How CQC monitors, inspects and regulates NHS trusts

June 2017

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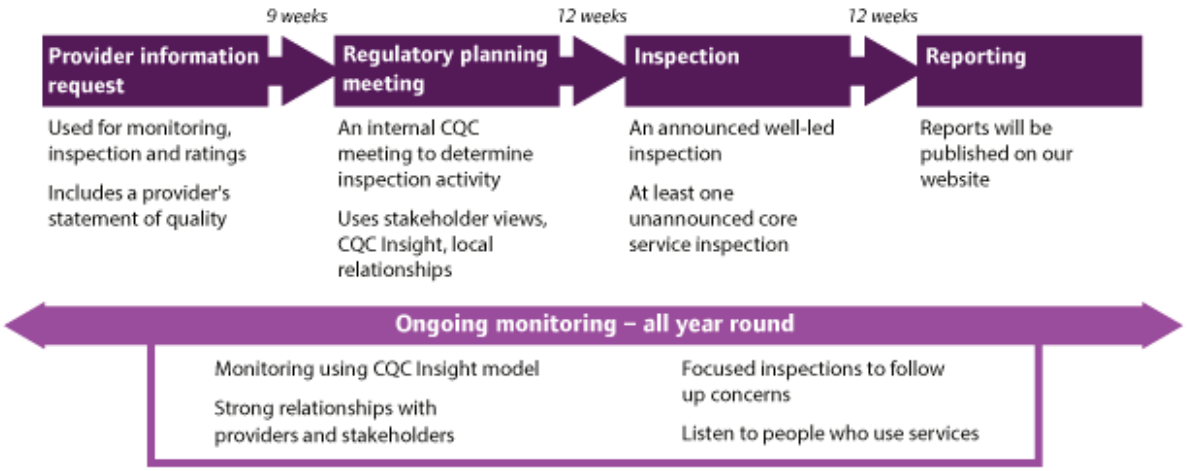
MONITORING AND INFORMATION SHARING

How we monitor and inspect NHS trusts



We aim to inspect each trust at least once between June 2017 and spring 2019, and approximately annually after that.

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, 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.

Provider information request

We will send a provider information request (PIR) to your trust's nominated individual approximately once a year. You have four weeks in which to return the information and any supporting documents through our online portal.

The PIR is currently in document format. When our new digital solution is active, we will email a link to your online PIR.

The PIR has two parts, which we send to you at the same time:

1. **Trust level request**. This is the main request, which asks you to tell us about the quality of your services against the five key questions. This includes any changes in quality or activity since your last inspection. We will also ask you to use the key lines of enquiry for the well-led key question to tell us about your trust's leadership, governance and organisational culture. This will support our assessment of well-led for the trust.

2. **Sector request**. This asks you to report on a limited number of key information items for core services that your trust provides. There are different requests for different sectors, for example community or acute. It is a much shorter list of questions to gather key information that is not available through other national data collections.

The PIR will be our only standardised collection for NHS trusts and is significantly smaller than our old style PIRs, informed by what we learned during our last phase of inspections. However, we may need to ask you for other specific information as well as the PIR. For example, we may need extra information to clarify queries during an inspection. We will keep track of these extra requests to limit duplication and to make sure that we only request information that we need, which is not available elsewhere.

As other national collections develop, we will update our own systems. For example, if we can access specific information from a national collection it will be removed from the PIR.

We will also develop an online system to collect information from providers. This will help to reduce repeat requests and improve how we share PIR information with other

relevant partners. For example, NHS Improvement can use the information to help identify support needs under its Single Oversight Framework.

If we make any changes to the PIR, we will always work with providers and other organisations to ensure that they are beneficial. Provider information collections from complex providers that operate across more than one sector will be coordinated to ensure that the information we ask for reflects all services provided and that it helps us to understand any changes the provider proposes to make.

Link to the PIR template

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 Improvement
- NHS England
- 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 model, including by:

- sharing data, aiming to draw on a single, shared set of metrics 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, special measures and areas of good practice
- improving coordination, from aligning the way we work together in engaging with individual providers to wider healthcare system oversight.

We have jointly developed an updated framework to judge whether a healthcare provider is well led. When we inspect the well-led key question at trust level, we will consult NHS Improvement on a trust's performance where appropriate. This will particularly include seeking NHS Improvement's input on the quality, financial and resource governance within a trust, to support the sustainable delivery of services. NHS Improvement also uses the joint well-led framework in its own guidance and work to support improvements in trust leadership.

We will work with NHS Improvement to assess and rate a trust's use of resources at the trust level. We will start introducing these assessments in non-specialist acute trusts in our next phase of regulation, and will initially publish them alongside our quality inspection reports.

