December 2025

NHS Confederation and NHS Providers joint response to the CQC assessment framework consultation

About us

The NHS Confederation

The NHS Confederation is the membership organisation that brings together, supports and speaks for the whole healthcare system in England, Wales and Northern Ireland. The members we represent employ 1.5 million staff, care for more than 1 million patients a day and control £150 billion of public expenditure. We promote collaboration and partnership working as the key to improving population health, delivering high-quality care and reducing health inequalities. For more information visit www.nhsconfed.org

NHS Providers

NHS Providers is the membership organisation for the NHS hospital, mental health, community and ambulance services that treat patients and service users in the NHS. We help those NHS foundation trusts and trusts to deliver high-quality, patient-focused care by enabling them to learn from each other, acting as their public voice and helping shape the system in which they operate. NHS trusts in England collectively account for £132bn of annual expenditure and employ 1.4 million people. For more information visit www.nhsproviders.org.

Introduction

We welcome the thoughtful and collaborative approach that the Care Quality Commission (CQC) is taking to rebuild the way it works with providers to ensure that people receive safe, effective, compassionate and high-quality care. We and our members contributed to the reviews conducted by Dr Penny Dash and Professor Sir Mike Richards and supported their findings.

Our members are supportive of CQC's commitment to improve and streamline its approach to assessment, though there is still much more to be done to restore confidence with those it regulates. NHS Providers and NHS Confederation have long pointed to the regulatory challenges experienced by providers, with the NHS Provider's 2024 regulation and oversight survey highlighting how providers find the regulatory system to be burdensome, duplicative and detached from the considerable pressures providers face.

Providers also noted that, as pressure increases in the system, leadership behaviours displayed by the regulators were not always in line with their own commitments, nor with their expectations of providers.

We therefore are supportive of the proposed direction of travel that the CQC has laid out in this consultation. However, questions remain over how each of these proposals will be applied in practice, particularly in the current operating context. We and our members stand ready to support the CQC in coproducing solutions that are workable, effective and address previous concerns.

Guiding principles for effective regulation

To guide our response to the consultation, we propose a set of principles and considerations focused on simplicity and impact.

1. **Supportive, improvement-focused regulation**
   Regulators should support providers to develop their improvement capability by fostering constructive, stable and trust-based relationships with providers. Regulation must go beyond compliance, using proportionate interventions, clear and constructive feedback, and the sharing of good practice. Regulators should ensure inspection teams are well-trained, consistent and credible, and that the tone and delivery of regulatory activity support learning and avoids unintended negative impacts.
2. **Protect people and public value**
   Regulation must protect patients and secure public value by ensuring services are safe, effective, and cost-efficient, with a clear focus on improving access, experience, and outcomes.
3. **Objective and independent judgement, informing proportionate and dynamic action**
   Regulators must provide objective, evidence-based, and independent judgement. This requires transparent and robust oversight of the quality of NHS organisations. Providers should be assessed using clear and consistent frameworks. Interventions should be based on a "right touch" approach, meaning they should be risk-based, targeted, and fair. Regulation should use diverse assessment methods, triangulation and smart data to avoid duplication, and anticipate future challenges. Ratings should be as up to date as possible, to ensure information available to the public is accurate.
4. **Alignment with the wider operating model**
   Regulatory frameworks should reinforce collaboration and integration, create national consistency, and be sensitive to the complexities of local health systems. They should provide clarity on roles, expectations, and priorities for providers, systems, and regulators. Inspection teams should be trained to understand sector specific as well as wider system challenges
5. **Transparency and accountability**
   Regulators should operate openly, keep processes simple and user-friendly, and have a clear rationale for decisions to help the public understand what trust ratings do and do not tell them about care in their local area. Public scrutiny should reinforce accountability while enabling learning and improvement.

Our view on key proposals

Part 1: Improving the assessment framework

Reintroducing rating characteristics as part of the assessment frameworks that describe expectations for the quality and safety of services

We **agree**, in principle, with the proposal to reintroduce rating characteristics. We believe this is a sensible way to more clearly and objectively define what "good" looks like across different services and could help address the confusion caused by the complexity of the previous quality statements. This should also enhance the objectivity and independence of judgments, make it easier for organisations to understand how to improve services and plan interventions and improve the public's understanding of what ratings do – and do not – tell them about care in their local area.

It is encouraging to see CQC's commitment that the characteristics should be co-produced with providers, and NHS leaders and staff should be involved early in the development process to ensure they are realistic and effective. We caution the CQC against introducing too many rating characteristics as this could undermine the clarity and accuracy of judgements. We would also recommend a robust calibration mechanism to ensure professional judgement is consistent across inspection teams, with clearer escalation routes, especially during the post-inspection factual accuracy process.

