection. To help us select and prioritise the specific areas to visit, we may either:

- select a random sample of some wards or parts of the service, or
- select others according to various factors about risk, quality and the context of the services.

Acute core services

We inspect eight core services in acute hospitals.

Urgent and emergency services

Urgent and emergency care refers to the service that people can access, without a referral, in an urgent or emergency situation. Its purpose is to treat patients presenting as an emergency or with urgent medical needs. Services include emergency departments, also called accident and emergency or A&E departments, and urgent care centres (UCCs). They may also include a clinical decision unit, ambulatory care unit, minor injury unit or walk-in centre. If the trust provides an urgent care centre we will also include this in the core service inspection.

An UCC may be located on one provider's premises but another provider may be responsible for it. In these cases the responsible provider must function effectively with the emergency department. We will look at the care pathways between the two providers during the inspection.

Please note: in CQC's inspections, the treatment of children in the emergency department is part of the urgent and emergency core service. We do **not** consider it as part of the trust's services for children and young people.

Medical care (including older people's care)

This includes the broad range of specialties not included in the other core services. In general terms, medical care includes those services that involve assessment, diagnosis and treatment of adults by medical interventions rather than surgery. Medical care also includes endoscopy services. Areas that we will inspect include:

- acute assessment units (also known as medical assessment units)
- general wards
- specialty wards, including gerontology (also known as care of the elderly) wards.

Surgery

This core service involves most surgical activity in the hospital. It includes planned (elective) surgery, day case surgery and emergency surgery. We inspect pre-assessment areas, theatres and anaesthetic rooms and recovery areas.

Surgical disciplines could include:

- trauma and orthopaedics (T&O)
- colorectal surgery
- general surgery
- urology
- ear, nose and throat (ENT)
- cardiac surgery
- vascular surgery
- ophthalmic surgery
- neurosurgery
- breast surgery
- upper gastro-intestinal surgery
- plastics and maxillofacial surgery
- thoracic surgery.

The surgery core service also includes interventional radiology.

We include some specialist surgery, including caesarean section, under the maternity core service.

Critical care

This includes areas where patients receive more intensive monitoring and treatment for life-threatening conditions. These areas are usually described as high dependency units

(level 2), intensive care units (level 3) or by the umbrella term, critical care units. Critical care should also include outreach services provided in other areas of a hospital.

The Department of Health has defined levels of care (Comprehensive Critical Care, 2000). The critical care core service includes care at levels 2 and 3, including high dependency units. Some trusts provide units for specific conditions such as renal or respiratory failure and spinal injury. The units are included in this core service if they are funded as a high dependency unit and/or are led by a consultant intensivist.

Maternity

This includes all services for women that relate to pregnancy. It includes ante and post-natal services, as well as labour wards, birth centres or units and theatres providing obstetric related surgery.

A hospital can provide some of these services in the community setting, or they may be the responsibility of a different provider. We will look at the pathways between the two settings when we inspect.

If a new born baby requires treatment in a special care baby unit (SCBU) or neonatal unit where a paediatrician delivers the care, this comes under the core service for children and young people.

Services for children and young people

This includes all services for children up to the age of 18 and includes:

- inpatient wards
- outpatients
- end of life care
- all paediatric surgery
- the interface with maternity and community services
- paediatric intensive care units
- arrangements for transition to adult services.

It does not include care provided in the emergency department, as this is covered under the urgent and emergency core service.

End of life care

End of life care involves all care for patients who are approaching the end of their life and following death. A trust may deliver care on any ward or as part of any of its services. It includes aspects of basic nursing care, specialist palliative care, bereavement support and mortuary services.

The definition of end of life includes patients who are 'approaching the end of life' when they are likely to die within the next 12 months. This includes patients whose death is imminent (expected within a few hours or days) and those with:

- advanced, progressive, incurable conditions
- general frailty and co-existing conditions that mean they are expected to die within 12 months
- existing conditions that put them at risk of dying if there is a sudden acute crisis in that condition
- life-threatening acute conditions caused by sudden catastrophic events.

We inspect end of life care that relates to stillbirths under the maternity core service. End of life care that relates to terminations of pregnancy and miscarriages are inspected under the gynaecology additional service.

Where a provider reports a very small number of deaths, we may report end of life care in the most relevant core service. This will usually be medicine or surgery and is likely to only affect specialist trusts.

We inspect end of life care services that relate to children and young people under the core service for children and young people.

Where a provider reports a very small number of deaths, we may decide to report end of life care in the most relevant core service. This will usually be medicine or surgery and is likely to only affect specialist trusts.

Outpatients

Outpatient services include all areas where people:

- receive advice or care and treatment without being admitted as an inpatient or day case
- undergo physiological measurements and diagnostic testing
- receive diagnostic test results.

It does not include children's outpatient services, as these are covered under the children and young people service.

Acute specialist trusts

When we inspect acute specialist trusts we only select the core services that are appropriate for the services the trust offers. Inspections will often be smaller because of the specialist nature of services. We may also adapt a core service to make it more meaningful to providers and the public. For example, the generic maternity core

service may not be appropriate for NHS trusts that specialise in treating women, as most of their activity would be captured under this one core service.

We will consider any additional services for specialist trusts individually. You can see further guidance on this under additional services.

We will always inspect the following two additional core services in a trust that specialises in treating children and young people:

- **Neonatal services:** These provide extra care for new born babies who may be born prematurely or need treatment in hospital after birth. The settings depend on the type of treatment, such as neonatal intensive care units (NICU) and special care baby units (SCBU).
- **Transition services**: Transition is the planned transfer of young people with long-term conditions and/or complex needs from child-centred to adult health and social care services. When we inspect this core service we will look at how transition works across all the trust's services, including how it works with other organisations.

Mental health care in acute trusts

When we inspect acute trusts we will now closely scrutinise how they provide mental health care and support for patients with mental health needs across all the core services we inspect.

This includes people with diagnosable mental health conditions, people with co-morbid conditions and people who are inpatients for physical health reasons, who have or develop mental health needs. The evidence we collect in relation to mental health care informs our judgement for each core service and at provider level, including the assessment of the well-led key question. Acute trusts don't receive an individual rating for the mental health care they provide. However, we use the evidence to inform the ratings at core service level, for well-led and at overall provider level. We expect acute trusts to show evidence of how they are meeting the needs of patients with mental health conditions.

Ambulance core services

We inspect three ambulance core services.

Emergency operations centre

The emergency operations centre (EOC) receives and triages 999 calls from the public and other emergency services. It gives advice and dispatches an appropriate service to the scene.

It also receives and triages 999 calls relating to major incidents and dispatches the appropriate response as a Category 1 provider under the Civil Contingencies Act 2004 (Part 1). This can include hazardous area response teams.

When callers do not need an ambulance response the EOC provides assessment and treatment advice ('hear and treat').

The EOC also manages requests from healthcare professionals to transport people from the community into hospital or between hospitals.

Emergency and urgent care services

Emergency and urgent care services include when ambulance crews assess, treat and care for patients at the scene. The patient can either be transported to hospital ('see and convey') or discharged from the care of the service ('see and treat').

The core service includes transport by air when the provider runs the air ambulance itself, or where it supplies staff to another entity, such as an air ambulance charity.

This core service covers the provider's planning and response to major incidents and emergencies as a Category 1 provider under the Civil Contingencies Act 2004 (Part 1). It takes into account special operations such as serious and protracted incidents.