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 (particular 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

When we will inspect

We aim to inspect each trust at least once between June 2017 and Spring 2019 in our next phase of regulation, and approximately annually after that. However, we may come back any time in the year if we think it is necessary. Our contact with your trust will be frequent and targeted. We will use information from our relationship management meetings and CQC Insight to inform our discussion about when and what to inspect.

Frequency of inspections of core-services and well-led

We will use a trust's previous ratings as a guide to setting maximum intervals for re-inspecting its core services alongside its inspection of the well-led key question. For example, we will re-inspect after:

- one year for core services rated as inadequate
- two years for core services rated as requires improvement
- three and a half years for core services rated as good
- five years for core services rated as outstanding

This is only a guide and we will also take into account other factors when deciding which core services to inspect.

We will take into account the trust's own assessment of the quality of its core services. If the trust tells us that services have improved, we will inspect them wherever we can.

Use of resources

We will work with NHS Improvement to assess and rate a trust's use of resources at the trust level. We will start introducing these assessments in non-specialist acute trusts in our next phase of regulation, and will initially publish them alongside our quality inspection reports.

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. We will also include specialist professional advisors with appropriate experience of organisational leadership and governance to support our trust-level inspections of well-led, such as relevant directors and heads of governance.
- Mental Health Act Reviewers
- Experts by Experience
- CQC inspection team support staff (where appropriate).

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

For scheduled inspections we determine our inspection activity for each trust at an internal Regulatory Planning Meeting where we review all information that we hold about the trust. The planning meeting happens within nine weeks of sending you a provider information request.

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 are annual and 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 core services that we inspect will therefore vary for each organisation. Inspections will happen within six months of issuing the PIR. 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.

The inspection of the well-led key question at trust level will follow the core service(s) inspection. This will be announced after the Regulatory Planning Meeting to give us time to schedule the appropriate interviews. On-site activity will take approximately two days. This assessment focuses on well-led 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 of 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 in special measures 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.

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 when the procedure is carried out in the theatre department.

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

Note: we will inspect high secure forensic services 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.

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

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)

We will also inspect mental health high secure services as a separate additional service (and not as part of the mental health forensic core service).

We will normally give a rating to an additional service for an individual provider and they will be subject to the 'frequency of inspection' principles in the same way as a core service. Mental health high secure services will always be rated. We will apply aggregation rules to the rating, therefore this may affect the overall trust-level ratings.

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. Cancer care is an example of such a service, as it cuts across providers in a range of sectors. Resilience planning is another example of a service that could be inspected in this way across all ambulance NHS trusts.

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.

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 activities under the MHA are aligned and integrated with our inspections of specialist mental health services under the Health and Social Care Act. 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.

As well as focusing on the MHA during our inspections, we will continue to carry out separate additional MHA monitoring visits to meet with patients. 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.

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. A list of approved accreditation schemes is available and updated regularly.

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. Alongside each report we plan to publish a separate 'evidence appendix', which includes supporting data and information.

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 after we have carried out the inspection of the well-led key question at the trust.

Quality checks

Before publishing, we check the quality and consistency of each report by peer review 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.

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

Use of resources

We will work with NHS Improvement to assess and rate a trust's use of resources at the trust level. We will start introducing these assessments in non-specialist acute trusts in our next phase of regulation, and will initially publish them alongside our quality inspection reports.

Factual accuracy check

When we have completed our quality checks on the inspection report, we will send the draft to your nominated individual and chief executive. For NHS trusts we will also share the draft report with NHS Improvement and NHS England as appropriate.

At this stage, we ask you to comment on the factual accuracy of the draft. You can challenge the accuracy and completeness of the evidence that we have used to reach the findings and decide the ratings. The draft report will include the draft ratings, so if we make changes as a result of factual accuracy comments, this may result in a change to one or more rating.

You have 10 working days in which to check the factual accuracy of a draft report and submit your comments to CQC.

The factual accuracy process doesn't deal with complaints about CQC or representations about proposed enforcement activity.

For more information please see our factual accuracy guidance and information on rating review.

Your 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?

