How CQC monitors, inspects and regulates independent healthcare services

May 2019

Updates to this guidance:

- Added list of accreditation schemes (May 2019)
- Checking the factual accuracy of your draft report (April 2019)
- Updating ratings and displaying a provider's regulatory history (April 2019)

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

CONTENTS

How we define independent healthcare services

We define independent healthcare services as health care provided by organisations that are not NHS trusts or NHS GP services (that is, private sector services). Examples are private corporations or companies, charities, social enterprises, voluntary and faith-based organisations and individual providers of care. This includes:

- independent acute hospitals
- single specialty termination of pregnancy services
- single specialty acute long-term conditions services
- single specialty dialysis services
- single specialty hyperbaric services
- single specialty refractive eye surgery services
- single specialty diagnostic imaging services
- single specialty endoscopy services
- single specialty laboratory services
- blood and transplant services
- independent ambulance services
- independent hospices
- independent community services
- independent mental health hospitals
- independent standalone substance misuse services.

A ‘single specialty’ is where the sole or main purpose of the service is to provide the speciality specified above.

Most fertility treatments that need to be licensed with the Human Fertilisation and Embryology Authority (HEFA) do not come within the scope of registration with CQC. If a service is registered with CQC and also licensed with the HFEA, we will only inspect and rate the parts of the service that are within CQC scope. This does not include treatments to assist conception and those that are licensed by the HFEA.

This guidance applies to all independent healthcare services except:

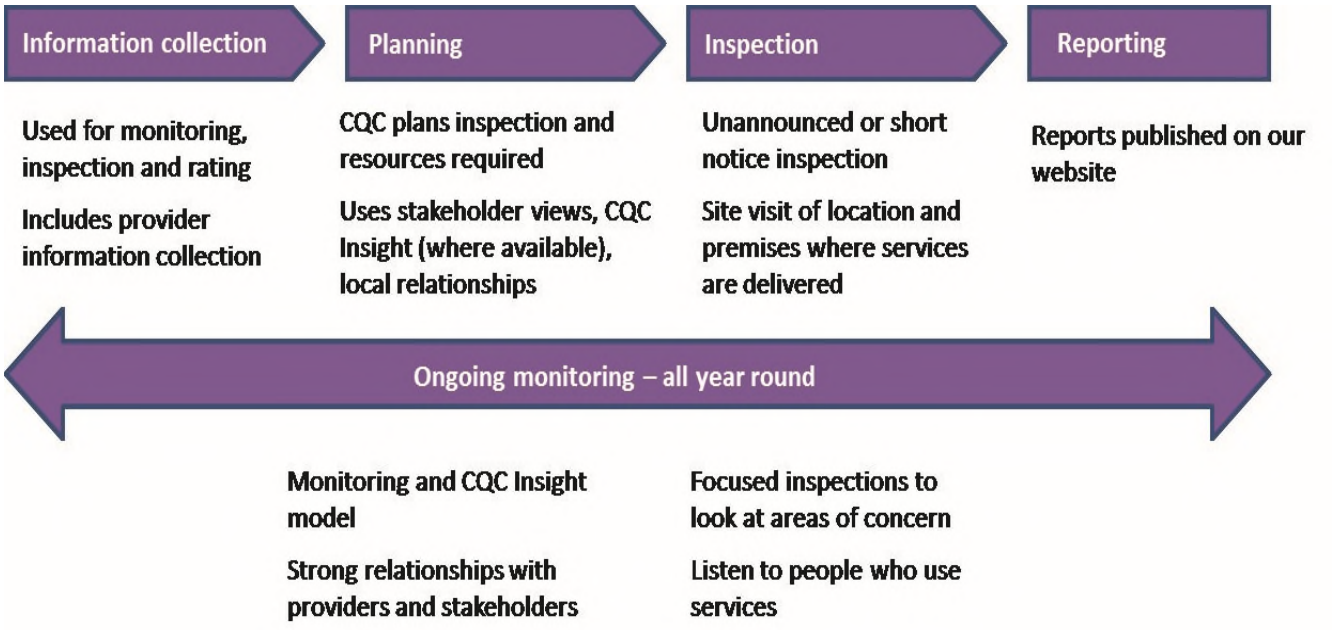
1. **Independent doctors and clinics that provide primary medical, mental health and non-hospital acute services.** There is separate guidance for these providers.
2. **Providers of community healthcare and/or mental health care (typically community interest companies (CIC)) that deliver multiple services to people in a specific geographical area, similar to an NHS trust.** We will follow our regulatory approach for NHS trusts for these providers.

The first inspection of community healthcare providers in this category will be a comprehensive inspection. This is to establish an initial baseline rating as we now have powers to rate these services. For subsequent inspections, and for inspections of mental health care providers that meet these criteria, we will inspect the five key questions in at least one core service annually, followed by an inspection of how well-led a provider is. Please see How we monitor, inspect and regulate NHS trusts for further details.

