

# How CQC monitors, inspects and regulates NHS GP practices

August 2021

Updates to this guidance:

- Removed references to CQC Insight, Provider Information Collection, Pre-inspection provider information request and Annual Regulatory Review, as these no longer apply
- Removed reference to inspection frequencies as these no longer apply

**Always check CQC's bulletins and [website](#) for the most up-to-date guidance**

# CONTENTS

<b>MONITORING AND INFORMATION SHARING</b> .....	<b>2</b>
How we monitor GP practices .....	2
How we work with national partners .....	2
How we work with local and regional partners and the public .....	2
How we manage our relationship with you .....	3
Fit and proper persons requirement: directors.....	4
<b>INSPECTION</b> .....	<b>5</b>
When we will inspect .....	5
The inspection team .....	5
What we will inspect .....	6
Site visits .....	9
Mental Capacity Act.....	13
<b>AFTER INSPECTION</b> .....	<b>14</b>
Your inspection report .....	14
Factual accuracy check .....	14
Your ratings .....	16
How we determine your aggregated ratings .....	19
Ratings principles .....	20
Request a rating review .....	22
How we publish inspection information.....	24
Enforcement .....	25
Special measures .....	27
Make a representation.....	28
Complain about CQC .....	29

# MONITORING AND INFORMATION SHARING

## How we monitor GP practices

Read information about our [monitoring approach](#).

## How we work with national partners

We are part of the [Regulation of General Practice Programme Board](#). This brings together the bodies responsible for the regulation and oversight of general practice in England. As members of this Board, we produced a [joint working framework](#) with NHS England and Improvement, supported by NHS Clinical Commissioners, to help our organisations work together more effectively, and reduce duplication and workload for general practice.

We share information about practices and people's experiences of them with some of our national partner organisations. These partnerships help us to be more efficient by reducing duplication and making the best use of shared information and resources. Our inspection teams have an ongoing relationship with organisations including:

- NHS England and Improvement
- General Medical Council
- Nursing and Midwifery Council
- General Pharmaceutical Council
- Healthwatch England
- Medical and Nursing Royal Colleges
- Parliamentary and Health Service Ombudsman.

## 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 what people tell us. 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.

Our inspection teams will have regular contact with people from local organisations, including:

- clinical commissioning groups
- local Healthwatch
- overview and scrutiny committees
- complaints advocacy services
- voluntary and community sector organisations (particularly those that represent people whose voices are seldom heard)
- local authorities
- local medical committees
- patient participation groups.

## 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.

They should be your first point of contact with CQC. You can contact your relationship holder 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 practice begins formally collaborating with others).

Your relationship holder may contact you for a number of reasons. For example, if CQC Insight suggests a significant improvement or deterioration in the quality of care, your relationship holder may ask you to explain the reasons behind this. Developing an ongoing relationship enables us to have a better understanding of the background and context of your practice.

# Fit and proper persons requirement: directors

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

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

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

## Information of concern

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

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

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

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

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

# INSPECTION

## When we will inspect

Our inspection activity will focus on where there is risk – read our update about [what to expect from our monitoring approach](#).

## Announcing inspections

Inspections are usually announced. We feel that this is the most appropriate way to make sure our inspections do not disrupt the care you provide.

When we announce inspections, we will usually give two weeks' notice to individual GP practices. The inspector will telephone your practice to announce the inspection and send a letter to confirm the date.

Throughout the inspection process, the lead inspector will support and communicate with you by letter, email and telephone to help you to prepare for the day and know what to expect.

## Unannounced inspections

We may also carry out an unannounced inspection, for example if we are responding to a particular issue or concern. This may be something identified at a previous inspection that we are following up, or new information.

At the start of these visits, the inspection team will meet with your practice's senior partner or senior manager on duty at the time and will feed back at the end of the inspection if there are any immediate concerns.

## Pre-inspection provider information request

We may ask you for information before we inspect. This will depend on the information available to us and will help us to prepare our inspection and to understand more about the care and the service you provide.

## The inspection team

Each inspection team is led by a CQC inspector or inspection manager and may include additional expert advisors. 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 issues identified before inspection. An inspection team may include:

- Specialist professional advisors. These are clinical and other experts such as GPs, practice nurses or practice managers.
- Experts by Experience. These are people who have experienced care personally or have experience of caring for someone who has received a particular type of care.
- A member of CQC's Medicines Optimisation Team.