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

It is a legal requirement to display your 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

Your rating is based on our assessment of the evidence we gather against the key lines of enquiry in the assessment framework for healthcare services. 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 at core service level, 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 you demonstrate 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, you 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

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

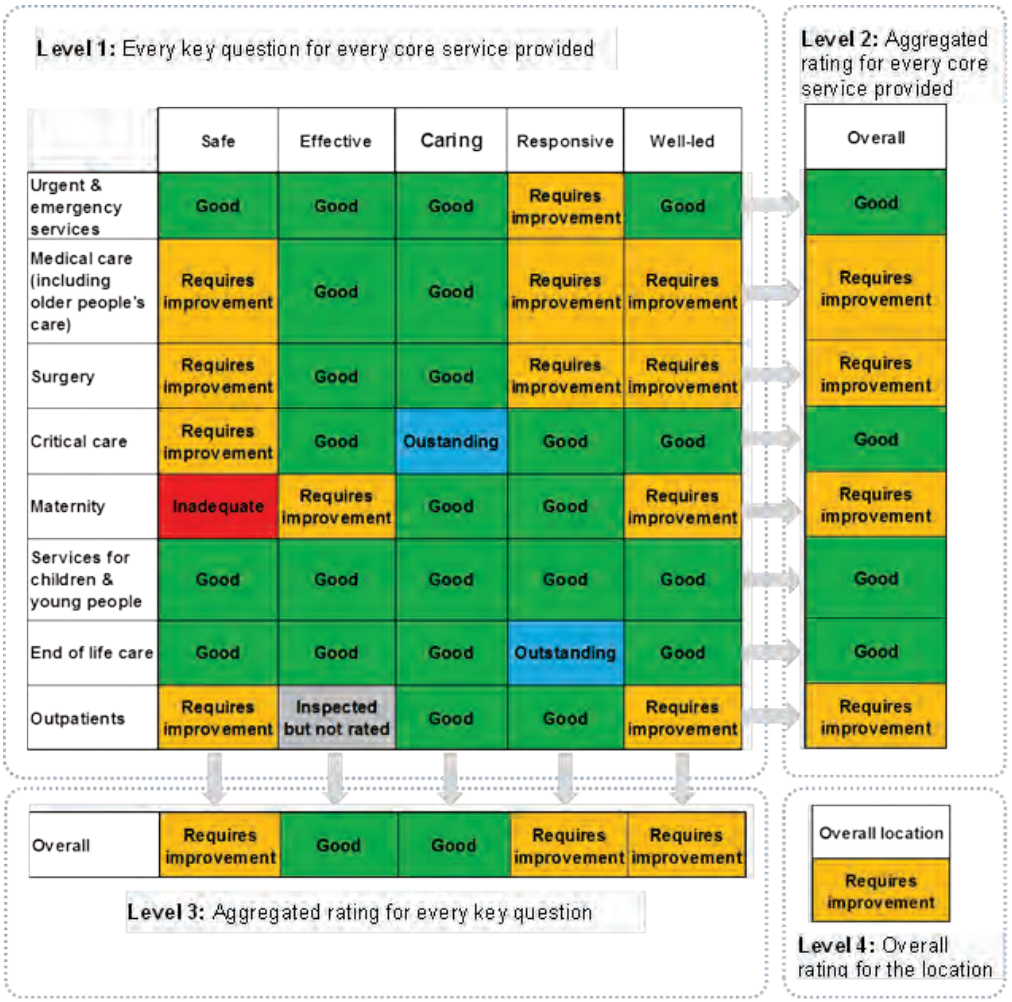
Level 1: A rating for every core service inspected against every key question

Level 2: An aggregated rating for each core service

Level 3: An aggregated rating for each key question, except for NHS trusts with one location (hospital). For these trusts, the rating for well-led will be determined by the assessment of the well-led key question

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

The following example shows how the four levels work together:



For NHS acute trusts with multiple locations, we also rate quality at the following two levels to reflect the additional aggregation:

Level 5: A rating for each of the key questions overall. For trusts with multiple sites, this is informed by our findings at level 3 for safe, effective, caring and responsive. The rating for well-led is determined by the assesment of well-led at trust level. For a trust with only a single site, this is equivalent to a rating at level 3.

Level 6: A rating for the NHS trust as a whole. For a single-site trust, this is equivalent to level 4.

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:

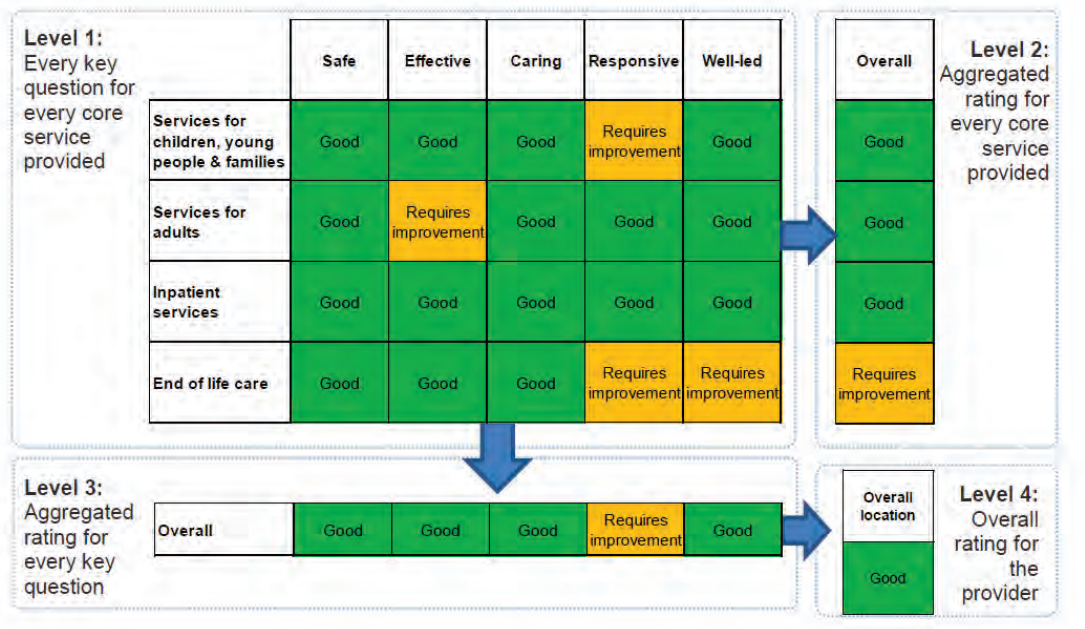
Level 1: A rating for every core service against every key question

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 of a trust's services in an inspection, but the inspection report will specify the date when we awarded the rating for each service. If we haven't inspected a core service or key question as part of the trust inspection, we will maintain the existing rating. We will state that we have 'reviewed evidence about quality and safety of care which did not identify any areas of potential concern or improvement to lead us to carry out an inspection.

Aggregated ratings will be a combination of previously allocated 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, you must display an updated ratings grid in relevant locations and on your website.

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

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 Limited to requires improvement where there are (X) number of underlying inadequate ratings	Principle 9 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.

Use of resources

We will work with NHS Improvement to rate a trust’s use of resources at the trust level. We will start introducing these assessments in non-specialist acute trusts in our next phase of regulation, and will initially publish them alongside our quality inspection reports.

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.

You cannot ask for a review of your ratings on the basis that you disagree with our judgements. Any dispute over ratings judgements should be raised during the draft report stage.

Any request for a review must relate solely to your 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).

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

You will find the link to the online form in the letter we send with your final report.

The review process

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

If it does not meet these grounds then we'll refuse the request and write to you 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 your request.

Our review may extend to ratings that you did not challenge. 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.

Complaints and appeals

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

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

The review decision

The chief inspector makes the final decision about each rating review.

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

We'll make the appropriate changes to your 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, you 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 and evidence appendices

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.

Special measures

Special measures apply to NHS trusts and NHS foundation trusts that have serious failures in the quality of care (usually when they are rated inadequate in at least two out of the five key questions at trust level, with one rating of inadequate for well-led) and where we have concerns that the existing management cannot make the necessary improvements without extra support.

We want to ensure that services providing inadequate care do not continue to do so. We can therefore recommend to NHS Improvement that the trust is placed into special measures. The purpose of this is to:

- Ensure that providers found to be providing inadequate care make significant improvement.
- Enable us to use our enforcement powers in response to inadequate care and to work with other organisations to ensure that care improves.
- Provide a clear timeframe for providers in which to improve the quality of care. If they do not, we will take further action. For example, we have the power to require NHS Improvement to place a foundation trust in special administration, or to recommend to the Secretary of State that an NHS trust be placed into special administration.

How special measures work

Trusts in special measures receive support from NHS Improvement to make the necessary improvements. This involves appointing an improvement director and securing external support from another trust. The trust's senior leadership may also be strengthened.

We usually re-inspect the trust at any time within 12 months of it going into special measures. But if we have significant concerns about quality, we will carry out another inspection sooner.

During the special measures period, we will keep regular contact with the trust and NHS Improvement to discuss progress. If there is enough evidence of good progress, NHS Improvement may recommend an earlier inspection. At this stage, if we feel the trust has made enough progress, we will recommend that it is taken out of special measures.

If the trust has not made sufficient progress when we re-inspect, we will consult with NHS Improvement to decide whether it should remain in special measures or if we need to take further action.

We developed our approach to special measures for NHS trusts with NHS Improvement. Please see:

A guide to special measures for NHS trusts

An addendum to the guide to special measures for NHS trusts

Financial special measures

NHS Improvement has a further set of criteria that it uses to determine if a trust should be placed in financial special measures. See Guidance on financial special measures for NHS providers (Annex H).

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.