Assessing quality and performance

As we use our new assessment approach we will ask providers for feedback so we can update and develop this guidance when needed.

Our new assessment approach

All our guidance to support you with our new approach to assessment is online. You can download and print the guidance, but we will sometimes refine and update it, so you must keep up-to-date.

Our new assessment framework retains our 5 key questions and the 4-point ratings scale. We will assess services against quality statements. These have replaced our key lines of enquiry (KLOEs), prompts and ratings characteristics.

We will gather evidence both on site and off site to make an assessment. The types of evidence we will consider are grouped into 6 evidence categories. We list the evidence categories we will look at for different sector groups.

Our assessments may be responsive (in response to information of concern) or planned. In both cases, we will be flexible and may expand the scope of an assessment if we need to.

We will continue to ask adult social care providers to complete an annual provider information return (PIR).

When it will affect you

We are now using our new approach to regulation across England.

It's important to make sure your registered details and contact information are up-to-date so that we can contact you about your assessment.

Our ratings and reports

After we complete an assessment we will use a scoring system to produce a rating for your service.

For some types of service, there is no legal requirement for CQC to give a rating. Read our guidance for services that do not receive a rating.

See how we will calculate the first scores. If your service currently has a rating, we have transferred that across by applying scores to quality statements. All provides will have a chance to check the factual accuracy of our draft assessment report.

Differences from our previous model

For health and care providers, there are some differences in how we assess the quality of their services:

- **Gathering evidence:** We'll make much more use of information, including people's experiences of services. We'll gather evidence to support our judgements in a variety of ways and at different times – not just through on-site inspections. This means inspections will support this activity, rather than being our primary way to collect evidence.
- **Frequency of assessments:** We will no longer use the rating of a service as the main driver when deciding when we next need to assess. Evidence we collect or information we receive at any time can trigger an assessment.
- **Assessing quality:** We'll make judgements about quality more regularly, instead of only after an inspection as we did previously. We'll use evidence from a variety of sources and look at any number of quality statements to do this. Our assessments will be more structured and transparent, using evidence categories and giving a score for what we find. The way we make our decisions about ratings will be clearer and easier to understand.

Up-to-date, transparent assessments of quality

By using our assessment framework as part of our regulatory approach, we will have the flexibility to:

- update the judgements and ratings for key questions and overall ratings when things change, based on more frequent assessment of evidence
- collect and review evidence in some categories more often than others. For example, we may collect evidence of people's experiences more often than evidence about processes
- be selective in which quality statements we look at – this could be one, several or all.

How often we assess

The frequency of assessments will depend on the information we receive and the evidence we collect.

Your next assessment will be either:

- planned
- responsive (where we've received concerning information).

We will regularly review how well the new single assessment framework is working. We will use feedback from providers about their experiences of their assessment to decide new frequencies of assessment for each sector using:

- what we have learned from the first 6 months
- our view of regulatory risk
- issues affecting the health and care systems.

Our approach will be informed by risk, and we will decide the order of our planned assessments of providers based on the level of risk.

Once the new frequencies are decided, we will publish a more detailed schedule for planned assessments. This will include a date by when we will have updated all ratings for all providers. We expect to publish this information in summer 2024.

Focus of our assessments

When we set out our detailed schedule for planned assessments, we will also define a set of priority quality statements for each type of service. We will typically assess these quality statements in each assessment, but will be flexible depending on the circumstances.

We will determine the specific quality statements for each type of service nationally. These will be based on findings from profiling of services to determine:

- where there are risks to people using services
- where services may have improved.

We plan to set the priorities and review them annually, as a minimum.

How we gather evidence

We will use the best methods to collect evidence depending on the type of evidence needed for a specific quality statement.

We will continue to build on our existing methods for collecting evidence. Although we will assess the evidence using a new framework, most of the information we consider will be similar to what we have been looking at in the past.

We will also apply the same rules when giving notice of assessments. This includes where we carry out unannounced on-site activity.

We will email you to tell you when an assessment is starting and may ask you for some types of evidence at this point.

We will give feedback to the provider when we have completed either an on-site or off-site assessment. If possible, we will give feedback about on-site activity immediately after completing it.

Methods we will use to gather evidence

The evidence we use in our assessments of quality may be gathered through both on-site and off-site methods. On-site activity remains really important and we expect to use our time visiting services in a more targeted way.

On-site activity

We will spend our time on site:

- observing care and how staff interact with people
- observing the care environment, including equipment and premises
- talking with people using the service
- talking with staff and service leaders.

We will carry out site visits when it's the best way to gather the evidence we need. For example, we'll do this:

- where people have communication needs that make telephone or video conversations challenging, or not suitable
- where there are concerns around transparency and confidentiality, for example to make sure someone isn't overheard or being influenced by others
- to check the validity of evidence we have already gathered in a setting

We may carry out a site visit to collect evidence without giving notice beforehand. We would do this, for example in response to a specific concern.

