RESEARCH REPORT

What Can You Actually Conclude from a CQC Hospital Rating?

An audit of England's published hospital ratings, two years after the Dash review

Adriaan van Heerden PhD (Cantab.) FRGS
Driving Value Through Analytics & AI

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Executive Summary

A CQC rating is the one piece of quality information about a hospital that anyone can look up in seconds. Patients use it, GPs cite it, commissioners act on it, and hospitals advertise it. When an independent review found the regulator wanting in 2024, the Health and Social Care Secretary said he knew the findings would worry "patients and families who rely on CQC assessments when making choices about their care".[1]

That review, commissioned by the government and led by Dr Penny Dash, found that around one in five locations CQC can inspect had never been rated, and that the oldest NHS hospital rating was more than ten years old. The Secretary of State's verdict was that CQC was **not fit for purpose**.[2]

This report asks what the public sees two years later. It audits the published ratings for all 2,188 CQC-regulated hospital locations in England, using a ratings snapshot taken on 1 July 2026, then checks a small cohort in detail against CQC's own inspection reports.

The defects are not marginal. **A third of hospital locations carry no rating at all.** Among those that do, the badge shown to the public is an aggregate of service-level judgements made at different times, under different frameworks, sometimes spanning a decade, and carried forward through later inspections that never re-test it. A random sample of 30 rated locations puts a figure on it. **Two-thirds of the sampled locations rest at least partly on evidence five or more years old**, and among the NHS locations sampled it was every one. No sampled location met the pre-specified test for a large mismatch between the overall rating and its lowest key question, in 21 testable cases, so the problem is not miscalculation but age, composition and the absence of any visible dating.

Key Findings:

- **726 of 2,188** hospital locations (**33%**) have no published overall rating – against the Dash review's estimate of around one in five across all sectors
- Among rated locations the median rating is **3.7 years old**; **390** are more than five years old and **18** are more than ten years old
- Of the eight general acute hospitals rated Outstanding at the snapshot, **seven were awarded under the framework CQC replaced in 2023**
- One of the eight, **Conquest Hospital, is rated Outstanding overall with Safe rated Requires improvement**
- **Royal Surrey** displayed Good for nearly four years before CQC corrected a calculation error in February 2024 and changed the rating to Outstanding
- A recent publication date is often not a recent assessment: four of the eight were republished after maternity-only inspections that state they did not re-rate the hospital
- In a random sample of 30 rated locations, **18 of 27** retrievable pages rested partly on evidence five or more years old – including **all 11** NHS locations sampled

Introduction: Scope and Method

This report uses a map of CQC-regulated hospital locations in England, built by the author from CQC's published directory and ratings data. The map is not a CQC product, and CQC has no involvement in it. Ratings are as at the snapshot of **1 July 2026**, and the CQC directory snapshot is dated **22 July 2026**. The population is every location CQC registers in its hospital sector: 2,188 in total.

The method has three stages. The first is descriptive: what the published ratings show across the whole population, including how many exist and how old they are.

The second is an audit: for a small, named group of hospitals, tracing each published rating back through CQC's own inspection reports to establish when it was awarded, under which framework, and on what evidence.

The third tests how often the problems that audit exposes occur across the sector, using a random sample of 30 rated locations drawn with a fixed seed, so that anyone can reproduce exactly the same sample. Twenty-seven of the 30 pages could be retrieved. The six tests were written down before any page was opened, so what counted as a defect could not be shaped by what turned up.

The hospitals audited at the second stage are the eight general acute NHS hospitals holding an Outstanding rating at the snapshot. They were chosen because they are the most consequential ratings in the dataset – the ones a board or a patient would most reasonably treat as exemplary – and because eight is small enough to check exhaustively.

Adriaan van Heerden, PhD (Cantab.) FRGS
adriaan@adriaanvanheerden.co.uk

This report was not commissioned by any organisation, and no payment was received for producing it. The author has no professional relationship with the Care Quality Commission or with any of the providers named. Nothing here is a judgement about the quality of care at any hospital named, or about the work of individual inspectors. The findings concern how judgements are aggregated, dated and displayed.