Developing a framework of supporting questions, like CQCs previous key lines of enquiry (KLOEs), to replace current quality statements.

We **agree** in principle with developing a framework of supporting questions. The single assessment framework brought together the previous KLOEs, prompt questions, and rating characteristics into a single set of quality statements. While the intention was to improve clarity, our members found this approach too complex.

A framework of supporting questions may reduce ambiguity which could support inspection staff to make more consistent and informed decisions. Providers may therefore have greater clarity on what they are being assessed on and 'what good looks like' within their sector compared with their peers. However, to support both providers and inspection teams, we recommend that the CQC includes illustrative examples of how providers could demonstrate how they are meeting rating characteristics within supporting guidance.

Re-introducing assessment frameworks that are specific to each sector, which more clearly reflect and articulate the context of those health and care sectors.

Overall, we **agree** with the CQC's proposal to replace its single assessment framework with sector-specific frameworks, which should help improve the robustness and tailoring of assessments. Rebuilding the CQC's sector-specific expertise and relationships will be key to restoring credibility with those it regulates.

Effective inspections require sufficient clinical input and sector expertise. A one-size fits-all model is liable to miss the operational and clinical nuances that vary between different sectors. Provider leaders have previously highlighted concerns around the variable quality of inspections, the lack of sector expertise

among inspectors and a perceived tendency of inspectors to go into organisations expecting to find serious faults.

However, the shift to sector-specific frameworks must not obscure 'cross sector' or 'system' issues. Patients move across multiple services, organisations and pathways. These transition points are often where many of the most significant patient safety risks occur. Narrowly drawn sector frameworks risk missing these cross-cutting issues, especially as care becomes more integrated and the prevalence of multiple long-term conditions increases. Additionally, some issues span multiple providers. For example, breaches recorded in acute hospitals are often attributed to the acute provider (such as those relating to mental health care), when, in reality, they stem from challenges in other health or care services.

The CQC's future approach to assessing services and rating providers must account for the fact that, while individual services will generally fit neatly into one of the four sectors, pathways regularly cross sectors, and providers may cover any combination of them. The CQC should also recognise that there can be significant warranted variation between services, even if they are in the same sector, often responding to the different needs of different populations; with varying models of care, numbers of people they support, staffing size and structures and organisational practices.

As set out in our guiding principles, frameworks should be flexible and adaptable to evolving models of care and changing system pressures. While the consultation suggests that the CQC will adapt its regulatory approach over time to respond to new care models, we are concerned this will not keep up with the current pace of change. For example, group models and shared leadership arrangements are already well established, both within and across sectors. Meanwhile, the first neighbourhood and Integrated Health Organisation (IHO) contracts are set to be held from 2026 and 2027, respectively, and many contracts, collaborations and provider models already exist to achieve similar aims. The DHSC and the CQC should work together with NHS leaders to develop a mechanism that allows them to explore entire patient pathways as well as individual services.

We also welcome the CQC's intention to publish detailed supporting guidance to show the key standards and sources of evidence it will use when assessing services within each sector, which will enhance the transparency of the regulatory approach. However, the guidance must be proportionate, easy to understand and act upon, regularly updated, and avoid adding unnecessary administrative burden. It should also be based on engagement with the sector.

As sector-specific frameworks are reintroduced, it is crucial to learn from past mistakes and the limitations of both assessment processes. The Review of CQC's single assessment framework and its implementation provides a detailed repository of learnings, including ensuring that the new frameworks undergo sufficient testing and CQC staff are provided with the training necessary to confidently implement it. Clarification is also needed urgently on what role, if any, the CQC will have in overseeing Integrated Care Boards. The current consultation does not address this and yet the answer to this question may have implications for the content of the NHS reform bill.

Part 2: How CQC makes judgements and awards ratings

Simplifying the rating approach

We **agree** with the ambition to simplify and rationalise the rating approach. The current scoring system is too complex, lacks transparency and is prone to variation in interpretation. Therefore, moving to a 'rounded assessment at key question level' could reduce bureaucracy and improve clarity with ratings that better reflect overall quality and lived reality - not just technical evidence scoring. It is vital that inspectors are sufficiently expert that to be able to consider complexity, risk and improvement trajectory as part of their overall judgement.