We will carry out on-site activity more frequently in settings where:

- there is a greater risk of a poor or closed culture going undetected in a service
- it is the best way to gather people's experience of care
- we have concerns about transparency and the availability of evidence
- we have a statutory obligation to do so, for example as a member of the National Preventative Mechanism we must visits places of detention regularly to prevent torture and other ill-treatment

Information we collect from national bodies

We will continue to use and develop insight from national data collections, particularly where there are nationally agreed measures of quality. For example:

- capacity tracker for adult social care services
- electronic staff record
- GP patient survey
- hospital episode statistics
- Learn from Patient Safety Events (LFPSE)
- measures from the National Clinical Audit Programme
- mental health services data set
- national SITREP information
- NHS staff survey
- prescribing datasets
- Skills for Care
- waiting times

We have a programme to manage the external data sources we use. Updates to the data sources depend on the schedules set by the bodies responsible for them.

Information we collect from providers

We will continue to:

- request an annual provider information request (PIR) from adult social care services, using the existing collection method
- carry out online reviews of clinical records

- request evidence directly from providers to support an assessment, most likely by email.

Where we request evidence, we will use information that a provider has available. Apart from the PIR for adult social care services, we will not specify a particular format for the information. We know services are at different levels of digital maturity so we will adapt our collection methods while they develop, in line with the plan for digital health and social care.

For now, providers do not need to submit evidence to us proactively. We will ask you for anything we need.

In addition to specific requests for evidence from providers, we will continue to carry out interviews with staff and workers in services, and with service leaders. We may do this online.

We will determine when we need to request evidence directly from providers based on the timetable for assessments.

Feedback we receive and our engagement activities

We will continue to use the feedback we receive from people and their representatives about their experiences. This could be:

- from our Give feedback on care service
- when people contact us, through our National Customer Services Centre

We will also continue to:

- run online focus groups or contact people with experience of using a service
- commission the NHS Patient Survey Programme to understand people's experiences of care.

We will also work with other people and organisations to help us collect evidence, for example local Healthwatch groups and our Experts by Experience. They can help us reach out to people, families and carers, and engage with communities whose voices are seldom heard.

The timetable for collecting these sources of evidence depends on the specific source. For some sources, such as Give feedback on care, this is ongoing. Other evidence sources will be updated less frequently – such as through patient surveys (which are conducted annually or every 2 years).

How we will use evidence in our assessments

We will bring together all relevant evidence for a specific evidence category. We will then make a judgement based on the requirements of the quality statement and the new scoring scale. As we do this, we will consider:

- whether the evidence collected covers the scope of the service sufficiently
- the quality and validity of the evidence.

Specialist support

To inform how we collect and use evidence, our teams will engage the expertise of our:

- Experts by Experience
- specialist advisors
- executive reviewers (colleagues who support on assessments of the well-led key question for NHS trusts).

Assessment teams can get quick access to specialists to support them to:

- understand which evidence to collect
- corroborate and analyse evidence
- interview key staff.

This helps ensure that our judgements maintain credibility.

Deciding what evidence collection methods to use

The evidence we collect and how we collect it depends on a combination of factors. We will take into account:

- the type of service
- the quality statement and relevant evidence category
- the information we already hold about a service

There isn't a full list of evidence that fits every service. We may need to follow up specific risks or circumstances that would need particular evidence. We do not want providers to prepare specific documents – rather we ask for information they already have.

Levels of ratings

We consider information about the quality of care provided when we look at the 5 key questions. We provide ratings at different levels for different types of service.

We use professional judgement and a set of principles to help us to determine the final ratings.

Some types of services are exempt from CQC's legal duty to give a rating. Read our guidance for non-rated services.

The levels we rate are:

- Level 1: A rating for every key question at service level. For example, a rating for how safe a care home is or how effective the surgery service at a hospital is.
- Level 2: An aggregated overall rating for the service. For example, the rating for a care home or the surgery service at a hospital.
- Level 3: An aggregated rating for each key question at location level. For example, the rating for how safe a hospital is.
- Level 4: An aggregated overall rating for the location. For example, the rating for a hospital.
- Level 5: An overall rating for an NHS trust. This is based on the trust-level assessment of the quality statements under the well-led key question and moderation.

The levels we will rate each type of service

We will rate services at the following levels:

- Adult social care services: levels 1 and 2
- GP services: levels 1 and 2
- Independent doctors and clinics: levels 1 and 2
- Independent health single specialty services: levels 1 and 2
- Independent health hospital (offering more than 1 service): levels 1, 2, 3 and 4
- Online primary care: levels 1 and 2

- Urgent care: levels 1 and 2
- Non-acute NHS trusts: levels 1, 2 and 5
- Acute NHS trusts: levels 1, 2, 3, 4 and 5.

How we will aggregate ratings

Changes in the provider of a service

When the provider of a service changes, we continue to show the previous ratings on our website. We use these ratings to plan a proportionate, risk-informed approach to the first assessment after a registration change. The first assessment will make new judgements and produce new ratings. Ratings from the previous provider are not used to produce a new aggregated rating.

Read more about why and when we continue the regulatory history of a service.

Using professional judgement

If we identify concerns during an assessment, we will use our professional judgement to decide whether to depart from applying our ratings principles. We will do this particularly where we need to aggregate ratings that range from inadequate to outstanding.

When we do this, we will consider:

- The extent of the concerns
- The impact of the concerns on people who use services
- The risk to quality and safety of services, taking into account the type of setting
- Our confidence in the provider to address the concerns
- Whether the provider has already taken action.

If concerns have a very limited impact on people, it may reduce the impact on the aggregation of ratings.