Why CQC rates hospitals

CQC was created by the Health and Social Care Act 2008, merging the Healthcare Commission, the Commission for Social Care Inspection and the Mental Health Act Commission into a single regulator for health and adult social care in England. It commenced work on 1 April 2009.[3]

CQC's present approach to hospitals is a direct response to failure. After the Mid-Staffordshire public inquiry reported in 2013, CQC appointed a Chief Inspector of Hospitals, rebuilt inspection around expert teams, and from 2014 began publishing a single label – Outstanding, Good, Requires improvement or Inadequate – for the services it inspects.[1] [4] The purpose of that label was to make quality visible to people who could not otherwise judge it.

A note on terminology

Location is CQC's registration unit: a place at which a regulated activity is carried out.[5] CQC's hospital sector is wider than everyday usage. Alongside NHS acute and mental-health hospitals it registers independent providers such as ophthalmology, diagnostic and cosmetic surgery clinics. Fewer than two in five rated locations carry the word *hospital* in their name.

General acute hospital is used here for an NHS acute location providing general rather than single-speciality services. CQC does not draw that distinction: its non-specialist category includes several single-speciality sites, among them four dental hospitals and a maternity hospital. Setting those aside is a judgement rather than a classification: it is set out in full in section 1, and every hospital concerned is named so it can be checked.

1. What the Published Ratings Show

Before examining how ratings are built, it is worth establishing how many there are and how old they are.

A third of hospital locations have no rating

Of 2,188 CQC-regulated hospital locations in England, **726 carry no published overall rating**. That is 33% of the hospital sector. The Dash review estimated in 2024 that around one in five locations across all sectors had never been rated.[2] The two measures are not identical – this one counts locations with no current published rating, in one sector – but they point the same way, and the hospital figure is the higher of the two.

> **726 of 2,188** hospital locations – **33%** – have no published overall rating

An unrated location is not a closed one, nor necessarily a poor one. It means the public has no summary judgement to consult. For a third of a sector, that is a substantial gap in the information the regulator exists to provide.

The ratings that do exist are ageing

Among the 1,462 rated locations, the **median rating is 3.7 years old**. **390 are more than five years old** and **18 are more than ten years old**. The oldest still on display dates from August 2014.

Age here is measured from the date a rating was published. Because a publication date often runs ahead of the judgement behind it – as section 2 shows – these are floors rather than estimates. The evidence underlying a rating is at least as old as its published date, and frequently older.

Age of published rating	Locations	Share of rated
Under 3 years	551	**37.7%**
3 to 5 years	521	**35.6%**
5 to 10 years	372	**25.4%**
More than 10 years	18	**1.2%**

NHS acute locations are better served than the sector as a whole – a median of 2.6 years, with 58% rated within three years – but even there **30% carry a rating more than five years old.**

Adriaan van Heerden, PhD (Cantab.) FRGS
adriaan@adriaanvanheerden.co.uk

Outstanding is rare, and rarer than it looks

Ninety-eight locations hold an Outstanding rating (6.7% of those rated). The distribution is uneven in a way that matters.

Inspection category	Outstanding / rated	Outstanding rate
NHS acute hospital – specialist	6 / 35	**17.1%**
NHS acute hospital – non-specialist	15 / 278	**5.4%**
Independent acute hospital – specialist	16 / 461	**3.5%**
Independent acute hospital – non-specialist	50 / 455	**11.0%**
Independent mental-health hospital	11 / 233	**4.7%**

Outstanding concentrates among providers doing one thing at volume. **Twenty of the 98** Outstanding ratings belong to single-procedure clinics: SpaMedica Ltd alone holds 12 cataract day clinics, four Window to the Womb ultrasound studios hold one each, and four cosmetic surgery or hair restoration clinics hold the rest. Only SpaMedica is a single registered provider holding multiple locations; the others are separately registered, though some share common ownership. Within the NHS, **13 of the 21** Outstanding acute locations are single-speciality: dental, eye, cardiothoracic, neurological, cancer, maternity and dialysis.