## What we will inspect

**Information from our monitoring activity helps to determine the type of inspection and what we will look at.**

### Types of inspection

#### Focused

We will carry out more focused inspections. This means we will not always consider all five key questions on each inspection.

Focused inspections enable us to follow up any potential changes in the quality of care that our monitoring activity has highlighted. These inspections only focus on certain key questions to explore particular aspects of care.

However, we will always inspect the effective and well-led key questions as a minimum. In some inspections, we may also inspect the safe, caring and/or responsive key questions if the information we have suggests that the quality of care has changed since the previous inspection. When we announce the inspection we will tell you what the focus of the inspection will be. We may change that focus if additional risks emerge during the inspection.

Focused inspections can change an overall rating at any time, using key question ratings from the focused inspection as well as the remaining key question ratings from the last inspection.

In some circumstances, we may carry out a comprehensive inspection of a practice rated as good or outstanding. We may do this, for example, where significant concerns arise or there have been significant changes to the quality of care provided.

#### Comprehensive

Comprehensive inspections address all five key questions, and ask is the service safe, effective, caring, responsive and well-led? We will always carry out a comprehensive

inspection of services that we have not yet inspected, or if a service has an overall rating of inadequate or requires improvement.

A comprehensive inspection for general practices includes all six [population groups](#).

## **Follow up**

We will inspect when we need to follow up on an area of concern. This could be a concern identified during an inspection that has resulted in enforcement action, or concerns that the public, staff or other stakeholders have raised with us.

These inspections do not usually look at all five key questions. They usually focus only on specific areas indicated by the information that triggers the inspection. Follow up inspections may be unannounced.

## **Inspecting GP practices who are working at scale**

We recognise that many GP practices are collaborating with other organisations in formal and informal ways. We are developing and testing our approach to inspecting to make sure services provide high-quality care, and that leadership and governance at all levels support this. Our strengthened relationship management and monitoring will help us to understand where collaboration is happening and how this will affect what we inspect. We will reflect any collaborative working in your inspection report.

If your practice is rated as good or outstanding, we will ask you for some contextual information about your links to other practices, federations or networks when we arrange the telephone call to carry out the provider information collection.

## **Inspecting complex providers**

If you deliver services across more than one sector, we try to align our inspections to be more efficient and to make the process simpler for you. For example, some organisations may provide a combination of primary health care services, acute hospital services, mental health care, community health services and ambulance services, and may also run care homes. We will use teams of specialists to inspect each of these services. Also read [how we rate services](#).

## **Population groups**

As well as inspecting and rating GP practices for the key questions, we also inspect six population groups. We only give a rating for the population groups against the effective and responsive key questions. These two ratings will then be aggregated to reach an overall rating for these population groups.

### **Older people**

This group includes all people in your practice population who are aged 75 and over. It includes those who have good health and those who may have one or more physical or mental long-term conditions.

It includes people who are living at home as well as those who are in a care home or a nursing home, where your practice provides general medical services to these people.

For this population group, an inspection will focus on the role of the GP practice in developing a proactive and personalised programme of care and support, which is tailored to the needs and views of older people registered with the practice.

## **People with long-term conditions**

People with long-term conditions are those with an ongoing health problem that cannot be cured. Long-term conditions can be managed with medication and other therapies. Examples of long-term conditions are diabetes, cardiovascular disease, musculoskeletal conditions, chronic obstructive pulmonary disease (COPD), long-term neurological disorders (such as epilepsy), HIV or cancers (this list is not exhaustive).

This population group does not include people with long-term conditions who are aged 75 and over as they are included in the older people population group. It does not include children or young people under the age of 18 with long-term conditions, as they are included in the families, children and young people population group.

## **Families, children and young people**

This group includes expectant and new parents, babies, children and young people.

For parents, this includes expectant and new parents only, and includes prenatal and antenatal care and advice, where provided by the GP practice. We will consider the specific services that a practice provides, including whether it is registered with CQC to provide the regulated activity of maternity services, as this will influence the level of services a practice can provide to mothers. For children and young people, we will use the legal definition of a child, which includes young people up to their 18th birthday.