MONITORING AND INFORMATION SHARING

How we monitor and inspect independent healthcare services

The diagram shows how our ongoing monitoring and inspections work for independent healthcare services.



CQC Insight

CQC Insight is a tool that brings together and analyses the information we hold about your service. It uses indicators that monitor potential changes to the quality of care that you provide. CQC Insight will help us to decide what, where and when to inspect and provide analysis to support the evidence in our inspection reports.

We will introduce CQC Insight for providers of independent healthcare in stages. It will start for the following services in quarter 4 of 2018/9:

- independent acute hospitals
- inpatient mental health care services (to include indicators on substance misuse services and services for people with a learning disability).

We will roll out CQC Insight for all other types of independent healthcare services when the available data is of sufficient quality, depth, and coverage to allow us to monitor them effectively.

What CQC Insight shows us

CQC Insight will give inspectors:

- contextual and descriptive information about providers, including registration details
- current and historic ratings
- an indication of performance, including comparison with similar registered services, changes over time, and whether latest performance has improved, deteriorated or is about the same as a previous equivalent period.

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

Sources of information

CQC Insight analyses information from a range of sources, which is tailored to each sector or type of service. For example, CQC Insight for independent acute hospitals will present findings from relevant national clinical audits; CQC Insight for independent providers of specialist mental health services will include analysis of the findings of our visits to people detained under the Mental Health Act 1983 (MHA) and relevant notifications under the MHA. Where possible, we will present analysis relating to services and key lines of enquiry (KLOEs).

When new data becomes available, we will refresh CQC Insight as soon as possible.

The content of CQC Insight will initially focus on existing data collections. We will continue to develop indicators and look at ways to improve how we use qualitative information, including what patients tell us about a service. In time, we will include indicators using information we collect directly from services through our provider information requests.

Provider information request

Before a comprehensive inspection we will ask you to provide information to help us to plan the inspection and to understand more about the care and the service(s) you provide.

The information we will request includes:

- information about your staff, such as types of roles, vacancies, and sickness
- details of significant events and serious incidents
- how you ensure that your service is safe, effective, caring, responsive, and well-led
- information on complaints
- policies, procedures and other documentation.

This list is not exhaustive as the information we request will be relevant to the type of service(s) you provide.

You have three weeks in which to complete and submit the provider information request. We will tell you how to submit the information, when to send it by, and who to contact if you have any questions.

We may also need to ask you for some additional specific information. For example, we may need extra information to clarify queries during an inspection. We will keep track of these extra requests to minimise duplication and to make sure that we only request information that we need, which is not available elsewhere.

As other national data collections develop, we will update our own systems so that if we can access specific information from another source we will not request the same information directly from providers.

To monitor services between inspections, we plan to move to a more routine information request from providers, which we will include in CQC Insight. We will work with providers to develop an online system to collect this information.

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. By working more closely with national partners, we will increase efficiency by reducing duplication and making the best use of shared information and resources. Our inspection and intelligence teams have an ongoing relationship with organisations including:

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

We also engage with other partner organisations, such as the Parliamentary and Health Service Ombudsman, the Independent Healthcare Sector Complaints Adjudication Service (ISCAS), 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. We will also seek to develop our relationship with the NHS Partners Network (NHSPN), the Private Healthcare Information Network (PHIN) and other bodies, as our approach develops.

How we work with local and regional partners and the public

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

We encourage people to share their experiences 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 clinical commissioning groups, where NHS services are provided by independent health providers under contract, our Inspectors and Inspection Managers will be in regular contact with people from the relevant:

- local Healthwatch
- overview and scrutiny committees
- independent NHS complaints advocacy services
- voluntary and community sector organisations (particular those representing people whose voices are seldom heard)
- local authorities
- independent mental health advocacy services
- independent Mental Capacity Act advocacy services.

Where appropriate, we also work with:

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

Responding to information of concern

We will respond to all information we receive that is a potential cause for concern and will consider any associated risks. We may discuss this information with you either at our next planned relationship management meeting or at the next inspection, or we may consider carrying out a focused inspection.

How we manage our relationship with you

Our relationship with you will contribute to our monitoring activity. We will allocate a relationship holder to every provider and location to develop a consistent understanding of your organisation and strengthen our relationship with you.

Your CQC relationship holder will either be an Inspector, Inspection Manager or Head of Hospital Inspection. We will try to keep the same person as far as possible. They should be your first point of contact with CQC. You can contact your relationship owner if you have any queries about your registration or if you need to tell us about any significant changes to your services (for example, if your service begins formally collaborating with others).

Your relationship owner may contact you for a number of reasons. For example, if our monitoring of your service suggests a significant improvement or deterioration in the quality of care, your relationship owner may ask you to explain the reasons behind this.