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

Where a rating is not consistent with the principles, we will record the rationale clearly in the report. We will review the decision using our quality control and consistency processes.

Adult social care

We rate these services at 2 levels.

- Level 1: we use our rating methodology and professional judgement to produce ratings for each of the 5 key questions.
- Level 2: we aggregate these separate ratings up to an overall service rating using the ratings principles.

Rating principles for adult social care

We decide overall service ratings using the following principles:

1. The 5 key questions are all equally important. We weight them equally when aggregating.
2. For an overall rating of outstanding, a service will normally need to have both:
    a. At least 2 key questions rated as outstanding
    b. The other key questions rated as good.

3. The overall rating will normally be good if there are both:
    a. no key questions rated as inadequate
    b. no more than 1 key question rated as requires improvement.
4. The overall rating will normally be requires improvement if 2 or more key questions are rated as requires improvement.
5. The overall rating will normally be inadequate if 2 or more key questions are rated as inadequate.

Health services

Ratings principles for health services

We follow these principles to determine how we aggregate and combine ratings.

Overarching aggregation principles

The following principles apply when we are aggregating ratings.

1. The 5 key questions are all equally important. We weight them equally when aggregating.
2. The services are all equally important. We weight them equally except where they are significantly small.
3. We treat all ratings equally when aggregating unless one of the principles below applies. 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 aggregation. We use our professional judgement to apply them to the specific combination of lower-level ratings that we are aggregating. We call these the underlying ratings.

4. The aggregated rating will normally be outstanding where:
    - The following number of underlying ratings are outstanding:
        - 1 or more where there are 1-3 underlying ratings in total
        - 2 or more where there are 4-8 underlying ratings in total
        - 3 or more where there are 9 or more underlying ratings in total
    - The remaining underlying ratings are good.
5. The aggregated rating will normally be no higher than requires improvement where the following number of underlying ratings are requires improvement:
    - 1 or more where there are 1-3 underlying ratings in total
    - 2 or more where there are 4-8 underlying ratings in total
    - 3 or more where there are 9 or more underlying ratings in total.
6. The aggregated rating will normally be no higher than requires improvement where the following number of underlying ratings are inadequate:
    - 1 where there are 4-8 underlying ratings in total
    - 2 where there are 9 or more underlying ratings in total.
7. The aggregated rating will normally be inadequate where the following number of underlying ratings are inadequate:
    - 1 or more where there are 1-3 underlying ratings in total
    - 2 or more where there are 4-8 underlying ratings in total
    - 3 or more where there are 9 or more underlying ratings in total.

How we rate NHS trusts

We are simplifying ratings for NHS trusts by publishing a single trust-level rating, rather than multiple levels of complex, aggregated trust-level ratings. This single rating will be the rating for the well-led key question for a trust.

We will now base the trust-level rating for the well-led key question on our assessment of the 8 quality statements under the key question. This will ensure a strong focus on leadership, culture and governance in our assessments. It will also help us avoid diluting our view or duplicating service-level assessments.

We will have a moderation process as part of our quality assurance checks. This will ensure we accurately reflect the trust's overall performance, sustainability and direction of travel. This process will:

- be driven by the aggregation principles
- allow for flexibility and professional judgement
- ensure we are fair and proportionate.

It will consider the:

- balance and proportionality of the scores for the 8 quality statements under the well-led key question, including taking account of NHS England's oversight of trusts
- evidence of quality and safety at the trust's services and locations
- wider picture of service-level ratings, including change over time.

How we reach a rating

To support the transparency and consistency of our judgements, we have introduced a scoring framework into our assessments.

Where appropriate, we'll continue to describe the quality of care using our 4 ratings: outstanding, good, requires improvement, or inadequate.

When we assess evidence, we assign scores to the relevant evidence categories for each quality statement that we're assessing. Ratings will be based on building up scores from quality statements to an overall rating.

This approach makes clear the type of evidence that we have used to reach decisions.

Some types of services are exempt from CQC's legal duty to provide a rating. Read our guidance for non-rated services.

Scoring

Using scoring as part of our assessments will help us be clearer and more consistent about how we've reached a judgement on the quality of care in a service. The score will indicate a more detailed position within the rating scale. This will help us to see if quality or performance is moving up or down within a rating.

For example, for a rating of **good,** the score will tell us if this is either:

- in the upper threshold, nearing outstanding
- in the lower threshold, nearer to requires improvement.

Similarly, for a rating of **requires improvement**, the score would tell us if it was either:

- in the upper threshold, nearing good

- in the lower threshold, nearer to inadequate.

Our quality statements clearly describe the standards of care that people should expect.

To assess a specific quality statement, we will take into account the evidence we have in each relevant evidence category. This will vary depending on the type of service or organisation. For example, the evidence we will collect for GP practices will be different to what we'll have available to us in an assessment of a home care service.

Evidence could be information that we either:

- already have, for example from statutory notifications
- actively look for, for example from an on-site inspection.

Depending on what we find, we give a score for each evidence category that is part of the assessment of the quality statement. All evidence categories and quality statements are weighted equally.

Scores for evidence categories relate to the quality of care in a service:

4 = Evidence shows an exceptional standard
3 = Evidence shows a good standard
2 = Evidence shows some shortfalls
1 = Evidence shows significant shortfalls

As we have moved away from assessing at a single point in time, we aim to assess different areas of the framework on an ongoing basis. This means we can update scores for different evidence categories at different times.