## **Working age people (including those recently retired and students)**

This includes all people in your practice population who are of working age and those recently retired (up to the age of 75). Working age includes adults up to the age of 75, whether or not they are in employment. For example, it includes students aged 18 and over.

Inspections will include a focus on how people in this group are able to access appointments and services at the practice.

## **People whose circumstances may make them vulnerable**

This population group may include a number of different groups of people. It includes those who live in circumstances that may make it harder for them to access primary care, or mean they are more at risk of receiving poor care. Some of these people may also be living in circumstances that make them vulnerable. We recognise that not everyone in this population group will consider themselves as being vulnerable.

We will determine which groups to focus on by looking at your practice's population and your own assessment of the groups of patients that are most vulnerable, find it particularly difficult to access primary care, or are at risk of receiving poor care. However, we expect to always include:

- people with a learning disability
- people who are homeless.

We may also include Gypsies, Travellers, vulnerable migrants and sex workers.

This is not an exhaustive list and you should determine which groups of people are most relevant in your practice population.

When we look at a group, inspectors will focus on access to general practice services generally, rather than the physical access to a practice for an appointment. This includes registration with a practice, and the ability to book appointments and receive services.

## **People experiencing poor mental health (including people with dementia)**

This includes the spectrum of poor mental health, ranging from depression, including postnatal depression, to severe and enduring mental illnesses, such as schizophrenia. It also includes people with dementia.

## **Site visits**

Site visits give us an opportunity to talk to people using your services, your staff and other professionals, to find out about their experiences. They allow us to understand how you deliver care and see how people's needs are managed.

As well as the evidence we collect as part of the site visit, we will usually collect some evidence through other methods. These include:

- virtual interviews with staff
- evidence requests
- [virtually accessing a provider's clinical systems](#).

Where services are managed from one location across multiple sites, we are likely to visit a number of the sites during an inspection.

## Gathering evidence during the site visit

To structure the site visit, the inspection team refers to the key lines of enquiry (KLOEs) in the [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
- using information from complaints and concerns sent through our website
- speaking with a member of your patient participation group or patient reference group.

### Your staff

On all inspections, we are likely to speak to the following members of staff:

- GP partners
- other GPs employed, including locums and trainee GPs
- practice managers
- practice nurses
- healthcare assistants
- other clinical staff
- administrative staff.

### Gathering information in other ways

We may also gather information by:

- reviewing records and clinical systems (read [GP mythbuster 12: Accessing medical records during inspections](#))
- tracking a patient's journey through their care pathway
- reviewing records
- reviewing operational policies and supporting documents.

We recognise that there are particular sensitivities about medical records held by GP practices. The relationship between GPs, practice nurses and their patients is often a close and long-lasting one, with a very strong expectation of confidentiality. Records may include very private and personal information, including information about relationships, mental health and sexual health. A GP or nurse from the inspection team will usually review medical records.

Read our information describing [why and how we look at medical records](#) during our inspections.

## **The start of the visit**

At the start of each inspection the inspector will meet with your registered manager. If the registered manager is not available the inspector can meet with another senior member of staff, for example a partner. This short introductory session will introduce the inspection team and explain:

- the scope and purpose of the inspection, including the powers we have
- the plan for the day
- how we will escalate any concerns that we identify during the inspection
- how we will communicate our findings.

We want you to be open and share your views with us about where you are providing good care, and what you are doing to improve in areas that you know are not so good.

If we find that you have not been open with us about issues of concern that you already know about, this will be reflected when we assess the well-led key question.

The inspection team will review the emerging findings together at least once during the inspection. This keeps the team up-to-date with all issues and allows them to shift the focus of the inspection if they identify new areas of concern. It also enables the team to identify which further evidence they might need in relation to a line of enquiry and what relevant facts might still be needed to corroborate a judgement.

## **Feedback on the visit**

At the end of the inspection visit, the lead inspector will meet with your registered manager and other appropriate members of staff to provide feedback. This is high-level initial feedback only, illustrated with some examples.