It also includes being prepared for, and supporting, events and mass gatherings.

If the ambulance trust manages emergency response from other parties, these are also included in the core service. Examples include:

- community first responder schemes involving the public
- co-responder schemes with agencies such as fire and rescue or the armed forces.

High dependency and intensive care transport between hospitals or other care settings is also included, as well as other specialist transport that requires an emergency ambulance. This might be:

- from hospital for end of life care at home
- for patients with mental health conditions who need specialist care.

Patient transport services

These are non-urgent and non-specialist services. They transport patients between hospitals, home and other places such as care homes.

The ambulance core service includes the patient transport control room and dispatch operation and any assessment of a patient's eligibility for the service.

This core service also includes any volunteer driver scheme where it is managed by the ambulance trust.

Other services (where relevant)

Some ambulance trusts also provide a 111 service, out-of-hours service and / or urgent care centre. CQC's Primary Medical Services team will inspect these services and coordinate this with our Hospital inspection team where relevant.

For all services included under the ambulance core service, we will look at how the trust manages business continuity. This includes when it only affects the provider, such as loss of facilities, or as part of a wider event, such as severe weather.

Community health core services

We inspect four core services within community health.

Community health services for adults

These include health services for adults provided in their homes or in a community-based setting. They often focus on providing planned care, rehabilitation following illness or injury, ongoing and intensive management of long-term conditions, coordinating and managing care for people with multiple or complex needs, and health promotion.

The core service includes:

- Community nursing services or integrated care teams, including district nursing, community matrons and specialist nursing services
- Community therapy services such as occupational therapy and physiotherapy
- Community intermediate care
- Community rehabilitation or reablement services
- Community outpatient and diagnostic services

The core service does not include:

- Community end of life care for adults (inspected as part of the community end of life care core service).
- Primary medical or dental care, urgent care services, community learning disability or mental health services (inspected as part of other additional services or relevant core services for other sectors). For example, mental health service inspections include the core service of community mental health services for people with a learning disability or autism.

Community health services for children, young people and families

This covers health services for babies, children, young people and their families in their homes, community clinics or schools. It includes universal health services and health promotion (such as health visiting and school nursing) and delivering and coordinating specialist or enhanced care and treatment including specialist nursing services, therapy services and community paediatric services. These services provide and coordinate care and treatment for children and young people with long-term conditions, disabilities, multiple or complex needs and children and families in vulnerable circumstances.

This core service can also include community sexual health services for people of all ages and community dental services for people of all ages where they are not covered as an additional service.

The core service does not include:

- Child and adolescent mental health services (included in the mental health CAMHS core service)
- Community end of life care for children and young people (included in the community end of life care core service).
- Community midwifery services (included in the acute maternity core service)
- Social care for children and young people (regulated by Ofsted).

Community health inpatient services

This includes all inpatient and day case wards in community hospitals for people of all ages.

Examples of the care provided include:

- Inpatient rehabilitation
- Inpatient intermediate care
- Inpatient nursing and medical care for people with long-term conditions, progressive or life-limiting conditions or for people who are old or frail
- Minor surgical procedures.

This core service does not include:

- Other community health services that the provider runs from a community hospital site, such as community nursing or therapy clinics or outpatient services (included in community health services for adults and/or for children, young people and families core services).
- End of life care provided to people on community inpatient wards (covered by the community end of life care core service).
- Any services that are run from the location but provided by other providers, such as walk-in centres.

Community end of life care

This includes all end of life care for adults, young people and children that is provided in people's homes and in community hospitals, whether provided by specialist palliative care or hospice at home teams or as part of other services such as district or community nursing. This core service also includes services in a hospice setting where they are run by a provider with a range of community health services.

Where a provider reports a very small number of deaths, we may decide to report end of life care under the most relevant core service, usually community health services for adults.

We will consider additional services individually.

Mental health core services

We inspect 11 core services.

Mental health wards

Acute wards for adults of working age and psychiatric intensive care units

Acute wards provide care and treatment for people who are acutely unwell and whose mental health problems cannot be treated and supported safely or effectively at home. This core service does not include wards where people stay for longer periods (for example, long stay or rehabilitation wards).

Psychiatric intensive care units (PICUs) provide high intensity care and treatment for people whose illness means they cannot be safely or easily managed on an acute ward. People normally stay in a PICU for a short period before they can transfer to an acute ward once their risk has reduced.

Long stay or rehabilitation mental health wards for working age adults

These wards provide care and treatment for people whose needs are more complex, which require them to stay in hospital for longer. People may be referred here after a period on an acute ward when they have not recovered enough to be discharged home. Rehabilitation wards may also provide step-down for people who are moving on from secure mental health services.

Forensic inpatient or secure wards

These wards provide care and treatment in hospital for people with mental health problems who pose, or who have posed, risks to other people. People in secure services have often been in contact with the criminal justice system. These services

may be low or medium secure, reflecting the different levels of risk that people may present.

Note: we will inspect high secure hospitals separately as an additional service.

Child and adolescent mental health wards

Child and adolescent mental health services (CAMHS) may assess and treat children and young people as an inpatient in hospital. This may be when community-based services cannot meet their needs safely and effectively because of their level of risk and/or complexity and where they need 24-hour nursing and medical care.

Wards for older people with mental health problems

These services provide assessment, care and treatment for people whose mental health problems are often related to ageing. This may include a combination of psychological, cognitive, functional, behavioural, physical and social problems.

Wards for people with a learning disability or autism

These are specialist inpatient services for adults with a learning disability and/or autism who need assessment and treatment for mental health conditions. There are different models of services, but all patients in these wards should have their mental and physical healthcare needs assessed and receive care and treatment in line with their care plan. In all cases, the clear goal is to support people to return to the community and a good quality of life. This involves locally provided treatment in the least restrictive setting.

Please also refer to our guidance on registering these services.

Community-based mental health and crisis response services

Community-based mental health services for adults of working age

These services provide care and treatment for people who need a greater level of mental health care than primary care services can provide. There is a wide range of service models and different types of interventions. People using these services may receive support over a long period or for short-term interventions.

Mental health crisis services and health-based places of safety

Community-based mental health crisis services provide care and treatment for people who are acutely unwell to avoid having to admit them to hospital. These services include crisis resolution and home treatment teams that see people in their

homes and crisis houses for people who cannot be treated at home but who do not need to be admitted to hospital.

A health-based place of safety is a room, or suite of rooms, where people are assessed when they have been detained by the police under section 135 or 136 of the Mental Health Act. People will usually stay in a place of safety for a very short period, normally no longer than 24 hours.

Specialist community mental health services for children and young people

Specialist community child and adolescent mental health services (CAMHS) provide assessment, advice and treatment for children and young people with severe and complex mental health problems. They also provide support and advice to their families or carers. Services are usually multi-disciplinary teams of mental health professionals providing a range of interventions in the community, working with schools, social care, charities, voluntary and community groups.

Community-based mental health services for older people

These services provide assessment, care and treatment to older people with mental health problems that are often related to ageing. People may receive services in their own home or in a care home.

Community mental health services for people with a learning disability or autism

These specialist services are usually provided by local community learning disabilities teams. There are different types of service models, but the teams normally include staff from a range of health professions, such as psychiatrists, clinical psychologists, speech and language therapists and nurses (learning disabilities and sometimes mental health). Many teams include social care professionals, such as social workers. These multi-disciplinary teams are providing more out-of-hours crisis services to support people with behaviour that challenges.