The first time we assess a quality statement, we score all the relevant evidence categories. After this, we can update our findings by updating individual evidence category scores. Any changes in evidence category scores can then update the existing quality statement score.

We will follow these initial 3 stages for services that receive a rating:

1. Review evidence within the evidence categories we're assessing for each quality statement.
2. Apply a score to each of these evidence categories.
3. Combine these evidence category scores to give a score for the related quality statement.

After these stages, the quality statement scores are combined to give a total score and then a rating for the relevant key question (safe, effective, caring, responsive, and well-led).

We then aggregate the scores for key questions to give a rating for our view of quality at an overall service level. See how we aggregate ratings for different types of services.

How we calculate quality statement scores

When we combine evidence category scores to give a quality statement score, we calculate this as a percentage. This provides more detailed information at evidence category and quality statement level. See the example of calculating scores (link to example).

To calculate the percentage, we divide the total evidence category scores by the maximum possible score. This maximum score is the number of relevant evidence categories multiplied by the highest score for each category, which is 4. This gives a percentage score for the quality statement.

We then convert this back to a score. This makes it easier to understand and combine with other quality statement scores to calculate the related key question score.

We use these thresholds to convert percentages to scores:

25 to 38% = 1
39 to 62% = 2
63 to 87% = 3
over 87% = 4

Our scoring model treats all evidence categories as equal when calculating the quality statement score. There are some circumstances where it is not appropriate to weight all scores as equal; in those cases, we will set our judgements at the quality statement level to reflect the findings across the evidence categories. For example, if we have served a Warning Notice that relates to a specific quality statement.

How we calculate key question scores

We then use the quality statement score to give us an updated view of quality at key question level.

Again, we calculate a percentage score. We divide the total by the maximum possible score. This is the number of quality statements under the key question multiplied by the highest score for each statement, which is 4. This gives a percentage score for the key question.

At key question level, we translate this percentage into a rating rather than a score, using these thresholds:

25 to 38% = inadequate
39 to 62% = requires improvement
63 to 87% = good
88% and above = outstanding

By using the following rules, we can make sure any areas of poor quality are not hidden:

- If the key question score is within the good range, but one or more of the quality statement scores is 1, the rating is limited to requires improvement.

- If the key question score is within the outstanding range, but one or more of the quality statement scores is 1 or 2, the rating is limited to good.

Our judgements go through quality assurance processes.

For services that have not previously been inspected or rated, we will need to assess all quality statements in a key question before we publish the rating. For newly registered services, we'll usually assess all quality statements within 12 months.

How we aggregate ratings using the rating principles

Overall location ratings are produced on the basis of the following principles:

1. The 5 key questions are all equally important and are weighted equally when aggregating.
2. At least 2 of the 5 key questions would normally need to be rated as outstanding and 3 key questions rated as good before an aggregated rating of outstanding can be awarded.
3. There are a number of ratings combinations that will lead to a rating of good. The overall rating will normally be good if there are no key question ratings of inadequate and no more than one key question rating of requires improvement.
4. If 2 or more of the key questions are rated as requires improvement, then the overall rating will normally be requires improvement.
5. If 2 or more of the key questions are rated as inadequate, then the overall rating will normally be inadequate.

Example: how we reach a rating

To assess quality against a particular quality statement, operational colleagues will look at the relevant evidence categories. In this example, we are just looking at the 'infection prevention and control' quality statement.

> **Infection prevention and control: "**We assess and manage the risk of infection. We detect and control the risk of it spreading and share any concerns with appropriate agencies promptly."

For this service, the key evidence categories for this quality statement are:

- People's experiences
- Feedback from staff and leaders
- Observation
- Processes

We would look at individual pieces of evidence under each evidence category and based on the strength of what we find, give a score of 1 to 4.

For example, in the ‘people's experience’ evidence category, we may look at:

- patient surveys
- complaints and compliments

To gather evidence in the ‘feedback from staff and leaders’ and ‘observation’ categories, we might schedule:

- an inspection to look at the care environment
- a call to speak with staff at the service.

We would then combine this new evidence with what we already hold on 'processes' to help us form a view of quality.

Example: combining evidence category scores to give a quality statement score

Evidence category	Score	Existing or updated score
People's experiences	3	updated
Feedback from staff and leaders	2	updated
Observation	3	updated
Processes	3	existing
Total score for the com bined evidence categor ies	**11**	

We calculate this as a percentage so that we have more detailed information at evidence category and quality statement level.

To calculate the percentage, we divide the total (in this case 11) by the maximum possible score. This maximum score is the number of relevant evidence categories multiplied by the highest score for each category, which is 4. In this case, the maximum score is 16. Here, it gives a percentage score for the quality statement of 69% (this is 11 divided by 16).

We convert this back to a score. This makes it easier to understand and combine with other quality statement scores to calculate the related key question score.

We use these thresholds to convert percentages to scores:

- 25 to 38% = 1
- 39 to 62% = 2
- 63 to 87% = 3
- over 87% = 4

In this case, the percentage score of 69% converts to a score of 3.