At the meeting, the inspector will:

- tell you about any issues that were escalated during the visit or that require immediate action

- tell you if we need additional evidence or if we need to seek further specialist advice to make a judgement
- tell you about any plans for follow-up or additional visits (unless they are unannounced)
- explain how we will make judgements against the regulations
- explain the next steps, including how we process the draft inspection report
- answer any questions from the practice.

We will carry out further analysis of the evidence before we can reach final judgements on all the issues and award ratings.

# Mental Capacity Act

If your service provides care or support for adults who have (or appear to have) difficulty making informed decisions about their care, treatment or support, you may need to refer to the Mental Capacity Act 2005.

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 a person's capacity is impaired, staff must know how to ensure that decisions made on the person's behalf are in their best interests.

Read more about the [Mental Capacity Act](#).

# AFTER INSPECTION

## Your inspection report

After each inspection we publish an inspection report on our website normally within 50 days of the inspection. The report presents a summary of our findings, judgements and any enforcement activity that we may have taken.

The report focuses on what our findings mean for the public. 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.

### Evidence tables

The evidence that we have used to arrive at our ratings decisions will be available in a separate evidence table, which we publish alongside the inspection report. This includes relevant [CQC Insight](#) data. Separate evidence tables help to make the reports shorter and more accessible.

### Quality checks

Before publishing, we carry out quality and consistency checks on all reports to ensure that our judgements are consistent.

## Factual accuracy check

When we have checked the quality of the draft inspection report (and evidence appendix/table, 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 – read how to [complain about CQC](#)
- enforcement activity that we propose – read 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, read [Factual accuracy check](#).

# Your ratings

We rate most providers 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](#). If you have an overall rating of good or outstanding, you may like to [promote](#) this in your communication materials.

We decide all ratings using a combination of aggregating the key question 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 health care 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, 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 provider doesn't have to demonstrate every characteristic of a rating for us to give that rating. Inspection teams use the ratings characteristics as a guide, not as a checklist or an exhaustive list. They consider best practice and recognised guidelines, and assure consistency through CQC's quality control process.

For example, if you demonstrate just one of the characteristics of inadequate but this has a 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 to be rated as good.

## Levels of ratings

For all inspections of GP practices from April 2018, we will only rate the six population groups against the effective and responsive key questions, and will aggregate these to an overall rating for each population group. We will not give a rating for the safe, caring and well-led key questions for the population groups. We will continue to give a rating for each of the five key questions and an overall rating for the practice.

This means that after we inspect your practice, your new ratings will not include all previous ratings for the population groups for the safe, caring and well-led key questions.

For each GP practice that we inspect, we will rate at four levels.

**Level 1:** Rate every population group for the effective and responsive key questions.

Inspectors will consider both:

- evidence that relates to individual population groups, and
- practice-level evidence that relates to all people using the service.