CQC's own specialist and non-specialist labels do not track this. SpaMedica's cataract clinics are classified as **non-specialist**, while the independent specialist category has the lowest Outstanding rate of all at 3.5%. The categorisation and the clinical reality point in opposite directions, which is itself a reason to be careful with the table above.

> **Twenty of the 98** Outstanding ratings belong to single-procedure clinics

Set the single-speciality sites aside and **eight general acute hospitals in England held an Outstanding rating** at the snapshot, out of 278 rated NHS acute non-specialist locations. That is 2.9%. Those eight are the cohort audited in section 2.

2. What Happens When You Check the Ratings

Each of the eight was traced back through CQC's published inspection reports to establish when its Outstanding rating was actually awarded, under which framework, and on what evidence. The results are set out below.

Hospital	Outstanding awarded	Framework	Latest publication
Wansbeck General	Nov 2015	pre-2023	May 2016
Hexham General	Nov 2015	pre-2023	Sep 2023, maternity only
Chelsea and Westminster	Nov 2019	pre-2023	May 2023, maternity only
Conquest	Nov 2019	pre-2023	Jan 2023, maternity only
Homerton University	Jan 2020	pre-2023	Sep 2023, maternity only
King's Mill	Feb 2020	pre-2023	Jul 2026, re-rated Good
Royal Surrey County	Jun 2020	pre-2023	Mar 2025
Wexham Park	Mar 2025	**post-2023**	Aug 2025

Seven of the eight were awarded under the framework CQC replaced in 2023. Two date from November 2015 and are now ten years and eight months old.[6] [7] Only Wexham Park holds an Outstanding awarded under the current assessment framework.[8]

> **One** of the eight Outstanding general acute ratings was awarded under the framework now in force

How an Outstanding badge is assembled

A location rating is not a single judgement. It is an aggregate of service-level ratings, each made at a different inspection, and the aggregate is carried forward when later inspections cover only part of the hospital. Chelsea and Westminster illustrates the pattern.[9]

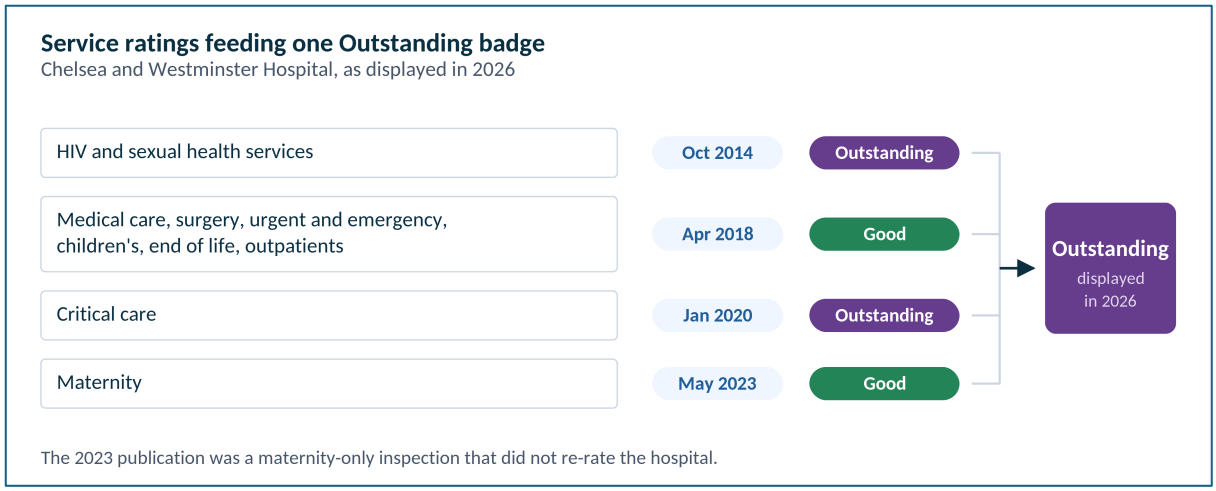

Figure 1. Service ratings feeding one Outstanding badge, Chelsea and Westminster Hospital. Compiled by the author from the CQC location profile.[9]

The badge a patient sees in 2026 rests in part on a judgement about HIV and sexual health services made in October 2014. The page does list those service ratings and their dates further down. What it never does is carry any of it into the badge, or state how old the oldest contributing judgement is.