We then use this score to give us an updated view of quality at key question level. In this case it is for the safe key question:

Example: combining quality statement scores to give a key question rating

Quality statement	**Score**	**Existing or updated score**
Learning culture	2	existing
Safe systems, pathways and transitions	3	existing
Safeguarding	3	existing
Involving people to man age risks	2	existing

Quality statement	Score	Existing or updated score
Safe environments	3	existing
Infection prevention and control	3	updated
Safe and effective staffin g	2	existing
Medicines optimisation	3	existing
Total score for the safe key question	**21**	

Again, we calculate a percentage score. We divide the total (in this case 21) by the maximum possible score. For the safe key question, this is 8 quality statements multiplied by the highest score for each statement, which is 4. So the maximum score is 32. Here, it gives a percentage score for the key question of 65.6% (this is 21 divided by 32).

At key question level we translate this percentage into a rating rather than a score, using these thresholds:

- 25 to 38% = inadequate
- 39 to 62% = requires improvement
- 63 to 87% = good
- over 87% = outstanding

Therefore, the rating for the safe key question in this case is good.

Calculating the first scores using our new approach

When we assess services using our new approach, we will need to apply scores for each quality statement to decide the ratings. This page explains how we will do this.

Services with an existing rating or findings about compliance

When we carry out our first assessment of your service, we will select which quality statements to look at. The selection of quality statements will be determined by national priorities, set by the type of service, as well as a consideration of the information we hold about your service.

For each of the quality statements selected, we will collect evidence and give a score for all the relevant evidence categories. This means the scores for those quality statements will be based entirely on our new assessment.

For the remaining quality statements, the scores will be based on our previous findings and the date of their assessment will be provided alongside. We will do this by using the current, published ratings for the relevant key question. These scores will be:

- 4 for each quality statement where the key question is rated as outstanding
- 3 for each quality statement where the key question is rated as good

- 2 for each quality statement where the key question is rated as requires improvement
- 1 for each quality statement where the key question is rated as inadequate

There are 4 exceptions to this approach where specific topics that have moved from one key question to another or are new to our assessment framework.

For all services these exceptions are as follows:

- The initial scores for the 'workforce wellbeing and enablement' quality statement will be based on the rating for the well-led question. This is because this topic area has moved from the well-led key question to the caring key question in our new framework.
- We will not apply an initial score for the 'environmental sustainability' quality statement. This is because it is a new area in our framework.

For services previously inspected using the adult social care framework only:

- The initial scores for the 'care provision, integration and continuity' quality statement will be based on the rating for the well-led key question.
- The initial scores for the 'providing information' quality statement will be based on the rating for the effective key question. This is because this topic area has moved from the effective key question to the responsive key question in our new framework.

Services that have not yet been inspected

If your service has not previously been inspected when we assess using our new approach, we will not apply initial scores as there are no previous findings to base these on.

For these services, we will normally collect evidence for all the quality statements within the first year.

Services we do not rate

For some types of service, we do not have the legal ability to give a rating.

We will assess these services using the new framework. However, unlike services we rate, there is no overall score or scoring for key questions, quality statements or evidence categories, and no overall rating. Read our guidance for non-rated services.

Services we do not rate

Some types of service are exempt from CQC's legal duty to give a rating. These include:

- primary dental services
- children's homes
- sexual assault referral centres
- blood and transplant services
- hyperbaric oxygen therapy services
- medical laboratories
- adult prisons, youth offending institutions and immigration removal centres

Our approach to assessing non-rated services is generally consistent with our approach to services that receive a rating using our single assessment framework. Assessments will be either:

- responsive (in response to information of concern)

- planned, using the evidence categories we will prioritise for each service. Planned assessments will initially focus on assessing services we have not yet assessed.

However, unlike services that we rate, there is no overall score or scoring for key questions, quality statements or evidence categories, and no overall rating.

Instead, we will provide a judgement to reflect whether a service is compliant with the regulations. Inspectors will judge each evidence category they assess as either:

- Regulations met
- Not all regulations met

They will then use these evidence category judgements to create a judgement for the quality statement they sit under, stating whether the service is meeting the regulations that are mapped to that quality statement.

- Regulations met indicates the provider is compliant with all regulations related to that quality statement.
- Not all regulations met indicates that the provider has breached one or more regulations related to that quality statement.

Those quality statement judgements then inform the overall key question judgement.

A judgement of 'not all regulations met' in any evidence category means the related quality statement and key question will also show as 'not all regulations met'.

Adapting our approach to trust-level assessments of the well-led key question in NHS trusts

We assess the well-led key question using quality statements at both assessment service group and trust level. At trust level, the focus is on the trust's board and senior leaders with trust-level responsibilities in the context of wider organisational performance.

We will continue to follow NHS trust methodology for providers of community healthcare and/or mental health care (typically community interest companies (CICs)) that deliver multiple services to people in a specific geographical area, similar to an NHS trust.

The first trust-level assessment of the well-led key question under the single assessment framework

The first trust-level assessments under the single assessment framework will cover all 8 quality statements under the well-led key question plus moderation. This will enable us to:

- create a starting point or 'baseline' and issue a first rating based on a full assessment at the trust level
- ensure that when we award our first new ratings under the new approach, we have confidence in those judgements and that we have considered the full scope of the assessment of both leadership and wider organisational performance
- reflect the challenges faced over the last few years in updating overall trust ratings
- recognise the changes to the area of the framework under the well-led key question and the complexity of assessing organisational leadership, culture and management.