Additional services

An additional service is a service that we do not inspect routinely for all providers as a core service.

Additional services in an individual provider

We may choose to inspect an additional service for an individual provider because:

- it represents a significant proportion of the provider's range of services

- we have identified it as potentially being rated outstanding
- we have identified it as being high risk

When we select an additional service to inspect in an individual provider, we will normally inspect, report and rate it in the same way as the core services. There are some additional services where we would not aggregate ratings or apply the maximum intervals for re-inspections because it would be disproportionate to do so. For example in a non-specialist trust, we would not usually aggregate ratings for diagnostic imaging or gynaecology.

Examples of additional services that we may inspect in an individual provider include:

Acute

- gynaecology (including termination of pregnancy)
- diagnostic imaging
- rehabilitation
- spinal injuries

Mental health

- substance misuse services
- specialist mental health eating disorder services
- personality disorder services
- perinatal mental health services
- specialised mental health services for people who are deaf
- specialist mental health services for people with acquired brain injury
- gender identity services

We will also inspect mental health high secure hospitals as a separate additional service (and not as part of the mental health forensic core service). We will always apply the aggregation rules to a mental health high secure hospital rating. Therefore this may affect the overall trust level ratings.

Community health

- community dentistry
- sexual health services
- urgent care

For specialist acute trusts we may adapt core services from other types of provider where they better reflect the trust's portfolio. For example, in a specialist women's trust we may inspect the following as a separate additional service:

- termination of pregnancy (this is inspected as a core service in independent healthcare)
- neonatal services (this is a core service for children's specialist trusts)

Additional services across providers

We may also select additional services to inspect across a range of providers or sectors. This will give us a broader view of the quality of services. We will inspect these services either within or across different sectors, or among a sample of providers.

When we inspect an additional service across a range of providers or sectors we will give a rating and publish a report for each service where appropriate. However, we will not normally apply our aggregation principles to these ratings and they will not affect overall trust-level ratings. This is because they will not be subject to the 'frequency of inspection' principles. If we included these ratings in our overall trust-level ratings, our overall ratings may become out of date. But we will take enforcement action where we need to.

Use of resources

NHS England paused its Use of Resources assessments in response to the COVID-19 pandemic. The assessments remain paused until NHS England resumes them.

In the meantime, the assessments are being re-evaluated and refreshed to ensure they are fit for purpose. Therefore, inspections do not currently include a Use of Resources assessment. This means that a trust's use of resources and combined rating will not be updated until NHS England advises us. NHS England's national team can provide more information about the Use of Resources assessments (england.uorenquiries@nhs.net).

The following describes the process for the Use of Resources assessments before they were paused.

Use of resources assessments were developed to improve understanding of how effectively NHS trusts are using their resources to provide high-quality, efficient and sustainable care for patients. This includes their finances, workforce, estates and facilities, technology and procurement. The Use of Resources assessment only applies to non-specialist acute trusts.

NHS Improvement assesses trusts' use of resources using the joint use of resources assessment framework. This describes the assessment process, which is based on a series of key lines of enquiry (KLOEs) and prompts. It takes a qualitative and quantitative approach by looking at initial productivity and finance metrics and then corroborating this with local intelligence, and rating characteristics.

The use of resources assessment team comprises a small group of senior staff from NHS Improvement. During the on-site visit, the assessment team will meet leaders from the trust who have responsibility for clinical and operational services, workforce and finances.

To prepare for the assessment and inform particular lines of questioning, the assessments include an analysis of the trust's performance against a small number of metrics, as well as evidence from local information gathered during NHS Improvement's day-to-day interactions with the trust and any other relevant evidence. Before the visit, NHS Improvement will ask trusts to provide a high-level commentary about their performance against the five KLOEs in the use of resources assessment framework. Trusts may also submit any more recent data that might help to inform the assessment.

NHS Improvement will collate all relevant qualitative and quantitative evidence into a report, which is used to reach a proposed rating for the trust's use of resources. The rating will be either: outstanding, good, requires improvement or inadequate. NHS

Improvement will also use the findings of the use of resources assessment to identify potential support needs at the trust as part of the Single Oversight Framework.

Before NHS Improvement submits the report and proposed rating to CQC, it carries out an internal quality assurance and calibration process that involves moderation at both regional and national level.

The draft report and proposed rating will be considered as part of the post-inspection process for reviewing and approving the inspection reports and ratings for the trust.

We will publish the final use of resources report and rating with the trust-level inspection report and the current trust-level quality ratings for that trust.

CQC also uses the use of resources rating to award trusts a combined rating at the overall trust level. We do this by aggregating the use of resources rating with our five trust-level quality ratings for the key questions of: safe, effective, caring, responsive and well-led.

Mental Health Act

The Mental Health Act 1983 (MHA) and its Code of Practice (2015) applies to all providers that are registered with CQC to assess and treat patients who are detained under the Act.

We are responsible for reviewing and monitoring how these organisations apply the Act when providing services.

Our primary monitoring activities involve visits by MHA reviewers, to meet with patients and look at the day-to-day operation of powers and duties under the MHA. The frequency of visits varies, up to a maximum period of two years.

We may also carry out a focused MHA monitoring programme to gather information to highlight local, regional or national trends. These visits will look at specific themes, patient groups or service types. Our primary aim is to identify current practice and areas for improvement and, where there is limited national data, gather evidence to inform future policy positions.

If we identify concerns on MHA visits, this may trigger further inspection or monitoring activity.

As well as monitoring the use of the MHA, CQC has other duties under the Act:

- we are responsible for administering the Second Opinion Appointed Doctor (SOAD) service
- we have the power to review the decisions of high security hospital managers over withholding patients' mail
- we have the power to investigate if somebody complains about how a provider has used the Act.

Any information we gather from our MHA activities will inform our monitoring and inspection activities. When we inspect your service, we will use the overall assessment framework for healthcare services and the specific prompts for specialist mental health care. Inspection teams will assess how you apply the MHA and review the way you discharge your duties under the MHA overall.

During an inspection, we will take account of any activity under the MHA when we make judgements.

See more about how we monitor the Mental Health Act.

Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act

If your service provides care or support for an adult who has (or appears to have) difficulty making informed decisions about their care, treatment or support, you may need to refer to the Mental Capacity Act 2005. This applies to all types of service provider.

The Mental Capacity Act helps to safeguard the human rights of people aged 16 and over who lack (or may lack) mental capacity to make decisions. This may be because of a lifelong learning disability or a more recent short-term or long-term impairment resulting from injury or illness.

This includes decisions about whether or not to consent to care or treatment.

Your staff need to be able to identify situations where the Mental Capacity Act may be relevant and know what steps to take to maximise and assess a person's capacity. If it is impaired, staff must know how to ensure that decisions made on the person's behalf are in their best interests.

Deprivation of Liberty Safeguards

The Safeguards are part of the Mental Capacity Act. If you apply to deprive a person of their liberty using the safeguards you must tell us about the outcome of the application. CQC has a duty to monitor the use of Deprivation of Liberty Safeguards in all hospitals and care homes in England. When we are inspecting and we see that a person has been deprived of their liberty, we will check that you have the correct authorisation and that you have met any conditions that the authorising body imposed. We look for evidence that you have tried to minimise restrictions on the person's freedom to a level that ensures their safety and wellbeing.