Where individual services are part of a larger or corporate provider, there may be a different relationship owner for the service level and the provider level. In this case, we will share information internally to gain a better understanding of quality across a provider, and reduce duplication.

Relationship meetings

You and your relationship owner will maintain contact through relationship management meetings. We will hold these meetings at least annually at provider and location level, either in person or by telephone. For larger organisations we are likely to meet more frequently.

Before a relationship management meeting, your relationship owner will review information we hold about the service, including from CQC Insight where available. If it suggests an improvement or deterioration in the quality of care for a service, we may ask you for further information, or to explain the reasons for this during the meeting.

If a provider has any significant concerns about quality, we expect you to raise them with your relationship owner, either as part of regular contact or at any time where a concern arises, and to tell us about the action you are taking to address them. If the provider has commissioned any external reviews, you should also disclose these to us as a matter of course.

Fit and proper persons requirement: directors

NOTE: this does not apply to providers that are individuals or partnerships. Individuals and partnerships are governed by Regulation 4.

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.

INSPECTION

When we will inspect

We will prioritise inspections of the following independent healthcare services:

- services that we have not previously inspected but now have the powers to rate
- services that we have inspected but not yet rated
- services that pose a higher risk
- newly-registered providers.

If you are registering with CQC as a new provider, we will normally aim to inspect within 12 months of registration. For services that are rated, you will receive your initial rating at this inspection. We will use your initial rating to determine when next to inspect your service.

For all subsequent comprehensive inspections, the maximum intervals for re-inspecting depend on your rating as follows:

Previous overall rating	**Maximum interval between inspection**
Inadequate	Normally within 12 months of publishing the last comprehensive inspection report
Requires improvement	Normally within two years of publishing the last comprehensive inspection report
Good	Normally within three and a half years of publishing the last comprehensive inspection report
Outstanding	Normally within five years of publishing the last comprehensive inspection report

These are maximum inspection intervals, therefore we may inspect more frequently, particularly if there is a risk. This flexible approach reflects CQC's commitment to deliver an intelligence-driven approach to regulation.

Our approach to rating independent healthcare services

Type of service	Rating	Maximum inspection intervals	Frequency applies from
Independent acute hospitals, *excluding standalone cosmetic surgery and hair transplant locations*	Already rated	**Inadequate:** one year **Requires improvement:** two years **Good:** three and a half years **Outstanding:** five years	April 2018
Single specialty: Acute long-term conditions			
Independent mental health hospitals			
Hospices			
Cosmetic surgery including hair transplant (involving a surgical procedure)	Will be rated at next comprehensive inspection		Date of publication of report for first rated inspection
Single specialty: Termination of pregnancy			
Single specialty: Dialysis			
Single specialty: Refractive eye surgery			
Single specialty: Diagnostic imaging			
Single specialty: Endoscopy			
Independent ambulance services			
Community health services			
Independent standalone substance misuse services			
Single specialty: Hyperbaric services	Not rated	Inspect by 2021	n/a
Single specialty: Pathology laboratories			
Blood and transplant services			

Notice periods

To enable us to observe normal practice in a service, we will introduce more unannounced inspections as part of our comprehensive inspection methodology for independent healthcare services. Because we request information from providers beforehand, we will carry out the inspection within three months of the provider submitting its provider information request. However, we will not announce the day on which we intend to inspect.

For practical reasons, we may need to give a short notice period of an inspection to some providers. This will usually be 48 hours' notice.

CQC's lead inspector may decide to carry out a short notice inspection for any of the following reasons:

- Where an unannounced inspection is likely to have a detrimental impact on the people who use the service and the quality of care of care they could receive.
- Where the availability of the service is variable and it opens on different days or times of the week.
- Where the service is dispersed and delivered across a large geographical area:

Our inspection teams will continue to ensure that in all instances the impact on the staff delivering the service, as well as the people using them, is kept to a minimum.

The inspection team

Each inspection team is led by a CQC Inspector or Inspection manager. Where appropriate, an inspection team will also include:

- Specialist professional advisors. These are clinical and other experts such as pharmacists, nurses, doctors, psychiatrists, psychologists, social workers, GPs, physiotherapists, occupational therapists, equality and diversity leads or health service managers.
- Mental Health Act Reviewers.
- 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.
- CQC inspection team support staff.

The specialist professional advisors and Experts by Experience who join the team reflect the type of services being inspected, the areas on which we plan to focus and the nature of any concerns identified before inspection. This will also influence the size of the inspection team.

What we will inspect

Types of inspection

Comprehensive inspections

Our usual approach is to carry out a comprehensive inspection of the services at a location level. This is when we inspect all of a provider's services across all five key questions at a location. The inspection will normally be unannounced (unless a short notice inspection applies) and it will typically take place within three months of the provider completing and returning the provider information request. The inspection will be carried out for a minimum of one day, although this may be longer depending on the type and size of services being inspected. Inspections that last longer than one day may not necessarily take place on consecutive days.