Current ratings will remain displayed 'as is' (including Use of Resources and combined ratings) until trusts receive their first assessments under the single assessment framework. At this point, trusts will be awarded their 'new' trust-level rating for the well-led key question – existing ratings (including those for Use of Resources and combined quality ratings) will be retired.

We will initially prioritise service-level inspections using the single assessment framework. This will allow us to focus on risks to patients and to update our overall view of service-level ratings.

This approach has a number of benefits:

- Quality at service level is important to gain a holistic view of quality at trust level. This approach would enable us to reflect a broad and up-to-date view of quality in our trust-level assessment and rating.
- Our new integrated assessment and inspection teams will need time to build their knowledge and relationships with the trusts in their networks. We also need to make sure that we still have the expertise within each new network to carry out robust assessments at the overall organisational level and provide the support, training and guidance needed.
- Trusts would have more time to become familiar with the new assessment approach before we start to award new trust-level ratings for the well-led key question, and we remove existing trust-level key question ratings from our website.

Working with NHS England

In our trust-level assessments of the well-led key question, we will work closely with NHS England. NHS England will use the Oversight Framework to identify where trusts may benefit from, or require, support and when and how it will intervene.

We will use the results of NHS England's oversight and assessments of trusts in our assessments.

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

- We work together to carry out our respective functions effectively, while recognising that each organisation is legally and operationally independent
- We make sure our definitions, measurement and operations are based on a single shared view of quality.
- We work to remove duplication between our organisations.
- We focus on quality and how it is maintained and improved alongside financial sustainability.
- We work together across all aspects of our regulatory and oversight model by:
    - sharing data and aiming to use a single, shared standard of measurement, both to review performance and to decide where to target support or oversight
    - co-ordinating how we gather evidence to plan assessment activity, using information from NHS England as evidence to inform our judgements
    - sharing information on the results of our assessments
    - co-ordinating how we engage with individual providers as well as with wider healthcare systems.

Guidance

This guidance describes how we assess the well-led key question. It helps NHS trusts and foundation trusts understand what good leadership looks like. The guidance has been jointly developed by CQC and NHS England.

- Guidance for NHS trusts and foundation trusts: assessing the well-led key question

Factual accuracy check

When we have checked the quality of the draft assessment report, we will send it to you to review.

This guidance is about our new type of assessment. If you were inspected using our previous process, you'll need to follow the factual accuracy check guidance for our old assessment process instead.

We will ask you to check the factual accuracy and completeness of the information 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 assessment teams and providers the opportunity to ensure they consider all relevant information that will form the basis of our judgements.

Assessment teams base their judgements, scores and ratings on all the available evidence, using their professional judgement and our scoring model. The assessment report does not need to reference all the evidence but it should include the best evidence to support our judgements.

How to submit factual accuracy comments

We'll email you a link so you can review the draft report online. You will be able to enter comments about factual accuracy against each section.

We'll send the email to the appropriate registered person. If your organisation has more than one registered person, for example a nominated individual and a registered manager, each registered person will receive the email.

It's important you make sure we have correct contact details for people who need to check the draft report when we carry out our assessment.

You can read the draft report online. You can also print or download it.

If you wish to raise one or more points about factual accuracy, you can:

- enter a comment against the relevant section of the report
- upload evidence to support comments you make against our evidence categories, if needed

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

In exceptional circumstances, you can submit factual accuracy comments using our MS Word form instead, for example if you are unable to use our online process.

Factual accuracy form for assessments under the new single assessment framework

Deadline for submitting comments

Once you receive our email with the link to your draft report, you will have **10 working days** from the date of the email to review the report and submit any comments about factual accuracy.

We will not extend this period unless there are exceptional circumstances. If you are unable to submit your comments before the deadline, you must tell us why immediately in writing. We will use our discretion to determine whether there are exceptional circumstances.

If there are no factual inaccuracies in the report, you can confirm you've reviewed it. We will then be able to publish the final version.

What you can correct

There are certain types of correction you can make:

- Typographical or numerical errors or, for example, incorrect job titles.
- Information that has contributed to a judgement, but which you believe is factually inaccurate. You will need to provide supporting evidence. This must relate to the position at the time of the assessment.

- Additional information, or information that was omitted, which you think we should consider. For example, you may have further examples of exemplary practice that demonstrate real benefits for people using your service, which may support a rating of outstanding rather than good. Again, this must be relevant to the time of the assessment.

The draft report is based on evidence we collected during our assessment. You can also send us information about action you have taken since the assessment that addresses the concerns we raised with you, or which is included in the draft report. The assessor will consider any further information you send us and determine whether the report should be amended.

Unless there are exceptional circumstances, this new information will not form part of CQC's decision around final judgements or ratings (where appropriate).

Example of possible outcomes from a factual accuracy check

During an assessment, the assessor asks to see a copy of a safety policy. A senior member of staff tells them there isn't one. The assessor includes this information in the draft report and it is considered as part of the judgement. CQC also considers the information when deciding whether to take enforcement action against the provider.