Six defects in what the public is shown

The audit surfaced six distinct problems. Each is evidenced from CQC's own published material.

1. **A recent date is often not a recent assessment.** Four of the eight were last published after maternity-only focused inspections. Chelsea and Westminster's 2023 report states: "We carried out a short notice announced, focussed inspection of the maternity service, looking only at the safe and well-led key questions. – We did not rate this hospital at this inspection. The previous rating of good remains." The page still shows May 2023 as the publication date and displays the hospital as Outstanding, so the report text and the badge above it disagree about what the previous rating even was.[9]
2. **An overall rating is not re-derived when a key question falls.** Conquest's location profile displays Outstanding overall, with Safe at Requires improvement and the remaining three key questions at Good or Outstanding. The Outstanding was awarded by a comprehensive inspection in 2019 that rated Safe as Good; Safe fell to Requires improvement after a maternity-only inspection in 2022. No rule was broken at the time. But the profile now displayed – one key question Outstanding, one below Good – is one that CQC's current published aggregation rule would not produce, and nothing on the page reconciles them.[10] [11]

3. **Ratings can simply be wrong.** Royal Surrey's June 2020 rating, in CQC's words, "should have been outstanding. Due to an error in our calculation of the rating, it was showing as good until February 2024 when we corrected it." The public saw the wrong rating for nearly four years.[12]
4. **A profile page can contradict the report beneath it.** Homerton's profile displays medical care as Outstanding. The underlying report states that medical care "is not rated as it did not cover all of the key lines of enquiry."[13]
5. **Partial coverage is not summarised.** Wexham Park's 2025 assessment covered urgent and emergency services and medical care. The other six service ratings feeding its Outstanding badge date from 2016, 2019 and 2023. The dates are listed further down the page, but the badge is the same either way: a rating derived from two services looks identical to one derived from eight.[8]
6. **Frameworks change; the badge does not.** Seven of the eight were rated under the comprehensive-inspection regime, one under the current scored quality-statement framework. The two regimes assessed different things in different ways, so the ratings are not straightforwardly comparable, and nothing on the page distinguishes them. A third framework is due later in 2026.[11] [14]

Section 3 puts numbers to how often problems of this kind occur, using a random sample.

A CQC rating is a durable label on a moving object

Ratings move, and the record lags

King's Mill illustrates the last problem in the set. It held Outstanding from February 2020. Following an inspection in March 2026 CQC re-rated it Good, published on 15 July 2026 – two weeks after this analysis's ratings snapshot.[15]

Seven general acute hospitals in England now hold an Outstanding rating, not eight. King's Mill had held its for six years, and when CQC finally looked again the rating did not survive.

Nothing on the page could have told a reader that. A carried-forward rating gives no signal about whether it is still true; only re-inspection settles that. And re-inspection is precisely what the Dash review found had become rare, with inspection levels still well below where they were before the pandemic.[2]

All population figures in this report are as at the 1 July 2026 snapshot and therefore still count King's Mill as Outstanding. The accompanying interactive map applies the correction and shows 97 Outstanding locations rather than 98.