For independent mental health services that provide a number of services, and where we have already rated, it may be more proportionate to carry out an inspection of only some, rather than all, services. This is because we have already rated them and they are often providing NHS-contracted services, therefore our approach will be consistent with our approach to NHS trusts that provide mental health services.

Focused inspections

We carry out focused inspections either in response to specific information that we have received or to follow up findings from a previous inspection. We may also carry out a focused inspection when we have taken enforcement action.

They broadly follow the same process as a comprehensive inspection but, as we do not usually look at all five key questions, they are smaller in scale.

After a focused inspection, the overall rating for a location can change at any time using key question ratings from the focused inspection as well as the remaining key question ratings from the last comprehensive inspection.

Focused inspections will normally be unannounced and do not include a provider information request.

Inspecting complex providers

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 an independent doctor providing primary care dental services. We will use teams of specialists to inspect each of the services.

Service inspections

We use inspection frameworks to inspect most services. As far as possible, these are aligned with the frameworks for NHS services, but with some differences that reflect how services are organised and the level of risk. For example, independent providers of termination of pregnancy services are subject to additional legal requirements, so we have a specific service-level framework for those providers.

We may not always inspect every ward or part of a service in a single inspection. In these cases, 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.

INDEPENDENT ACUTE HOSPITALS

We inspect the following services in independent acute hospitals:

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

Diagnostic imaging

This service includes all areas where people:

- undergo physiological measurements and diagnostic tests
- receive diagnostic test results.

Diagnostic imaging includes imaging services and screening procedures, such as X-rays, fluoroscopy, MRIs, PET, CT and DEXA scans, ultrasound (including baby ultrasound that is not part of a maternity service), nuclear medicine scans, and

mammography. It does not include children's diagnostic services, as these are covered under the children and young people service. The exception is where **only** children aged 16 years and over are seen, in which case these will be reported on under diagnostic imaging.

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 hospital may deliver care on any ward or as part of any of its services. It includes aspects of 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 service. End of life care that relates to spontaneous miscarriages are also inspected under the maternity service.

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

Maternity

This includes all services for women that relate to pregnancy, with the exception of gynaecology, which we inspect under surgery services, and termination of pregnancy, which we inspect under the termination of pregnancy service.

However, the inspection framework for maternity does include 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 service for children and young people.

Medical care (including older people's care)

This includes the broad range of specialties not included in the other 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
- chemotherapy wards/suites
- endoscopy units/suites.

Outpatients

Outpatient services include all areas where people receive advice or care and treatment without being admitted as an inpatient or day case.

It does not include children's outpatient services, as these are covered under the children and young people service. The exception is where **only** children aged 16 years and over are seen, in which case these will be reported on under outpatient services.

Services for children and young people

This includes all services for children between birth and up to the age of 18, including:

- 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 urgent and emergency care.

In cases where a location admits **only** children aged 16 years and over for surgery, then the surgery for this age group will be reported under surgical care.

In cases where **only** children aged 16 years and over are seen as an outpatient, then outpatient services for this age group will be reported under outpatients. The same principle applies for diagnostic and screening.

Surgery

This 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
- cosmetic surgery
- thoracic surgery
- gynaecology
- hair transplant surgery.

The surgery service also includes interventional radiology. We include some specialist surgery, including caesarean section, under the maternity service.

Cosmetic surgery

We will inspect independent clinics that carry out cosmetic surgery or hair transplant surgery under our approach to inspecting surgery in independent acute hospitals. By cosmetic surgery, we mean surgery carried out by a healthcare professional for cosmetic purpose where the procedure involves instruments or equipment inserted into the body.

Termination of pregnancy

This includes termination of pregnancy provided for all ages and incorporates ancillary activities that the provider carries out wholly or mainly in relation to termination of pregnancy. For example, sexual health screening, and assessing and determining the legal grounds for abortion. Termination of pregnancy refers to the treatment for terminating a pregnancy by surgical or medical methods, including feticide. Prescribing of abortifacient medicine is considered treatment for termination of pregnancy.

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.

They may also include a clinical decision unit, ambulatory care unit, minor injury unit or walk-in centre. If the hospital provides an urgent care centre we will also include this in the inspection.

An urgent care centre 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 urgent and emergency care. We do **not** consider it as part of the hospital's services for children and young people.

SINGLE SPECIALTY SERVICES

For single speciality providers, we inspect the following services:

Diagnostic imaging and endoscopy services

This covers those services that provide diagnostic imaging or endoscopy as their sole or main service.

Diagnostic imaging

This includes all areas where people:

- undergo physiological measurements and diagnostic testing
- receive diagnostic test results.

Diagnostic imaging includes imaging services and screening procedures, such as X-rays, fluoroscopy, MRIs, PET, CT and DEXA scans, ultrasound (including baby ultrasound that is not part of a maternity service), nuclear medicine scans, and mammography.