Scenario 1:

As part of the factual accuracy check, the provider sends this policy to CQC, stating that it did exist at the time of the inspection and that they do not know why the senior member of staff told the assessor that they didn't have one. The assessor is satisfied that the document was available at the time of assessment so includes this information in the final report and it is considered as part of the judgement. CQC also considers the information when deciding whether to take enforcement action against the provider.

Scenario 2:

As a result of the factual accuracy check, the provider tells us that they have now implemented a policy. The assessor includes this information in the final report, but does not consider it as part of the judgement. CQC also considers the information when deciding whether to take enforcement action against the provider.

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

- an assessment rating or score solely because you disagree with it
- how we carried out an assessment – see how to complain about CQC
- enforcement activity that we propose – see how to make a representation about proposed enforcement activity

If you need to ask us for information before you can submit factual accuracy comments, your request should be short, specific and should clearly justify why you need the information to raise a point of factual inaccuracy. You should send your request directly to your assessor, if you're already in contact with them. Otherwise email enquiries@cqc.org.uk, quoting your assessment reference number (starts with AP) and marking it for the attention of the assessment team.

We will not release the inspector's full notes from an inspection. We will consider requests for extracts of notes about a specific issue where this is reasonably necessary to enable you to understand the basis for a statement in the draft report that you believe is factually inaccurate (that is, if the basis of our statement is not clear from the draft report).

To protect the confidentiality of people reporting concerns to us we will not identify someone who has shared this information with us.

Requesting information from CQC describes the types of information you can ask us for.

How we'll respond

After we have considered your points and any supporting information, we'll decide whether to amend the draft report.

We'll email you a link to the final version of the report before it is published. We'll also respond to any comments you've submitted about factual accuracy.

If we have evidence that supports a point in the draft report, we are entitled to rely on this. If you dispute the point, but you have not provided any evidence in support, we may ask you to provide it.

All factual accuracy responses will be reviewed by another member of CQC's staff who is independent of the original assessment.

Draft judgements and ratings

The draft report includes what we have found during the assessment. This will include judgements, scores and ratings, where appropriate.

If the assessor corrects any factual details in the report or accepts any additional evidence, they will amend the draft report.

Any actions that a provider takes after the inspection will not affect ratings or judgements for non-rated services. The assessor will determine whether changes as a result of the factual accuracy check have an impact on a judgement or rating and will explain any changes in their response.

We may change draft ratings or judgements if we determine that the evidence on which they are based is inaccurate or incomplete.

How we publish our findings

Once we have completed our assessment and the factual accuracy check process is over, we will publish a report of our findings.

This information will be published in a different format to the inspection reports under our previous model. The biggest difference is that the information is all published as web content on our website rather than in a PDF document.

This means the information will be easier to use on a mobile device and more accessible to people using assistive technology.

What the report will cover

Your report will be structured around our new assessment framework. It will contain sections for each area of the framework we have looked at during the assessment.

This means information on what we have found about:

- Your service overall
- The key questions we have assessed
- The quality statements we have assessed under each of those key questions.

For hospitals and other services where we previously reported on multiple core services, there will also be a section of the report with information about the location overall.

Overall service information

The information in this section will include:

- An overall rating for the service, where appropriate
- A summary of our current view of the service written by our assessment team
- Where relevant, a summary of people's experiences of the service written by our assessment team.

The description of our current view of your service will explain the judgements for key questions or overall rating and any concerns we have. It will not be based solely on the findings of the latest assessment.

For example, where an assessment has only looked at a small part of your service, we will use what we know from previous assessments alongside this.

Where we have looked at evidence about people's experience of your service during the assessment, we will include a summary of this. As with the summary of our current view of the service, this section will use information from previous assessments where needed.

Key question information

For services that receive a rating, for each of the key questions we have assessed, we will publish a:

- Rating
- Score
- Summary of our findings.

The score we publish for a key question will be out of 100 and will be calculated from the scores awarded for the quality statements within that area.

The score is used to help us reach the rating and ensure this is done consistently.

For services that do not receive a rating, we will publish a judgement for each key question of either:

- Regulations met
- Not all regulations met

Quality statement information

For each of the quality statements we have assessed, we will publish a:

- Score
- Statements explaining what that score means (we refer to these as 'judgement statements')
- Summary of our key findings for each evidence category we looked at.

The score we publish for a quality statement will be on a scale of 1 to 4. It will be based on the evidence categories we have looked at for the quality statement.

Overall location information

For hospitals and other services where we previously reported on core services, we will continue to publish aggregated information about the location overall.

For example, as well as the information above about a particular service (such as surgery or maternity) at a hospital, we will also publish:

- A rating and summary for the hospital overall
- Ratings, scores and summaries for the key questions we have assessed for the hospital overall.

How we will improve the information we publish

When we publish the first reports under our new model, the pages on our website for your service will look the same as they do now.

However, we will deliver some improvements to the way we display the information. These will include:

- New visualisations of the scoring information to make it clear where a service sits on our ratings scale and in comparison with equivalent services nationally and locally.
- Separate profiles for services at the same location but where we do not aggregate ratings to an overall level. For example, where a care home and a homecare agency or a GP practice and an out-of-hours GP service are provided from the same location.

We will also improve the way you can refine search results using ratings and scores.

Rating process review

Providers can request a review of the quality control processes followed when an assessment results in a rating being published.

The rating assurance process review involves checking whether we followed our processes when scoring an assessment and reaching a rating.