3. How Common Are These Defects?

The eight-hospital audit shows that these problems exist. It cannot show how often. To test that, a **random sample of 30 locations** was drawn from the 1,462 carrying a published rating, using a fixed seed so the sample can be reproduced, and six tests were defined **before** any page was opened. Twenty-seven of the 30 pages could be retrieved; the sample and the computation are published alongside this report.[16]

What was tested	Found in	95% interval
Rating rests partly on evidence 5+ years old	**18 / 27 (67%)**	48–81%
Combines service judgements 2+ years apart	**6 / 13 (46%)**	23–71%
Headline date more than 6 months newer than any evidence behind it	**5 / 26 (19%)**	9–38%
No service-level breakdown shown at all	**2 / 27 (7%)**	2–23%
Overall rating exceeds lowest key question by 2+ levels	**0 / 21 (0%)**	0–15%
Rating changed since the 1 July 2026 snapshot	**0 / 26 (0%)**	0–13%

Denominators differ because not every test applies to every location. Where a rating rests on a single service, there are no separate judgements to combine; where key questions are not shown, there is nothing to test for consistency.

The staleness is systemic. The arithmetic is not.

Two results matter most, and they point in opposite directions.

Two-thirds of the sampled locations display a rating resting at least partly on evidence five or more years old. Among the NHS locations in the sample it was **every single one** – 11 of 11.

Eleven is a small sample, and the interval around that figure runs from 74% to 100%. The uncertainty is about how close to universal the problem is, not whether it is widespread. Independent locations fared better at 7 of 16, largely because many are single-service clinics assessed once, recently.

> **18 of 27** sampled locations rest partly on evidence five or more years old – and **11 of 11** NHS locations did

No location in the sample showed the arithmetic problem. In 21 testable cases, not one displayed an overall rating exceeding its lowest key question by two or more levels. Conquest, in the eight-hospital cohort, is unusual. So is Royal Surrey's calculation error. Neither should be read as typical, and this report does not claim they are.

That distinction matters. The problem with CQC's published ratings is not that they are frequently miscalculated. It is that they are frequently **old, composite and undated in any way the reader can see** – and that is the common case, not the exception.

The system is most current where it is least reassuring

One further pattern is visible in the population data, and it cuts against the reader's instinct. **Poor ratings are markedly fresher than favourable ones.**

Published rating	Locations	Median age	Over 5 years old
Inadequate	11	**0.9 years**	9%
Requires improvement	279	**2.4 years**	12%
Good	1,074	**3.9 years**	30%
Outstanding	98	**4.1 years**	32%

The likely mechanism is straightforward: a poor rating brings inspectors back, and a favourable one does not. Among NHS acute locations the gap is the same direction, a median of 2.1 years for poor ratings against 3.4 for favourable ones.

> The rating a patient takes comfort from is the one most likely to be **out of date**

Read from the other direction the effect is starker still. Of the **390 ratings more than five years old, 356 – 91% – are Good or Outstanding.** Of the 18 more than ten years old, **every one** is Good or Outstanding.

> **All 18** ratings older than ten years are Good or Outstanding. Not one is a warning.

This is the opposite of what a reader would assume, and it matters for how the ratings should be used. A published warning is relatively likely to reflect the present. A published reassurance is relatively likely to reflect the past.

What this sample cannot tell you

- **Thirty is a small sample.** The intervals above are wide. The 67% figure is consistent with anything between roughly half and four-fifths.
- **Three pages could not be retrieved** during the audit window. They are excluded rather than assumed. Whether that reflects the site or the retrieval method could not be established, so no conclusion is drawn from it.
- **The tests measure what is visible on published pages**, which is the right target for a question about what the public can conclude, but it is not an audit of CQC's internal records.
- **Nothing here measures quality of care**, or whether any rating is substantively right.

4. What Can and Cannot Be Concluded

What a member of the public can conclude

Three things, and they are not trivial:

- That CQC assessed the service and published a judgement based on the evidence it gathered. The underlying reports are detailed, free and public.
- That where a rating is both recent and comprehensive, it says something real about the services assessed at the time they were assessed.
- That a poor rating is more likely to be current than a favourable one. Ratings of Requires improvement or Inadequate have a median age of **2.4 years**, against **3.9 years** for Good and Outstanding.