Endoscopy

When inspecting single specialty endoscopy services, we will look at procedures carried out within an endoscopy unit, including:

- oesophago-gastro- duodenoscopy (OGD)
- small bowel enteroscopy
- colonoscopy
- sigmoidoscopies
- capsule endoscopy
- endoscopic ultrasound (EUS)
- endoscopic retrograde cholangio-pancreatography (ERCP)
- bronchoscopy.

When inspecting single specialty endoscopy services, the definition excludes services that include medical consultations carried out in an outpatient setting using endoscopes without a channel to pass fluid or instruments through, such as a fibre optic (flexible) nasoendoscope, or a fibre optic (flexible) rhinolaryngoscope. It also excludes consultations that include examination with the use of a rigid sigmoidoscope.

Dialysis

This applies to single specialty independent services providing dialysis for patients with kidney failure as their sole or main service.

Hyperbaric oxygen therapy or treatment

This applies where the sole or main service is providing hyperbaric oxygen therapy or treatment for the purpose of treating a disease, disorder or injury. Not all hyperbaric services are required to register with CQC; for example those provided to employees in connection with their work, or those that are not provided or supervised by specific types of healthcare professionals.

Long-term conditions: neurological rehabilitation and long-term care

This applies where the provider's sole or main service is typically providing facilities, medical treatment, rehabilitation and care of people with neurological conditions or disabilities, and acquired brain injuries. These hospitals can offer very long lengths of stay and are different to acute, community or mental health hospitals. Inspections of these hospitals are likely to involve community and mental health care professionals, as well as acute and specialist practitioners.

Refractive eye surgery

This applies to providers that carry out vision correction services using surgical procedures as their sole or main service. This type of service is ordinarily provided for self-referring, self-pay patients and is mostly elective surgery and not funded by the NHS or private medical insurers. The service may also include laser eye surgery, refractive lens surgery, refractive lens exchange (RLE) and intraocular lens implants (IOLs).

Termination of pregnancy

This applies where termination of pregnancy is provided as the sole or main service. For a description of this service please refer to the definition of service in the acute section.

Where these single specialty services also provide male sterilisation, this will be considered within the inspection of the overall termination of pregnancy service.

We also inspect the following single specialty services:

- blood and transplant services
- laboratories.

INDEPENDENT AMBULANCE SERVICES

We inspect the following services for independent ambulance providers:

Emergency and urgent care services

These 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’).

This 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 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 provider manages emergency response from other parties, these are also included. 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 service includes the patient transport control room and dispatch operation and any assessment of a patient's eligibility for the service.

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

Independent ambulance services may also carry out activities that are outside the scope of CQC registration and exemptions may apply. We will not inspect these activities.

INDEPENDENT COMMUNITY HEALTH SERVICES

We inspect the following services:

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.

This 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.

This does not include:

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

Community health services for children, young people and families

This includes 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 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.

This does not include:

- child and adolescent mental health services (included in the mental health CAMHS service)
- community end of life care for children and young people (included in the community end of life care service).
- community midwifery services (included in the acute maternity 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 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)
- end of life care provided to people on community inpatient wards (covered under community end of life care)
- 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 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 service, usually community health services for adults.

Community sexual health services

Services covered by this service include:

- STI screening, diagnosis, treatment and prevention
- contraception services, including emergency contraception
- other genitourinary services
- specialist HIV testing, treatment and care services
- health promotion and healthy relationship advice
- psychosexual medicine and counselling
- contact tracing/partner notification for sexual partners at risk of STI.

Community dentistry

Community dental services are all commissioned by NHS England Area Teams to provide a wide range of care not provided by primary care dental services. These services include:

- a full range of treatment services to patients with special needs (both adults and children)
- a referral service for other health and social care practitioners

- dental care for patients who would have difficulties accessing ordinary primary care dentistry
- specialist services, for example special care dentistry, paediatric dentistry and orthodontics
- general anaesthetic and sedation services
- access services, for example out-of-hours services, domiciliary care and Dental Access Centres (DACs)
- public health, including screening, health promotion and epidemiology
- access for groups of people who may be vulnerable.

Community urgent care

These are community facilities delivering care that can be accessed without a referral, in an urgent or emergency situation. The purpose of urgent care is to treat patients presenting as an emergency or with urgent medical needs. Services include urgent care centres (UCCs), minor injuries units (MIUs) and walk-in centres.

HOSPICES

For independent hospice providers, we inspect the following services:

Hospices for adults

Hospices offer wide-ranging, personalised care to improve the quality of life and wellbeing of adults with a life-limiting or terminal illness. Services may be delivered in an inpatient unit and/or at home.

Hospices for children

Children's hospice services offer wide-ranging, personalised care to improve the quality of life and wellbeing of babies, children and young people with life-limiting conditions or terminal illness. Hospices for children and young people may also care for young adults, up to the age of 30 and beyond. Services may be delivered in an inpatient unit and/or at home.