When we inspect your service, we specifically look at how well you are using the Mental Capacity Act, including the Deprivation of Liberty Safeguards. We report on this under the effective key question, alongside your approach to consent and the evidence we gather will inform our decision when we give a rating.

Read more about the Mental Capacity Act and the Deprivation of Liberty Safeguards.

How we take accreditation schemes into account

A trust may participate in certification schemes for some of its clinical services. These are more commonly known as accreditation schemes.

A trust's participation in accreditation schemes is reflected in the well-led key question at provider level as evidence of a commitment to quality improvement and assurance. Achieving accreditation under a specific scheme is reflected in the effective key question for the relevant core service.

We will only use an accreditation scheme in this way if it meets key quality standards that assure us of its quality and rigour.

Reducing CQC inspection activity

We will use accreditation schemes that relate to a particular core service to inform and, in some cases, reduce our inspection activity. We only do this if we are assured that a scheme meets quality standards and:

- there is adequate uptake among NHS trusts, to enable benchmarking
- the scheme's standards can be mapped to, and cover the breadth of, CQC's assessment framework.

The Health Quality Improvement Partnership (HQIP) helps to develop and support accreditation schemes that enable CQC to use them as part of our regulation. The current approved accreditation schemes are:

Relevant in the acute sector:

- Joint Advisory Group on GI Endoscopy (JAG)
- Imaging Services Accreditation Scheme (ISAS)
- Medical Laboratories 15189
- Improving Quality in Physiological Services Accreditation Scheme (IQIPS)
- Gold Standards Framework Quality Hallmark Award in End of Life Care
- Anaesthesia Clinical Services Accreditation (ACSA)
- Commission for the Accreditation of Rehabilitation Facilities (CARF)
- CHKS International Accreditation Programme
- Code of Practice for Disability Equipment, Wheelchair and Seating Services (CECOPS)
- MacMillan Quality Environment Award (MQEM)

Relevant in the mental health sector:

- Accreditation for Inpatient Mental Health Services (AIMS) covering the following branches:
    - AIMS – WA (Working Age Units)
    - AIMS – PICU (Psychiatric Intensive Care Units)
    - AIMS – AT (Assessment / triage wards)
    - AIMS – Rehab (Rehabilitation wards)
- Quality Network for Older Adults Mental Health Services (QNOAMHS)
- Quality Network for Inpatient Learning Disability Services (QNLD)
- Quality Network for Inpatient CAMHS (QNIC)
- Quality Network for Community CAMHS (QNCC)
- Quality Network for Perinatal Mental Health Services
- ECT Accreditation Scheme (ECTAS)
- Psychiatric Liaison Accreditation Network (PLAN)
- Memory Services National Accreditation Programme (MSNAP)
- Accreditation for Psychological Therapies Services (APPTS)

AFTER INSPECTION

Your inspection report

We publish inspection reports on our website. These present a summary of our findings, contextual information and any enforcement activity that we have taken.

When we publish a new inspection report it will reflect changes from the most recent inspection for each core service and each key question inspected. It will show our ratings judgements and whether a rating has changed.

The report focuses on what our findings mean for the people who use the service. If we find examples of outstanding practice during inspection, we describe them in the report to enable other providers to learn and improve. We also describe any concerns we find about the quality of care. The report sets out any evidence we have found about a breach of the regulations and other legal requirements.

Reports will be published within three months of the inspection of the well-led key question at the trust.

Use of resources

NHS Improvement's use of resources assessment team will write a report on the findings following the site visit to a trust. This report will be published alongside CQC's quality report for the trust and will include a full report of the findings from the use of resources assessment.

CQC's trust-level inspection report will also include a summary of the findings about how well the trust is using its resources. The inspection report will also include the final use of resources rating, and highlight any areas that need to improve and any outstanding practice identified during the use of resources assessment.

CQC will then consider and approve the use of resources report in consultation with NHS Improvement, as part of our post-inspection quality check and ratings approval process for the inspection report for each relevant trust.

Quality checks

Before publishing, we check the quality and consistency of each report to quality assure our findings and check that our judgements are consistent nationally. We discuss the judgements of the inspection at an internal ratings approval meeting.

Trusts will have an opportunity to check the factual accuracy of the draft report before we publish it.

Factual accuracy check

When we have checked the quality of the draft inspection report we will send you the draft documents. We will ask you to check the factual accuracy and completeness of the information that we have used to reach our judgements and ratings, where applicable.

The factual accuracy checking process allows you to tell us:

- where information is factually incorrect
- where our evidence in the report may be incomplete.

The factual accuracy process gives inspectors and providers the opportunity to ensure that they see and consider all relevant information that will form the basis of CQC's judgements.

Inspection teams base their judgements and ratings on all the available evidence, using their professional judgement and CQC's published ratings characteristics for health care and for adult social care services. The inspection report does not need to reference all the evidence but it should include the best evidence to support our judgements.

We will send an email to the appropriate registered person. This will include:

- a copy of the draft report
- a link to download a form to provide your response.

Download the appropriate form to submit your response, as set out in the letter in the email. Once you have received the email with the draft report, you have **10 working days from the date of the email** to submit the form with your comments.

If you do not wish to submit a response tell us immediately. We will then be able to publish the final report.

Providers are responsible for making sure that the factual accuracy of the draft report has been checked by the responsible person and that any factual accuracy comments regarding the draft report have been approved and submitted.

The factual accuracy checking process should not be used to query:

- an inspection rating
- how we carried out an inspection – see how to complain about CQC
- enforcement activity that we propose – see how to make a representation about proposed enforcement activity

The draft report includes the draft judgements and ratings, where appropriate. If the inspector corrects any factual details in the report or accepts any additional evidence, they will amend the draft report. They will determine whether this has an impact on a judgement or rating(s) and will explain any changes on the form. We may change draft ratings if we determine that the evidence on which they are based is inaccurate or incomplete.

For more details and guidance on how to respond, see Factual accuracy check.

Use of resources assessments

For some non-specialist NHS acute trusts, the draft inspection report includes the findings of NHS Improvement's use of resources assessment, and a proposed use of resources rating.

If a trust challenges the evidence in the inspection report relating to the use of resources assessment, we will refer these comments to the NHS Improvement assessment team. NHS Improvement will work with us to review the evidence in light of the comments.

NHS Improvement will review and respond to factual accuracy comments from trusts. They will follow a process and timeline consistent with our own.

A member of staff from NHS Improvement will review all factual accuracy comments relating to use of resources findings. This person will be authorised to sign off use of resources reports. They will be independent of the original use of resources assessment and site visit.

We will send trusts the response to factual accuracy comments about use of resources as part of our response to comments for the full draft inspection report.

Changes to the findings on use of resources as a result of factual accuracy comments may result in a change to the use of resources rating.

Your trust ratings

After an inspection, we rate NHS trusts for the quality of care overall and for our five key questions: are they safe, effective, caring, responsive and well-led?

For non-specialist acute trusts, we also give a rating for the trust's use of resources, and award a combined rating for the trust based on the combination of the six trust-level ratings.

We award ratings on a four-point scale: outstanding, good, requires improvement, or inadequate.

It is a legal requirement for all providers to display CQC ratings.

We decide all ratings using a combination of aggregating the core service ratings and the professional judgement of inspection teams. We provide ratings at different levels and we use a set of ratings principles to help us to determine the final ratings.