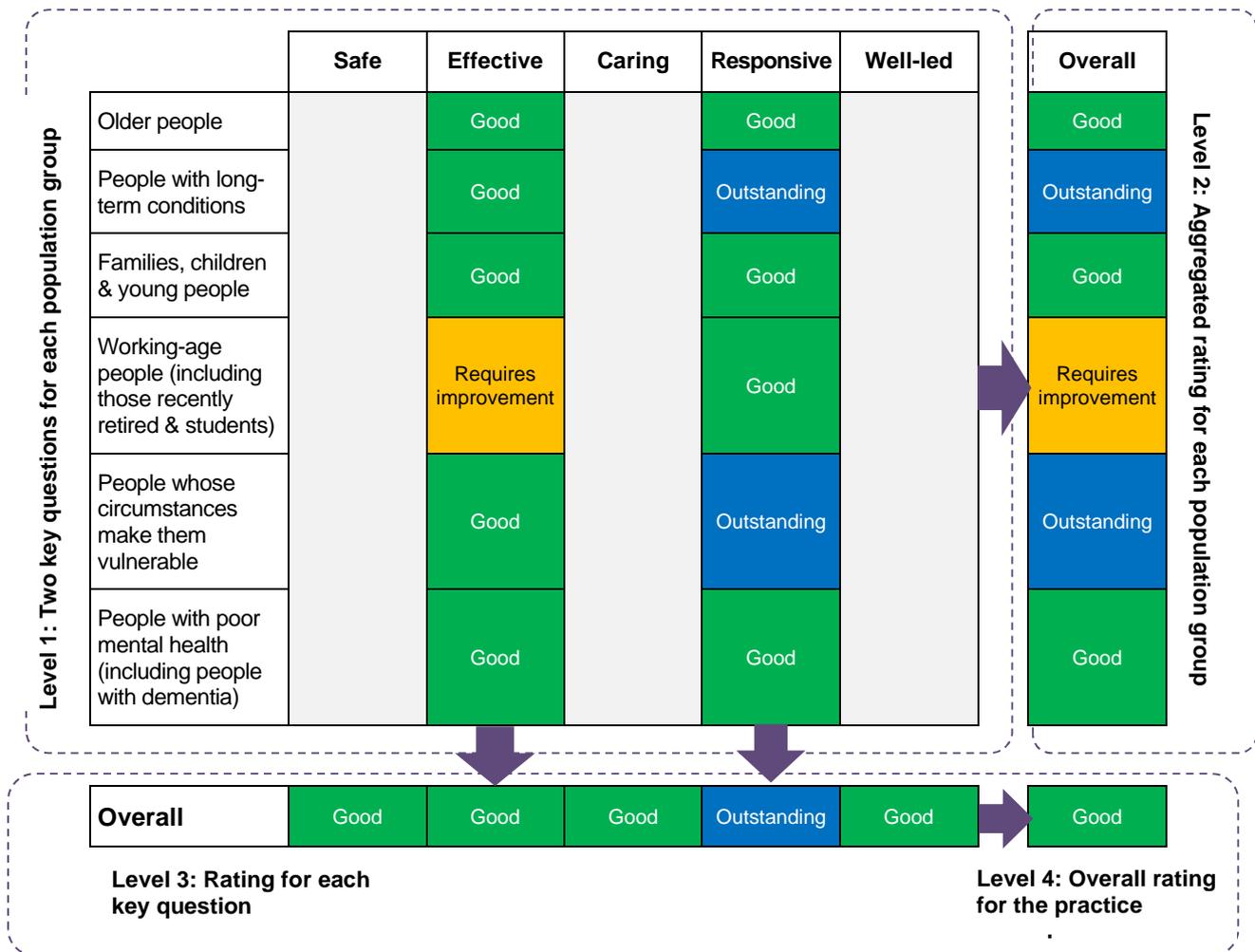
Considering the impact of practice-level evidence on the six population groups together with evidence about a specific population group provides the basis for the ratings at this level. If there is evidence that is specific to a particular population group, it may mean that we award different ratings for different population groups for the effective and responsive key questions and overall.

**Level 2:** An aggregated rating for each population group. This is aggregated from the two ratings at Level 1 for effective and responsive for each population group.

**Level 3:** A rating for each key question. For the effective and responsive key questions, this is aggregated from the ratings at Level 1. For the safe, caring and well-led key questions, there are no Level 1 ratings, so the rating is based on the evidence we have for the practice as a whole.

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

The following example shows how the four levels work together:



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'.

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 reconsider our previous rating. In this case, we would suspend our rating and then investigate the concerns.

# How we determine your aggregated ratings

## Using professional judgement

To ensure that we make consistent decisions, we follow a set of [ratings principles](#) and apply professional judgement when rating at population group and key question level. 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 applying 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, or where action has already been taken.

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

Where a rating decision is not consistent with the principles, we will record the rationale clearly in the inspection report and the decision will be reviewed using internal quality control and consistency processes.

## Updating ratings

The change to how we rate the six population groups means that all previous ratings for population groups for the safe, caring and well-led key questions will be removed after the next inspection of your practice. We will carry forward the other ratings from previous inspections and aggregate them with updated ratings.

Focused inspections can change an overall rating at any time, using key question ratings from the focused inspection as well as the remaining key question ratings from the last inspection. A change to a rating for a key question can result in a change in an overall rating for a provider when we apply the ratings aggregation rules.

After we have published an inspection report, you must [display your updated ratings](#) in relevant locations and on your website.

Where there is a change of ownership or address at an existing location, CQC's website and internal systems will continue to display the provider's '[regulatory history](#)' (rating and inspection report under a previous provider).