INDEPENDENT MENTAL HEALTH SERVICES

For independent mental health providers, we inspect the following services:

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 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 mental health 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.

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 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 1983. 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.

We also inspect the following independent mental health 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.

INDEPENDENT SUBSTANCE MISUSE SERVICES

For independent substance misuse providers, we inspect the following services:

Hospital inpatient-based services

These services provide assessment and stabilisation, and assisted withdrawal for people with substance misuse problems. Services are available 24 hours a day, and are provided by a multidisciplinary clinical team with specialist training in managing addiction and withdrawal symptoms.

The clinical lead in these services is usually a consultant in addiction psychiatry, or another substance misuse medical specialist. The team may also include psychologists, nurses, occupational therapists, pharmacists and social workers. People whose use of alcohol or drugs needs to be supervised in a controlled medical environment may be admitted to an inpatient unit. Treatment may be provided on a specialist ward, or as part of their care on another ward.

Residential substance misuse services

These services provide structured drug and alcohol treatment where people have to be resident at the service in order to receive treatment. This includes abstinence-based recovery services, as well as medicine-assisted recovery programmes, such as detoxification or stabilisation services. Teams vary according to the service's

treatment programme, but may include psychosocial project workers, social workers, doctors and nurses.

Community-based services

These services provide care, treatment and support in the community for people with substance misuse problems. They may also help people who have a dual diagnosis or co-occurring disorders (COD), where the person is experiencing a mental health problem and also has a substance misuse problem.

People are primarily cared for by a doctor, nurse or social worker, but services are provided by a broad range of health and social care professionals, working in multidisciplinary teams. This could include in GP practices or other community settings, or part of health services in secure settings. The teams are also supported by community pharmacists when providing controlled drugs. Treatment is likely to involve the use of medicines, usually opioid substitution therapy, alongside psychosocial interventions.

Site visits

Site visits enable us to talk to people using services, staff and other professionals to find out their experiences. They allow us to observe care being delivered and to review records to see how people's needs are managed both within and between services.

Gathering evidence during the site visit

To structure the site visit, inspection teams use the key lines of enquiry (KLOEs) and associated prompts in CQC's assessment framework for healthcare services. They also look at any concerns identified beforehand through our monitoring activity. This enables them to focus on specific areas of concern or potential areas of outstanding practice. They collect evidence against the KLOEs using a variety of methods.

People who use services

We will gather the views of your patients, their family and carers, by:

- speaking with them individually or in groups
- using information from complaints and concerns sent through our website.

We will also send you:

- posters to publicise the inspection and give people the opportunity to speak to the inspection team
- comment cards for people to fill in.

We ask you to display these in a prominent position at reception and in other busy areas.

Sometimes we include Experts by Experience on inspections, particularly in mental health services. Experts by Experience are people who use care services or care for someone who uses health and/or social care services. Their main role is to talk to people who use services and tell us what they say. If we include an Expert by Experience on an inspection, they will talk to people at the premises on the day of the inspection or by telephone. In some services, people find it easier to talk to an Expert by Experience rather than an inspector. Experts by Experience can also talk to carers and staff, and can observe the care being delivered.

Your staff

The inspection team will interview staff at all levels. We will usually interview the following people or their equivalents:

- chair of the medical advisory committee
- director of nursing/matron/clinical services manager
- service leads for each of the services (for example, clinical director, nursing lead, directorate manager, theatre manager/ward manager)
- complaints lead
- senior lead for human resources.

Where appropriate, the inspection team will hold focus groups to gather feedback from other members of staff, which may include:

- consultants and other medical staff
- registered nurses and midwives/sisters
- healthcare assistants
- allied health professionals
- administrative and support staff.

Focus groups may not always be appropriate because of the small number of staff or disruption to patient care. In these cases, we will gather views by speaking with staff during the inspection. We may also seek the views of staff through an online survey or email.

Gathering information in other ways

We may also gather information by:

- tracking a patient's journey through their care pathway
- observing care
- reviewing records
- reviewing operational policies and supporting documents.

Feedback on the visit

At the end of the inspection visit, the lead inspector will meet with your registered manager or nominated individual to provide feedback. This is high-level initial feedback only, illustrated with some examples. We will carry out further analysis of the evidence before we can reach final judgements on all the issues and award ratings.

Mental Health Act 1983

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 MHA.

We are responsible for reviewing and monitoring how these organisations apply the MHA 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 2008. 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 this 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 MHA.

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 2005 and Deprivation of Liberty Safeguards

Mental Capacity Act 2005

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 (MCA). 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 provider may participate in certification schemes for some of its clinical services. These are more commonly known as accreditation schemes.

Achieving accreditation under a specific scheme is reflected in the effective key question for the relevant service at location level.