However, simplification cannot mean avoiding nuance, and cannot come at the price of weakened consistency, fairness and transparency. Regulatory frameworks must balance transparency for the public - enabling them to make informed choices about their care - with the operational detail required by NHS leaders to improve care quality. Excessive detail risks becoming unusable to service users, while too little reduces complex performance to a single rating.

Supporting inspection teams to deliver expert inspections, impactful reports and strong relationships with providers

We **agree** with the CQCs ambition to improve their way of working. As the national regulator, the CQC plays an important role in helping shape the values, behaviours, and culture of the healthcare sector. This is fundamental to delivering consistently high-quality patient care. Our members often report negative behaviours and attitudes from inspection staff, including prioritising process over patient outcomes, a lack of receptiveness to examples of good practice and a lack of grounding in the complexities of running complex NHS organisations – for example in relation to balancing risk and efficient use of resources. We are therefore pleased to see that the CQC have committed to develop the skills of their workforce in 'relational skills'. Investment in inspector training, calibration and decision-making oversight, could help mitigate against the risk of unwarranted variation in application of the assessment frameworks. This will be supported by a return to chief inspectors being responsible for specialist inspection teams across each sector, across hospitals, mental health, primary and community care and adult social care services; critical to the credibility of the policy and regulatory process. NHS leaders would also welcome a return to a larger element of peer review within inspection teams.

Importantly, there is a need to reset expectations of what it means to be an inspector. Historically, CQC inspections have often focused on identifying what is not working, rather than recognising areas of strength or good practice. This review of the assessment approach offers an opportunity to reorient inspectors toward supporting change and driving improvement, highlighting excellence as well as addressing gaps.

Improvements can also be made to inspection reports. The CQC has in recent years sought to provide a clear narrative within their reports to reflect organisations' structural challenges and improvement trajectories, with varying levels of success. The rationale for each rating should be carefully documented and moderated so that the public, providers and CQC colleagues can assure themselves that the rating is robust, objective and defensible.

We have witnessed a positive shift in the CQC's recognition of some providers' operational pressures, accounting for the impact of industrial action among other challenges. This recognition needs to become the norm. Providers appreciated the 'must do and should do' section of inspection reports, which no longer

exists. Reintroducing this section would be helpful for providers, as inspection reports currently do not indicate which findings relate to breaches of regulatory requirements. This lack of clarity makes it difficult for providers to address the issues effectively. Providers would also welcome reintroduction of provider-specific insight reports.

NHS leaders require clear and effective escalation mechanisms to challenge or seek review when they believe judgments have been applied inconsistently. Yet many have expressed a lack of trust in the factual accuracy process for the CQC's reports. This process should be reviewed and improved, with input from providers.

Introducing an overall Trust-level quality rating

At a point when confidence and trust in the CQC's assessments are very low, we **do not agree** with the reintroduction of single quality ratings for trusts, as there is a heightened risk that their performance is oversimplified or misrepresented.
Before deciding whether to reintroduce single ratings, there are numerous considerations that should be explored in more detail with provider leaders and staff, patients and system partners:

- Is there sufficient confidence in the objectivity and consistency of CQC assessments and judgments to issue a one-word rating?
- Is it realistic to publish a single-word rating that provides an accurate and objective summary of quality and safety for a range of different audiences?
- Is it clear and accessible to those audiences, particularly public and patients, what a CQC rating does and does not show?
- Do the additional benefits of a single rating outweigh the risks of unintended consequences?
- If introduced, does the CQC have the capacity and capability to keep single ratings up to date to ensure they accurately reflect the quality of care?

The government's development of league tables illustrates how challenging it is to translate the performance of a diverse organisation into a single rating that is meaningful and accurate. This challenge is growing as trusts increasingly consolidate into large, multi-site organisations with billion-pound budgets. The review of the single assessment framework highlighted some of these difficulties, including how the importance of different evidence categories varies across services and data availability differs considerably between sectors.

As one acute leader put it in NHS Provider's 2024 regulation survey: "*In statistical terms it [is] like assuming that a mean is a true representation of the data ignoring range, mode, median, or any nonparametric measures – totally excluding any qualitative methodology*." Respondents to this survey favoured a narrative descriptive judgement, which they felt would be fairer and would be better at capturing differences in the quality of care between trusts with the same rating. Indeed, even those who favoured single-word ratings tended to think these would be better if reviewed more frequently or were supported by a clear narrative.

Additionally, we are aware that board capability is an important indicator of how effective an organisation is and is likely to be. Currently NHS England and the CQC consider elements of this separately. There may be benefit in ensuring these assessments are aligned and mutually reinforcing, to avoid duplication and to

improve providers confidence in resulting judgements; particularly if single-word ratings are to be reintroduced.