Ratings characteristics

Each rating is based on our assessment of the evidence we gather against the key lines of enquiry in the assessment framework for healthcare services and, for relevant non-specialist acute trusts, the use of resources assessment framework. Inspectors refer to the corresponding ratings characteristics for the key lines of enquiry and use their professional judgement to decide on the rating.

When deciding on a rating for services, the well-led key question or use of resources, the inspection team asks:

- Does the evidence demonstrate a potential rating of good?
- If yes – does it exceed the standard of good and could it be outstanding?
- If no – does it reflect the characteristics of requires improvement or inadequate?

A core service or trust doesn't have to demonstrate every characteristic of a rating for us to give that rating. For example, if a trust demonstrates just one of the characteristics of inadequate but it has significant impact on the quality of care or on people's experience, this could lead to a rating of inadequate. On the other hand, even providers rated as outstanding are likely to have areas where they could improve. In the same way, trusts don't need to demonstrate every one of the characteristics of good in order to be rated as good.

Inspection teams use the ratings characteristics as a guide, not as a checklist or an exhaustive list. They take into account best practice and recognised guidelines, and assure consistency through CQC's quality control process.

Levels of ratings

We provide ratings at different levels, depending on the type of trust.

NHS acute trusts

Service and location level ratings

For each acute hospital location we inspect, we rate the quality of care at four levels:

Level 1: A rating for each of our five key quality questions of: safe, effective, caring, responsive and well-led in every service that we have inspected (a core service or additional service).

Level 2: An aggregated rating for each service that we have inspected

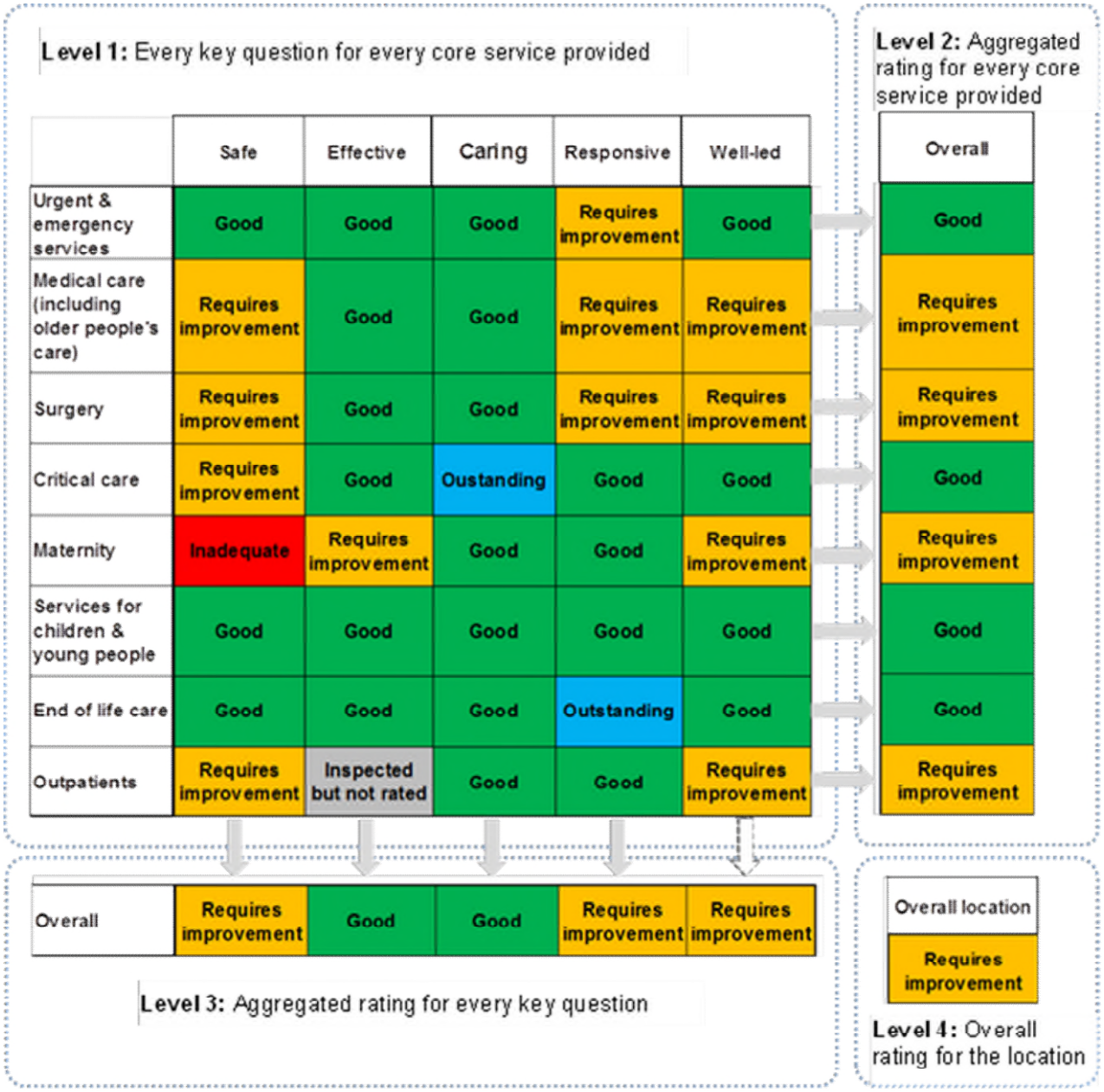
Level 3: A rating for each key question in each location in the trust (hospitals and other services).

These ratings are normally based on the aggregation of the ratings for that key question in each service in the location. For NHS acute trusts with one location (hospital), the rating for well-led in that hospital location will be determined by the trust-level assessment of the well-led key question (see level 5 below).

Level 4: An aggregated overall quality rating for the location as a whole.

For NHS acute trusts with one location (hospital), this will be the same as the overall quality rating for the trust as a whole (see level 6 below).

The following example shows how the four levels work together:



Note: the aggregation of the well-led key question to Level 3 above does not apply in all trusts, for example trusts with one location (hospital).

Trust-level ratings

We also award ratings at the level of the overall trust:

Level 5: A rating for each of the key questions overall for the trust.

For trusts with multiple sites (hospitals and other services), this is informed by our ratings in each location for safe, effective, caring and responsive, while the rating for well-led is determined by the assessment of well-led at trust level. The rating for use of resources (where applicable) is based on a trust-level assessment conducted by NHS Improvement.

For a trust with only a single site, the trust-level ratings for each key question are the same as the location-level key question ratings (level 3 above).

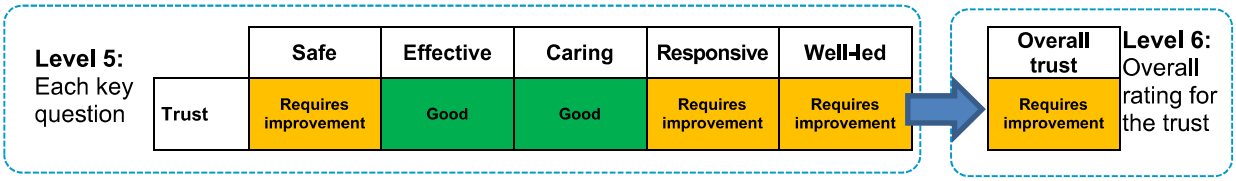
Level 6: A rating for the trust as a whole.