It is not a further opportunity for reconsideration of the evidence or judgements made, unless we find an error in the quality control process.

Ground for review

The rating assurance process review comes after the factual accuracy check process is complete and ratings are published.

The only ground for requesting a rating process assurance review is that we have failed to follow our process for making rating decisions.

You cannot ask for a review on the basis that you disagree solely with our judgements, reasoning, the score or rating awarded.

Any request for a review must relate to the latest assessment that has awarded a rating. We cannot consider references or comparisons to previous ratings or those for other providers or services.

It is not a process for raising complaints or making representations in relation to enforcement actions.

How to request a rating process review

There will be a link to our online form when we confirm that a final report and rating is being published.

You can only submit a review request by using our online form.

This form must be completed by either the:

- registered manager
- nominated individual
- chief executive (NHS trusts or local authority only)
- named liaison person (local authority only)

You must submit the request **within 15 working days** of the publication of the rating, and you can only submit one request for an assessment.

Your request should provide details of how you consider the quality control process was not properly followed. There is a limit of 500 words for a request for review.

The review process

We will display a message on the relevant profile page on our website to show a review is taking place. The rating will remain published on the website.

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

This involves checking if we followed the correct quality control processes when awarding the scoring and ratings. We do not reconsider the evidence or judgements made. In practice this means checking that:

- our teams carried out the relevant checks of the scores and associated ratings before publishing them
- providers had the opportunity to check the factual accuracy
- any challenges from the provider were properly considered before we published the assessment.

As we will look at the processes followed in awarding the score and rating, our review may extend to scores or ratings you received at the same time. You may not consider these need reconsideration. All scores and ratings can go down as well as up as a result of a review.

If the grounds for review are not met we will refuse the request and write to you to explain why.

If the grounds for review are met, an independent reviewer will review the aspects of the process that were not followed correctly. This independent reviewer is either:

- a member of staff not involved in the original assessment or
- an external reviewer if their expertise is relevant to your request.

The independent reviewer will make a recommendation to an appropriate CQC deputy director in Operations. They will make the final decision.

We aim to complete all reviews within 50 working days.

Once the review is complete, we'll let you know the outcome.

We'll make the appropriate changes to the score or 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.

Complaints and appeals

If you have also made a complaint or are 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.

How we manage our relationship with services

With our new assessment framework we can be more agile and responsive.

The way we engage with the services we assess will evolve as we use our new approach.

Our assessment teams

The roles in our teams have changed. The following are the roles that are most likely to contact your service.

Regulatory co-ordinator

The regulatory co-ordinator works across sectors. They will be the main point of contact for any general enquiries you have for our assessment team. They are also responsible for:

- Engaging with local groups such as Healthwatch, patient advocacy and participation groups or voluntary and community organisations
- Supporting the assessor and inspector in triaging, assessment planning and evidence gathering
- Making sure our records reflect an up-to-date position on risk and activities for your service.

Assessor

The assessor will be a specialist in your sector. They are responsible for:

- Reviewing data about your service
- Reviewing information and notifications we have received related to your service
- Deciding when to assess your service, what we will look at and who will take part
- Carrying out off-site assessment activities
- Agreeing scores with the inspector and writing parts of the report
- Handling factual accuracy checks for your report with the inspector
- Publishing your scores and report.

Inspector

The inspector will be a specialist in your sector. They are responsible for:

- Working with the assessor to monitor the risks for your service
- Planning and carrying out the on-site activities of your assessment

- Agreeing scores with the assessor and writing parts of the report
- Handling factual accuracy checks for your report with the assessor
- Taking enforcement action.

Operations manager

The operations manager works across sectors and is responsible for:

- Managing the assessment team responsible for assessing your service
- Having oversight of risk and systems issues in the local area
- Taking some decisions about enforcement action

How we will engage with different sectors

The following arrangements set out our relationship with locations at a local level. Where there has been engagement at a corporate or brand level this will continue.

Adult social care

We will not continue our relationship management approach at the level of each location. Instead, our engagement with your service will be through our ongoing assessment work.

You can contact us through this website or by calling us and the information will be shared with the assessment team.

We are not making any changes to the way we engage with large providers of adult social care services through our market oversight work.

Our engagement with providers that are not included in market oversight will remain responsive and risk based.

Primary medical services

We will not continue our relationship management approach at the level of each location. Instead, our engagement with your service will be through our ongoing assessment work.

You can contact us through this website or by calling us and the information will be shared with the assessment team.

NHS trusts and community interest companies (CICs)

We will continue to hold engagement meetings with NHS trusts and CICs at the provider level. These meetings should:

- Be held quarterly
- Be led by our assessors, operations managers or senior specialists as determined by risk
- Include an executive board member from the trust or CIC.

One meeting a year should also include a deputy director from CQC and the chief executive of the trust or CIC.

For NHS trusts, CQC's Medicines team will also hold structured conversations with medicines optimisation leaders each year. We will use information from these conversations about risk to inform our regulatory decisions.

Independent healthcare services

We will not continue our relationship management approach at location level except where we think there is significant risk of poor care.

Instead, our engagement with your service will be through our ongoing assessment work.

You can contact us through this website or by calling us and the information will be shared with the assessment team.

We are not making any changes to our current arrangements for the oversight of national, independent providers of mental health services.