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

Informing CQC inspection activity

We will use accreditation schemes that relate to a particular service to inform our inspection activity and enable us to take a proportionate approach. For example, we only do this if we are assured that a scheme meets quality standards and:

- there is adequate uptake 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 service-level inspection and each key question inspected. It will show our ratings judgements and detail 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 normally be published within three months of the inspection.

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.

Providers 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 (and evidence appendix, if appropriate), 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 (and evidence appendix/table, if appropriate)
- 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.

Your ratings

After an inspection, we rate 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 for all providers to display CQC ratings.

We decide all ratings using a combination of aggregating the service level 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.

Where there is a change of ownership or address at an existing location, CQC's website and internal systems will display the provider's 'regulatory history' (rating and inspection report under a previous provider). See Continuation of regulatory history for more information.

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. 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 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 service or location doesn't have to demonstrate every characteristic of a rating for us to give that rating. For example, if a location 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 locations rated as outstanding are likely to have areas where they could improve. In the same way, locations 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 rate independent healthcare providers in the same way that we rate other services. This includes awarding a rating for the five key questions: are services safe, effective, caring, responsive and well-led, and then aggregating these up to an overall rating at service and/or location level. Where an independent healthcare provider delivers a number of services we will also aggregate the ratings for these services to an overall location level rating.

We rate at these levels on our four-point scale: outstanding, good, requires improvement and inadequate.

We decide all ratings using a combination of aggregating the ratings for the key questions and the professional judgement of inspection teams. We use the same set of ratings principles to help us to determine the final ratings that we use for all other services, which are published on our website.

Ratings will be based on our assessment of the evidence we gather against the key lines of enquiry in the assessment framework for healthcare services. Inspectors will refer to the corresponding ratings characteristics for the key lines of enquiry and use their professional judgement to decide on a rating.

Sometimes, we won't be able to award a rating. 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' when we publish an inspection report. We may also suspend a rating at any level. For example, we may have identified significant concerns which, after reviewing but before a full assessment, lead us to re-consider our previous rating. In this case, we would suspend our rating and then investigate the concerns.

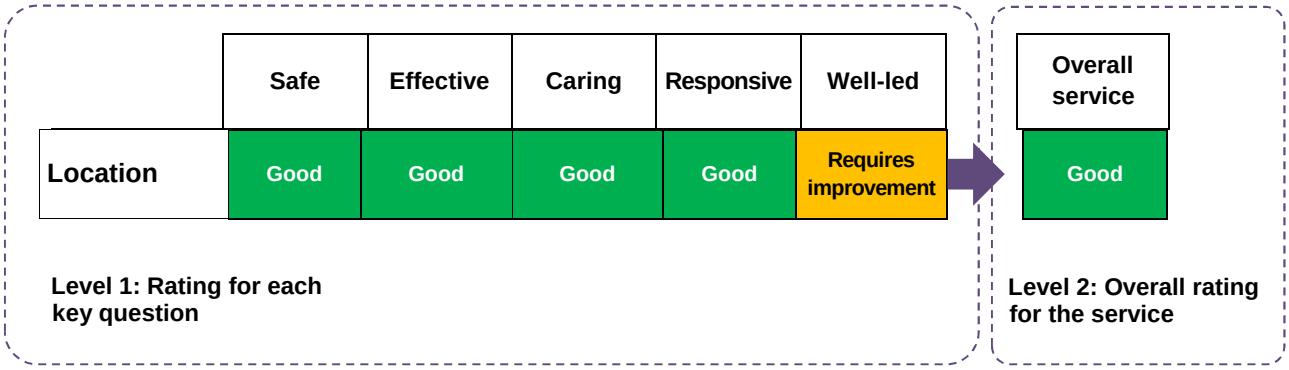
We will rate at different levels according to the type of provider and the number of services they provide (where relevant). For all types of independent healthcare services we will rate at the following levels:

Level 1: A rating for each of the key questions for the service.

Level 2: An overall rating for the service. This will be an aggregated rating informed by our findings at level 1.

Rating example 1 shows how the two levels work together for a single specialty service:

Rating example 1



Rating example 2 shows how the four levels work together for a provider that delivers more than one service. For example, for each independent acute hospital location, we would rate the quality of care at four levels:

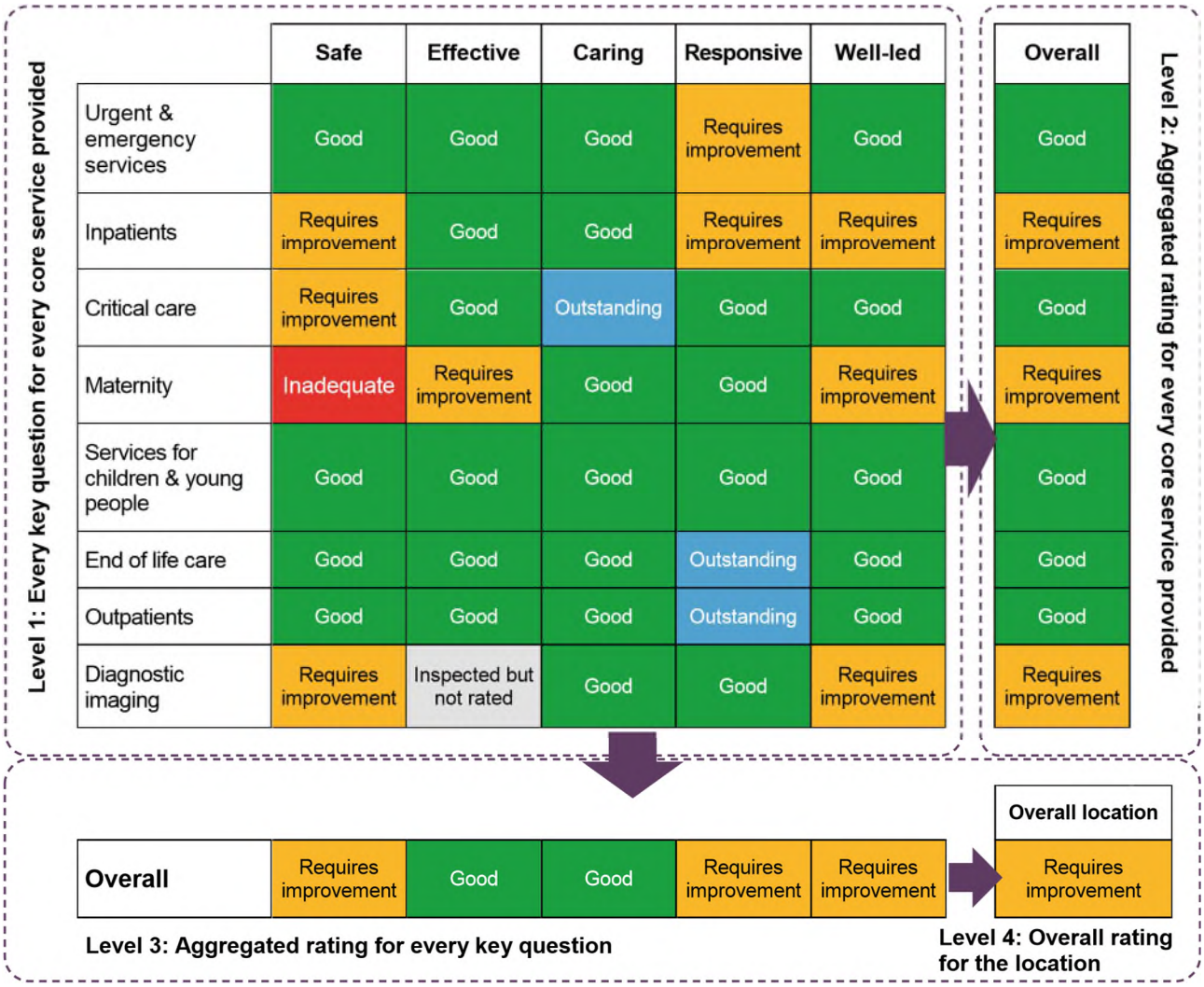
Level 1: A rating for every service inspected against every key question.

Level 2: An aggregated rating for each service.

Level 3: An aggregated rating for each key question, except for providers with one location (hospital).

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

Rating example 2



How we determine your aggregated ratings

Using professional judgement

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

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 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 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	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

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 request for a review must relate solely to your latest final inspection report. We cannot 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, and you can only submit one request for an inspection report.

There is a limit of 500 words for a request for review across all the ratings you wish to challenge (except for larger NHS trusts and independent hospitals that provide several core services or have multiple locations).

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

Where the grounds for a rating review are met, CQC's Chief Inspector of Primary Medical Services and Integrated Care, Chief Inspector of Hospitals or a Deputy Chief Inspector of Adult Social Care makes the final decision.

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 recent inspections
- the inspection report (and, where relevant, evidence appendices)
- current ratings.

We also send email alerts to people who are interested in a 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 the standard required 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 can amount to an offence and CQC can consider prosecution 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.

Responding to inadequate care

We want to ensure that services found to be providing inadequate care do not continue to do so. Where a service is repeatedly rated as requires improvement, we will use our power to require a report (improvement action plan) from the provider. The plan must explain what the provider will do to make the improvements needed to achieve a better overall rating.

Services rated as inadequate overall will be placed straight into special measures.

The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve.
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to cancel their registration.

Special measures does not replace CQC's existing enforcement powers: it is likely that we will take enforcement action at the same time as placing a hospital into special measures. And in some cases we may need to take urgent action to protect people who use the service or to bring about improvement, in accordance with our enforcement policy.

We have published detailed guidance about our approach to special measures for independent healthcare services.

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.