This includes a rating of the trust's overall quality, based on our findings at trust level (level 5) under the five key quality questions that CQC inspects (safe, effective, caring, responsive and well-led).

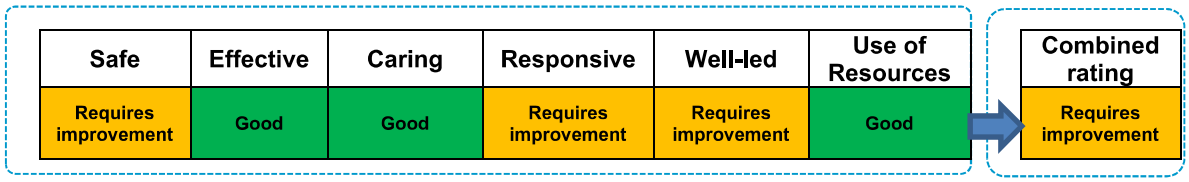
For a single-site trust, the overall quality rating for the trust will be the same as the overall rating for the hospital location (level 4 above).

Where applicable, we will also award a combined rating at the trust level, based on the findings of the five trust-level quality ratings plus a use of resources rating.

The diagram below shows how these two levels work together to produce an overall quality rating for the trust:



The diagram below shows how we produce a combined rating based on the six trust-level ratings from the five trust-level quality ratings plus use of resources:



Aggregated ratings are determined by using our ratings principles and the professional judgement of inspection teams to balance them. We don't aggregate the rating for the well-led key question at overall trust level. We award this rating based on our separate assessment of this key question at trust level.

Mental health, ambulance and community health service trusts

Mental health, ambulance and community health services are frequently delivered from multiple locations. Therefore, we don't give a rating at location level. The levels of ratings for these trusts are:

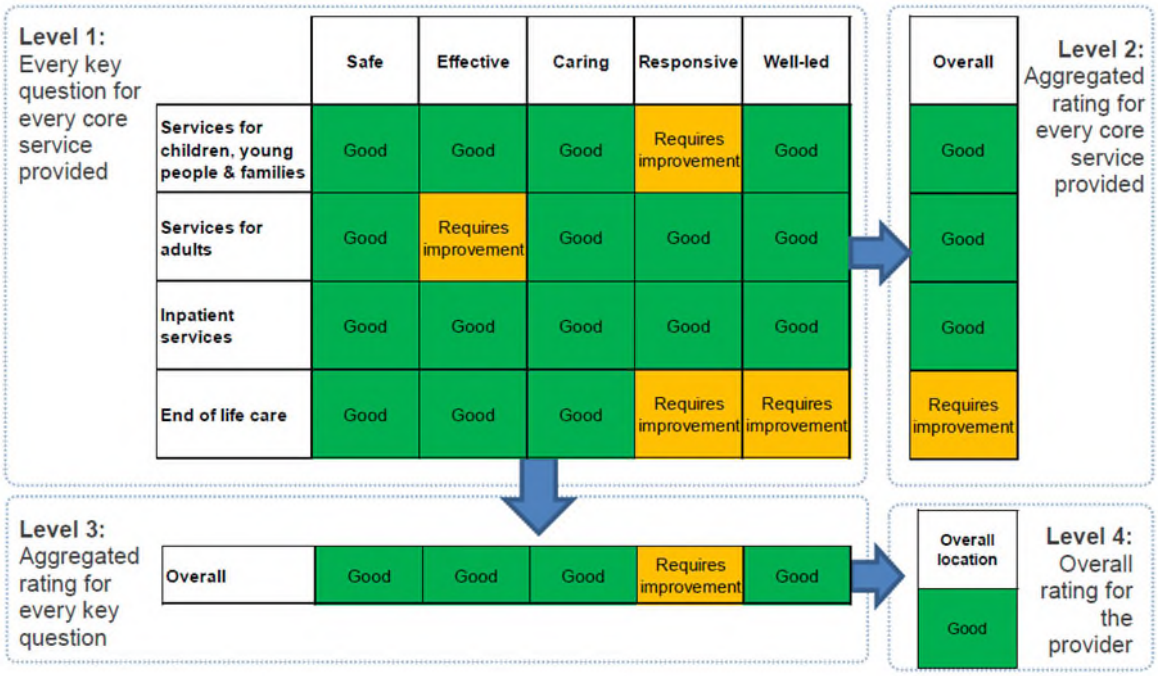
Level 1: A rating for every core service against every key question

Level 2: An aggregated rating for each core service

Level 3: An aggregated rating for each key question

Level 4: An aggregated overall rating for the provider as a whole

The following example shows how the levels work together in a community health trust:



When we would not rate

For all types of trust, sometimes we won't be able to award a rating after an inspection. This could be because:

- the service is new
- we don't have enough evidence
- the service has recently been reconfigured, such as being taken over by a new provider.

In these cases we will use the term 'inspected but not rated'.

We may suspend a rating if we identify significant concerns that lead us to re-consider our previous rating. The rating will be suspended until we have investigated the concerns and/or re-inspected the service.

How we determine your aggregated ratings

Complex providers

If your NHS trust delivers a combination of different service types, for example mental health services and care homes, we will assess how well your trust manages quality across the range of services and give ratings that reflect this. Our rating for the well-led key question will reflect all of the services that your trust provides. We will use professional judgement to agree ratings for complex trusts to ensure that ratings are meaningful and proportionate. We will discuss this with you at the start of your inspection.

Merged trusts

When a trust acquires or merges with another service or trust in order to improve the quality and safety of care, we will not aggregate ratings from the previously separate services or providers at trust level for up to two years. During this time, we would expect your trust to demonstrate that you are taking appropriate action to improve quality and safety. We will consider this at the point of the merger or acquisition and discuss this with you at the start of your inspection. Our inspection report for the trust will clearly explain why we have not included some services in the rating.

Updating ratings

We will only review and update ratings at overall trust level following a trust-level assessment of the well-led key question and a planned inspection of core services. If we haven't carried out an on-site inspection, the previous rating for the trust will still apply.

We will not usually inspect all services during an inspection, but the inspection report will show the date when each service was rated. If we haven't inspected a core service or key question as part of the trust inspection, the existing rating will not change. In these cases, the report will state that after reviewing evidence about quality and safety of care, we did not identify any areas of potential concern or improvement that required an inspection.

We will aggregate ratings by combining the previously allocated ratings and new ratings from recent on-site inspection activity. Focused inspections that look at a specific concern may result in a change to a core service or location-level rating, but will not lead to a change in the overall trust rating.

After we have published the report for an inspection of core services and the well-led key question, trusts must display an updated ratings grid in relevant locations and on the trust's website.

From April 2019, where there is a change of ownership or address at an existing location, CQC's website and internal systems will continue to display the provider's 'regulatory history' (rating and inspection report). See continuing regulatory history for more information.

Using professional judgement

To ensure that we make consistent decisions, we follow a set of 16 ratings principles and apply professional judgement when rating core services, locations and providers. Our ratings must be proportionate to all available evidence and the specific facts and circumstances.

Before we start an inspection we will identify whether your trust matches one of the following scenarios, and discuss this with you:

- Is a service or location significantly different from the other services or locations? For example, its type and mix of services (including other than hospital care), size, type of setting or the population groups it serves. If yes, we may use professional judgement to decide whether to depart from the ratings principles.
- Has the trust recently taken over another service or location? If yes, we will not aggregate ratings from the previously separate services or providers at trust level for up to two years.