What a member of the public cannot conclude

- **That the rating describes the hospital today.** It may aggregate judgements made across a decade.
- **That it describes the whole hospital.** It may rest on a fraction of the services provided.
- **That the publication date is the assessment date.** In half the audited cohort it was not.
- **That two identically rated hospitals are comparable.** They may have been assessed years apart, under different frameworks, across different services.
- **That the arithmetic is right.** One of eight was wrong for nearly four years.
- **That the page matches its own report.** One of eight does not.
- **That an absent rating means anything at all.** A third of the sector has none.

> The headline badge is close to uninformative on its own. The underlying report, read with its **date and scope** attached, is informative.

What this means for boards

For an NHS board, three practical consequences follow. First, a favourable location rating is not evidence that care is currently good, and it should not be accepted as assurance on its own. Before it is used as assurance – in a board paper, a quality report or an external submission – establish when it was awarded and which services it covered. These details are on the location's CQC page and are quick to check.

Second, benchmarking against similarly rated peers is unsafe unless the ratings are of comparable vintage, framework and scope. In this dataset that condition is rarely met.

Third, the assessment rules matter for anyone being assessed now, and they are changing. Under the framework in force at the time of writing, a single quality statement scored 1 or 2 caps its key question at Good regardless of strengths elsewhere, so the practical route to a better rating runs through eliminating weak scores rather than showcasing strong ones. CQC has since consulted on removing numerical scoring altogether, so check the rules in force before planning around them.[11]

What should change

Two different problems have been described here, and they need different remedies.

The first is that many of the underlying judgements are old and may no longer hold. **Presentation cannot fix that.** Dating a ten-year-old rating clearly does not make it informative; it makes it honestly uninformative, which is better but is not the same thing. Establishing whether an old rating is still true means going back, and inspection capacity is the constraint the Dash review identified.[2]

The second is that the public cannot see what a rating is made of: its age, its coverage, the framework behind it. That is presentational, and every fix below could be made without a single additional inspection. What presentation can do is stop the first problem hiding inside the second. A system that displays its own staleness makes the case for re-inspection; one that displays a confident single label conceals the need for it. On that basis:

1. **Date the badge.** Show the date the overall rating was awarded, not the date the page was last touched. This matters most for favourable ratings, which are the oldest in the system and the ones the public reads as reassurance.
2. **Show the coverage.** State how many of the location's services the rating rests on, and when each was last assessed.
3. **Mark the framework.** Distinguish ratings awarded before and after the 2023 change so that like is compared with like.

4. **Re-derive or retire.** When a key question falls below Good, either recalculate the overall rating or mark it as superseded.
5. **Reconcile the layers.** A profile page should not be able to contradict the report it links to.
6. **Flag the gaps.** Distinguish “not yet assessed” from “assessed, no overall rating” so that a third of the sector is not silently blank.
7. **Expire what cannot be vouched for.** Where a rating passes an agreed age without re-inspection, mark it as lapsed rather than continuing to display it as current. It is more useful to publish nothing than to publish a judgement no one has tested in a decade.

5. What CQC Is Already Doing

This report describes a problem the regulator has itself acknowledged. Following the Dash review,[17] CQC began a reform programme and on 26 May 2026 published its priorities for “delivering more assessments and tackling aged ratings”. It reported being on track to publish reports for at least 9,000 assessments across all sectors by September 2026.[18]

Those priorities include explicit age triggers for prioritising re-inspection. They differ markedly by sector.

Sector	Age trigger for prioritising re-inspection
Adult social care	Ratings over **6 years** old
Mental health	Outstanding over **8 years**, Good over **5**, Requires improvement over **3**
Primary care and community	Ratings older than **7 years**
Hospitals, secondary and specialist care	**No age threshold published**

Hospitals are the only sector without a number. The published priority is “services that have not been assessed for a significant period of time and where our monitoring indicates a need to be re-inspected”.[18] That is a qualitative test, applied to the sector in which every NHS location sampled for this report carried a rating resting at least partly on evidence five or more years old.