It is also worth noting that Ofsted has set out a renewed approach to grading schools after inspections, which aims to provide parents with more granularity and nuance about a school's performance via the provision of more detailed information using narrative summaries of strengths and areas for improvement. There may be learning that the CQC can take from this new approach.

Given these complexities, the attention single-word ratings would likely attract and the current level of confidence in the CQC's judgments, we believe reintroducing a single trust rating at this stage would pose considerable risk, including to the CQC's own recovery.

No longer awarding overall ratings for locations

We understand the CQC's decision to reconsider location-level ratings and agree that aggregating ratings may mask variation in the quality of services. However, local level ratings can be a useful reference point to drive local quality assurance and public accountability, and their removal may make it more difficult for boards to communicate performance at individual hospitals. It may also impact service users and families/carers, as an overall trust-wide rating does not reflect the variety of services provided. We therefore recommend maintaining both an individual location rating alongside the overall trust rating with a clear explanation about how they relate to one another.

The CQC should look at all approaches, including assessing services across pathways or integrated care models rather than rigidly by site. Where multiple services exist within large, merged organisations, it must be clear which ratings apply to which services.

Engagement with providers, staff, patients and system partners is crucial before any changes are made, and any changes must be communicated clearly to the public.

Other comments

The CQC should ensure that changes made to their regulatory approach align with other changes to the health and care system's operating model, particularly with regards to quality and safety. For example, this means maintaining consistency between the CQC's definition of what "good care" looks like and the definitions set out in the National Quality Board's forthcoming Quality Strategy. If they were to vary, providers risk being asked to deliver to competing visions of what quality looks like, undermining improvement efforts. The CQC should also align its sector specific frameworks with the Modern Service Frameworks being developed by DHSC, following commitments made in the 10-Year Health Plan.

The CQC should also ensure that its regulation is complementary, and not duplicative or contradictory, to how trusts and foundation trusts are assessed under the NHS Oversight Framework and capability assessments. Indeed, trusts may be victim to mixed signals if the CQC and NHSE (and in future, DHSC) oversight do not align.

Regulation should, as far as possible, also align with the government's wider policy priorities, particularly where the aim is to improve care for patients. As new delivery models emerge, such as IHOs and

neighbourhood health providers, the DHSC, NHSE and CQC must work together to reimagine how providers (and ICBs) are overseen and regulated. This requires greater collaboration and integrated working, yet the current oversight regime often makes this harder, not easier. Its focus on activity-based organisational performance, league tables and a move away from system control totals runs counter to the goal of joined-up working. This is a challenging balance to strike as the statutory functions and associated accountabilities of the boards of distinct organisations must also be recognised.

Coordinated reporting could also reduce the administrative burden on providers, and the sector specific insights that the CQC reports may generate could be helpful in informing system oversight. Crucially, the CQC can play an important role in better enabling a cohesive, national, proactive approach to quality so that providers can better track downward trends in quality and understand where improvement is needed. This could be achieved by consistently sharing data to give a clear picture of trends and to help providers benchmark themselves, cultivating close working relationships and alerting providers early to emerging quality concerns.

The CQC should also continue strengthening its operational processes to ensure effective delivery of its assessment frameworks. A priority is increasing the frequency of assessments, as some providers have not been re-inspected for several years. There is a concern that only the biggest causes for alarm will be inspected, leaving those previously labelled as 'Requires Improvement' but who have managed to improve services to remain labelled as such. A 'Requires Improvement' or 'Inadequate' rating remains publicly visible and can negatively influence public confidence, staff morale, recruitment and partnership opportunities. Increasing inspection frequency will also be integral to ensure providers are fairly assessed by the National Oversight Framework, which uses CQC ratings as context, and when undergoing forthcoming assessment to become an FT, an advanced FT or to hold an IHO contract.

The CQC must also provide clear timelines for re-inspection if providers are rated 'Requires Improvement' or 'Inadequate'. Providers have consistently told us that they feel 'stuck' in 'Requires Improvement' despite taking significant steps to address compliance issues, implement governance improvements and strengthen quality assurance. Providers would welcome the CQC taking a more dynamic and responsive inspection model that acknowledges improvements more promptly and reduces unnecessary reputational harm.

Overall, we are supportive of the CQC's proposed direction of travel. We and our members stand ready to support the CQC to coproduce solutions as the success of these proposals will lie in engagement of the sector.

We would be very happy to discuss our submission further or coordinate engagement with our members. If this would be of interest, please contact annie.bliss@nhsconfed.org and isabelle.brown@nhsproviders.org.