If we identified concerns in the inspection we'll consider the following criteria and use our professional judgement to decide whether to depart from the application of the ratings principles – particularly where we need to aggregate ratings that range from inadequate through to outstanding:

- The extent and impact of the concerns on people who use services and the risk to quality and safety, taking into account the type of setting and the population group. If concerns have a very limited impact on people, it may reduce the impact on the aggregation of ratings.
- Our confidence in the service to address the concerns.

We can't predict what future models of care and configurations of services will look like, so we have based our approach to aggregation on these principles to enable us to be flexible and respond to change.

The inspection report will explain in detail how we reached the rating decision.

Ratings principles

We follow these principles to determine how we aggregate and combine ratings, and in some circumstances, how we put a limit on ratings.

Reflecting enforcement action in our ratings

Where we are taking enforcement action, we will reflect this in the ratings at the lowest level (key question at individual core service level).

1.	Where we have identified a breach of a regulation and we issue a Requirement Notice, the rating linked to the area of the breach will normally be limited to 'requires improvement' at best.
2.	Where we have identified a breach of a regulation and we take action under our enforcement powers, such as issuing a Warning Notice or imposing a condition of registration, the rating linked to the area of the breach will normally be 'inadequate'.

Overarching aggregation principles

The following principles apply when we are aggregating ratings.

3.	The five key questions are all equally important and should be weighted equally when aggregating.
4.	The core services are all equally important and should be weighted equally, except where they are significantly small.
5.	All ratings will be treated equally when aggregating unless one of the other principles below applies. **Note:** We can adjust the following principles for combinations where it is not appropriate to treat ratings equally.

Aggregating ratings

We use the following principles as the basis of the aggregation and use our professional judgement to apply them to the specific combination of underlying ratings.

6.	The aggregated rating will normally be 'outstanding' where at least X number of the underlying ratings are 'outstanding' and the other underlying ratings are 'good'.

Number of underlying ratings	Number (X) of underlying outstanding ratings
1 – 3	1 or more
4 – 8	2 or more
9+	3 or more

7.	The aggregated rating will normally be limited to 'requires improvement' where at least X number of the underlying ratings are 'requires improvement'.

Number of underlying ratings	Number (X) of underlying requires improvement ratings
1 – 3	1 or more
4 – 8*	2 or more*
9+	3 or more

* **Combined trust ratings**: Where six trust-level ratings are being aggregated for a combined rating at the trust level (the five key quality question ratings at trust level plus a use of resources rating), the aggregated rating will normally be limited to 'requires improvement' where three or more of the underlying ratings are 'requires improvement'.

8.	The aggregated rating will normally be limited to 'requires improvement' at best where X number of the underlying ratings are 'inadequate'.
9.	The aggregated rating will normally be limited to 'inadequate' where at least Y number of the underlying ratings are 'inadequate'.

Number of underlying ratings	Principle 8	Principle 9
	Limited to requires improvement where there are (X) number of underlying inadequate ratings	Limited to inadequate where there are (Y) number of underlying inadequate ratings
1 – 3	Not applicable	1 or more
4 – 8	1	2 or more
9+	2	3 or more

Aggregating the overall location or trust levels

We apply additional principles when aggregating to the higher ratings levels (location level and trust level ratings).

10.	For each of the key questions of safe, effective, caring, responsive and well-led, the aggregated rating should consist of: • An aggregation of the underlying service ratings Plus • An assessment of any relevant hospital or trust level evidence.
11.	For foundation trusts only, where NHS Improvement finds a failure to comply with licence conditions or is taking regulatory action, the overall trust rating will normally be limited to 'requires improvement' at best.
12.	For foundation trusts only, where NHS Improvement puts a trust 'under investigation', the overall trust rating will normally not be 'outstanding'.
13.	For non-foundation trusts, where NHS Improvement finds material issues with a trust or where formal action is required, the overall trust rating will normally be limited to 'requires improvement' at best.
14.	For non-foundation trusts, where NHS Improvement finds concerns requiring investigation, the overall trust rating will normally not be 'outstanding'.
15.	An overall trust rating will not normally be 'outstanding' unless its score in the most recent national inpatient survey (question relating to overall experience) is higher than the median for the country.
16.	An overall trust rating will not normally be 'outstanding' unless, in the most recent NHS Staff Survey, the percentage of staff who would recommend the trust as a place to work or receive treatment is higher than the median for the country.

Request a rating review

Grounds for review

The only grounds for requesting a rating review after completion of the factual accuracy process and publication are that we have failed to follow our process for making ratings decisions.

Trusts cannot ask for a review of their ratings on the basis that they disagree with our judgements.

Any request for a review must relate solely to the trust's latest final inspection report. We can't consider references to previous reports or those for other providers.

How to request a review of ratings

All rating review requests must be submitted using our online form by one of:

- the registered manager
- the nominated individual
- the chief executive (NHS trusts only).

Trusts must submit the request **within 15 working days** of the publication of the report. Trusts can only submit one request for an inspection report.

The link to the online form is included in the letter we send with the final report.

The review process

We will first consider whether the request meets the grounds for review.

If it does not meet these grounds then we'll refuse the request and write to the trust to explain why.

If it does meet the grounds, CQC staff not involved in the original inspection will review the aspects of the process that were not followed correctly.

As well as our own staff, we may use independent reviewers if their expertise is relevant to the request.

Our review may extend to ratings that were not challenged. All ratings can go down as well as up as a result of a review.

During the review, we will display a message on the relevant profile page on our website to show it is taking place. The report will remain published on the website.

Reviewing the use of resources rating

NHS trusts may also request a review of the use of resources rating. The request for a review should be submitted using the online form, within 15 working days of publication of the report. The standard grounds for review described above apply to these ratings.

Where the request for a rating review relates to the use of resources rating, CQC will work with NHS Improvement using a process consistent with CQC's wider rating review processes.

The request for a review will be handled by members of NHS Improvement staff who were not involved in the original use of resources assessment, and they will have access to an independent reviewer.

Complaints and appeals

If a trust is making a complaint against us or challenging our enforcement action, we will pause the review until these are complete.

We will let the trust know when we start to consider the request – this is usually once the complaint or challenge is complete (including any appeal to the First-tier Tribunal).

The review decision

Where the grounds for a rating review are met, the Chief Inspector of Hospitals makes the final decision.

Once the review is complete, we'll let the trust know the outcome. We aim to complete all reviews within 50 working days.

We'll make the appropriate changes to the trust's report and ratings as a result of the review on our website as soon as possible.

The review is the final CQC process for challenging a rating. However, trusts can challenge the ratings elsewhere, such as by applying for a judicial review.

How we publish inspection information

Every time we inspect a health or social care service, we publish information about it on our website.

This includes:

- details of current and recent inspections
- the inspection report

We also send email alerts to people who are interested in a particular service, location or area.

Current and recent inspections

When we are inspecting a service, we display a message on its profile webpage. We remove this when we publish the inspection report.

The inspection report

We publish your inspection reports on the appropriate profile webpages. The ratings and summaries appear on the webpage, and the report is available as a PDF document.

Email alerts

Visitors to our website can sign up for email alerts about our inspections related to particular locations.

Anybody who has signed up to receive alerts about one of your locations will get an email:

- when we have inspected the location, and
- when we publish the report.