## Ratings principles

Our inspection teams use a set of principles when rating services, locations and providers to ensure that we make consistent decisions. The principles will normally apply but will be balanced by inspection teams using their professional judgement. Our ratings must be proportionate to all the available evidence and the specific facts and circumstances.

### Reflecting enforcement action in our ratings

Where we are taking enforcement action we will reflect this in the ratings at the key question level.

1.	Where we have identified a breach of a regulation and we issue a Requirement Notice, the rating linked to the key question relevant to 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 key question relevant to 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 six population groups are all equally important and should be weighted equally.
5.	All ratings will be treated equally when aggregating unless one of the other principles below applies.  <b>Note:</b> We can adjust the following principles for combinations where it is not appropriate to treat ratings equally.

### Aggregating ratings

There are too many combinations of ratings and the resulting aggregation to show here. However, 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.

We will apply the principles in the tables below in the following situations:

- **When aggregating the effective and responsive key questions to an overall population group rating.** When using the following principles the number of underlying ratings here will usually be two.
- **When aggregating the six population groups to an overall key question rating for the effective and responsive key questions.** When using the following principles the number of underlying ratings here will usually be six.
- **When aggregating the five key questions to an overall service level.** When using the following principles the number of underlying ratings here will usually be five.

There may be circumstances where we do not rate for one or more of these. For example, a GP practice at a university may not provide services to all six population groups. In these instances the number of underlying ratings may be fewer.

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 – 6	2 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 – 6	2 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 – 6	1	2 or more

When determining an overall rating for the effective and responsive key questions, we will also apply the following principle:

10.	For the effective and responsive key questions, the aggregated rating should closely align with the underlying population group ratings, plus an assessment of any practice level evidence.
-----	---

## 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 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, 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.

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 normally within 50 days of the inspection.

This includes:

- details of recent inspections
- the inspection report
- current ratings
- evidence table.

We also send email alerts to people who have registered an interest 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 and evidence table are available as PDF documents.

## 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 your practice will get an email:

- when we have inspected the practice, 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

## Responding to services rated as inadequate

We want to ensure that services found to be providing inadequate care do not continue to do so. We have therefore introduced 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, working with other organisations, ensure that services make improvements and are aware of the support available.
- Provide a clear timeframe within which providers must improve the quality of care. If they do not, we will take action to cancel their registration.

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

Services that are rated as inadequate for a key question or for a population group will be re-inspected within six months. If there is still a rating of inadequate for any key question or population group after six months, the service will be placed into special measures.

Once a service is placed in special measures we will re-inspect within six months to check that it has made sufficient progress to improve. After this inspection, if we feel the service has made sufficient progress, we will remove it from special measures.

If sufficient progress has not been made when we re-inspect, and we give a rating of inadequate for any key question, population group or overall, we will take further action to prevent the service from operating, either by proposing to cancel its registration or vary the terms of its registration. There will then be a further inspection, normally within six months. If sufficient progress has still not been made, and there is a rating of inadequate for any key question, population group or overall, we are likely to proceed to cancel the registration or to vary the terms of registration. This will mean that the provider's registration will be cancelled.

Special measures does not replace CQC's existing enforcement powers: we are likely to take enforcement action at the same time as placing a provider into special measures. 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.

Read our [detailed guidance](#) about our approach to special measures.

### Services rated as requires improvement

Where services are rated as requires improvement on more than one consecutive inspection, it shows that they cannot demonstrate the necessary leadership or

governance processes to assure and improve quality. In these cases, we will consider whether this may represent a breach of Regulation 17 (good governance). We may also ask the provider for a written report to set out how it will assess, monitor and improve the quality and safety of its services. This improvement action plan needs to be agreed with the provider's commissioners.

If we rate a service as requires improvement for a third time, we will hold a formal management review meeting (MRM) to consider the next steps and the potential use of our enforcement powers.

Where we register larger primary care providers, we will monitor quality across all their services. Where there are concerns across the group, we may consider taking action to hold the provider to account, for example by using our enforcement powers.

## 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.

Read 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.

Please send your representations form by email to

[HSCA\\_Representations@cqc.org.uk](mailto:HSCA_Representations@cqc.org.uk).

## 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.

Read 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](mailto: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](mailto: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.