> Every sector but one has a published age trigger for re-inspection. **Hospitals do not.**

CQC has also demonstrated what the remedy looks like. In March 2026 it began "Returning to Good and Outstanding", a programme of focused reassessments of lower-risk GP practices rated good or outstanding whose last inspection report was published between 2017 and 2022.[18] That is precisely the intervention these findings imply: targeted at the ratings most likely to be stale and least likely to be revisited on risk grounds. It applies to primary care, not to hospitals.

A further change is under way. Between October and December 2025 CQC consulted on replacing the single assessment framework with sector-specific frameworks, reframing its 34 quality statements as a smaller set of supporting questions and removing numerical scoring. Feedback on the four draft frameworks closed on 12 June 2026, with implementation due later in the year.[19] When that lands, a hospital's displayed rating may have been awarded under any of three regimes, and nothing on the page will distinguish them.

None of this diminishes the findings. It sharpens the recommendation. The direction of travel is right, the age triggers exist, and the mechanism has been piloted. What is missing is their application to the sector where the evidence is oldest, and any attention to how ratings are presented. None of the changes consulted on would tell a reader how old a rating is, how much of a service it covers, or which framework produced it. So 9,000 new assessments will be published into the same system that hides those things.

Conclusion

The Dash review found an organisation that could not consistently judge the quality of care.[2] [17] Two years on, the judgements it has made are still being presented to the public in a form that obscures their age, their scope and occasionally their accuracy.

The inspectors are not the problem. The reports underlying these ratings are careful, detailed and public, and every finding in this report came out of them. The problem is the layer above: a single coloured label standing in for an aggregate of judgements made across a decade, presented without the context that would let anyone interpret it.

There is an opportunity in the programme now under way. CQC expects to publish reports for at least 9,000 assessments by September 2026. Unless the presentation is fixed alongside them, those judgements enter the same system that hides when they were made and how much of a service they covered – and in five years they will be the stale ones. Dating the badge, showing the coverage and marking the framework are low-cost presentation changes if they are designed in now, and considerably more work to retrofit later. They are the difference between publishing more ratings and publishing more information. Until that changes, the honest advice to a patient choosing a hospital, or a board citing its rating, is the same. **Do not read the badge. Read the report, and check its date.**

Adriaan van Heerden, PhD (Cantab.) FRGS
adriaan@adriaanvanheerden.co.uk

Evidence and Sources

All sources cited in the text are listed below in order of first appearance. Ratings figures are derived from the author's map of CQC-regulated hospital locations in England, ratings snapshot 1 July 2026 and CQC directory snapshot 22 July 2026. Location profiles and inspection reports were retrieved on 3 August 2026. Quotations from inspection reports are taken from the PDF linked on each location profile listed below.

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About the Author

Dr Adriaan van Heerden, PhD (Cantab.) FRGS, specialises in helping organisations drive value through analytics and AI implementation. With a background in moral philosophy and complex, large-scale NHS transformation, he brings rigorous analytical frameworks and an ethical perspective to complex challenges in health and care.

adriaan@adriaanvanheerden.co.uk

Note on Methodology: Population figures are computed by the author from CQC's published directory and ratings data, at the snapshots stated above. The eight-hospital cohort was audited by retrieving each location profile, its inspection timeline and its published inspection reports from cqc.org.uk on 3 August 2026, and reading them against one another. This report was developed with AI assistance for research, analysis, editing, formatting and proofing using an iterative prompting and cross-checking process. All final analysis, conclusions and recommendations remain the author's own. Corrections are welcome: the sample, the tests and the computation are published alongside this report, and any error identified will be acknowledged and corrected.[16]

Scope and Limits of Analysis: The population analysis covers hospital locations in England only. The detailed audit covers eight hospitals and is not a random sample; it is the complete set of general acute NHS hospitals rated Outstanding at the snapshot. Frequency estimates come from a separate seeded random sample of 30 rated locations, of which 27 pages were retrievable, and carry wide confidence intervals that are stated in full. The sample list, the tests and the computation are published alongside this report so the figures can be checked or reproduced.[16] Ratings change; figures are as at the dates stated.