We send these alerts once a week.

Enforcement action

We only publish information about enforcement action once any representations and appeals processes are complete.

The exception to this is urgent enforcement action, where we update our website with information straightaway. This includes action such as:

- suspending a provider or registered manager
- placing conditions on a provider's registration because of major concerns.

Read more about our enforcement action and representations.

Informing the media

We routinely send summary information about our findings to local, national and trade media.

We will normally send more in-depth details to the media when we:

- publish inspection reports with overall outstanding or inadequate ratings
- take enforcement action
- prosecute.

Enforcement

If the care you provide harms people or puts people at risk of harm, we can take enforcement action to protect them. We do this so that you make improvements to prevent any further harm or risk of harm. If the improvements you need to make are small and low risk, we may work with you without taking enforcement action.

If you provide poor quality care you may be committing an offence. If you do commit an offence we can take criminal enforcement action to hold you to account. Our guidance helps you to understand the level of care that people should receive. If the level of care falls below this and people are harmed or put at risk, you may be committing an offence and we may take criminal enforcement action.

Types of enforcement action

The type of enforcement action we can take will depend on whether we are protecting people or holding you to account.

- We will take **civil enforcement action** to protect people; and/or
- To hold you to account we will take **criminal enforcement action** if you fail to meet prosecutable fundamental standards.

Our enforcement policy describes this in more detail.

Deciding which enforcement action to take

This will depend on a number of factors including:

- the level of harm or risk that has occurred
- the actions you have taken to prevent harm from happening again
- the quality of care you have provided previously

- whether you have had any enforcement action taken against you before
- in respect of criminal enforcement, in accordance with the Code for Crown Prosecutors.

Our enforcement policy and enforcement decision tree explain in more detail how and when we take enforcement action.

Following up enforcement action

We will inspect your services to check whether you have made the changes needed to improve. If you have not made the necessary changes we can take more severe enforcement action. In serious cases we can cancel your registration so you can no longer provide care.

Offences

Certain regulations have offences attached to them. This means that if you breach the regulation, it is an offence and CQC can prosecute as part of our enforcement action.

The offences and our powers to prosecute are set out in the following legislation:

- Health and Social Care Act 2008 as amended
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
- Care Quality Commission (Registration) Regulations 2009

Our enforcement policy details the fixed penalties and fines payable for offences.

For the regulations where we cannot prosecute, we can use other regulatory actions, which are set out in our enforcement policy.

Mandated support and the recovery support programme

NHS England and NHS Improvement use our ratings to help decide if NHS trusts need extra support.

Trusts have access to extra support when there are issues to do with finance or quality of care. This support is part of the NHS System Oversight Framework 2021/22. The framework explains how NHS England and NHS Improvement work with NHS organisations in England.

There are two levels of support, depending on how serious or complex the issues are.

1. Mandated support

This is provided by the NHS England and NHS Improvement regional teams. Under some circumstances, the regional teams may also access support from the national intensive support team. If you need this level of support, you will enter segment 3 of the NHS System Oversight Framework.

2. Mandated intensive support

This is provided by the national intensive support team through the national Recovery Support Programme. If you need this level of support, you will enter segment 4 of the NHS System Oversight Framework.

The Recovery Support Programme has replaced Special Measures for NHS trusts.

How our ratings influence mandated support and mandated intensive support

Our ratings are one of the possible criteria for trusts entering mandated support and mandated intensive support. The NHS Oversight Framework sets out other criteria and factors.

Mandated support

If we give a rating of requires improvement overall and for our well-led key question, NHS England and NHS Improvement will decide if you need mandated support.

If you do, the NHS England and NHS Improvement regional team will work with you and us to agree exit criteria. These are the criteria you would need to meet before the support can end.

The team will continue to support you until you're ready to meet the exit criteria and you can demonstrate sustained improvement.

Mandated national intensive support

How you enter the programme

If we give a rating of inadequate for well-led and for at least one other key question, we make a recommendation that you enter mandated intensive support.

The final decision over whether you need mandated intensive support is made by NHS England and NHS Improvement.

Mandated Intensive support is delivered through the national Recovery Support Programme. The programme provides support either at organisational level or across

an Integrated Care System (ICS). This level of support includes the appointment of an improvement director. The improvement director will coordinate support and help you develop an improvement plan. The improvement plan will include an indicative timescale for meeting the exit criteria. This is typically within 12 months.

Our role

We will stay in close contact with you, NHS England and NHS Improvement during the process. We will also continue to monitor quality. We normally carry out a follow-up inspection within 12 months of when the support starts.

If you enter mandated intensive support on our recommendation, you will also need a recommendation from us before you can exit the programme.

What happens after you exit the programme

When you exit mandated intensive support, NHS England and NHS Improvement will provide you with an exit support package.

At this point, you normally move from segment 4 to segment 3 of the NHS System Oversight Framework.

Visit the NHS England website to find out more about the Recovery Support Programme.

Make a representation

If CQC takes civil enforcement action the relevant registered person has the right to make representations to us. You can make a representation if we:

- issue a warning notice
- impose, vary or remove conditions of registration
- suspend registration, or extend the period of suspension of registration
- cancel registration

Warning notices

A registered person must make representations against a warning notice in writing within 10 working days of CQC serving the notice.

See our guidance on making representations against a warning notice: Representations against warning notices

Please use this form to make representations: Notice representations form

Please note: there is no right of appeal to the First-Tier Tribunal against a warning notice; you can only make representations to us about it.

Notice of proposal

A registered person can make a representation against a notice of proposal before we decide whether to adopt it and serve a notice of decision. You must make a representation within 28 days of CQC serving the notice.

If we issue a notice of decision, a provider can appeal about it to the First-tier Tribunal.

See our guidance about making representations against a notice of proposal: Representations and appeals guidance

Please use this form to make a representation: Notice representations form.

We will consider all representations and aim to respond to them within 20 working days.

Please note: Each form only covers one regulated activity (please specify which one in the appropriate section of the form).

To make representations about more than one regulated activity, you must complete and submit a separate form for each one.

Please send your representations form by email to HSCA_Representations@cqc.org.uk.

Complain about CQC

We aim to provide the best possible service, but we do not always get it right. CQC welcomes your feedback to help us improve our services and ensure we are responding to your concerns as best we can.

Your complaint should be made to the person you have been dealing with because they will usually be the best person to resolve the matter. If you feel unable to do this, or you have tried and were unsuccessful, you can contact our National Customer Service Centre by phone, letter or email.

Post

CQC National Customer Service Centre
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

Phone: 03000 616161
Email: enquiries@cqc.org.uk
Opening hours: 8.30am – 5:30pm, Monday to Friday

What will happen next?

Your complaint will be forwarded to our National Complaints Team who will make contact with you to discuss your concerns and confirm how CQC will respond to them.

We will try to resolve your complaint informally within seven working days so that we can address the concerns as soon as possible. If a formal investigation is needed, we will propose a date for response (usually within 30 working days) and agree this with you. Your complaint will be investigated by someone not connected to the issues and the process will be overseen by the National Complaints Team. You will then receive a report detailing our findings and if appropriate, what we have done, or plan to do, to put things right.

What if I am still not happy?

If you remain unhappy with the outcome of your complaint, you can contact the Parliamentary and Health Service Ombudsman (PHSO) via your local Member of Parliament. Visit the PHSO website to find out how.