13. Conclusions

13.1 General conclusions

This report complements that undertaken by Dr Penny Dash. My overall findings are entirely in line with hers, so will not be repeated here in full. However, these include that:

- Operational performance is poor, with far fewer inspections carried out than in earlier years.
- There is a serious backlog in processing registrations, which has major adverse consequences for adult social care and for independent health providers.
- Some providers have not been re-inspected for several years. This can have a marked negative effect on organisations with a rating of requires improvement, especially if they are dependent on income from fees.
- Patients and service users are not well served by aged ratings and unrated services.
- Inspection/assessment reports are taking several months to be published, even though inspections are not of the same scale as the previous inspections.
- The new regulatory platform and provider portal are functioning poorly. This is causing distress to providers and to CQC staff and is contributing to major delays in report publication.
- Senior staff with a background in healthcare are poorly represented at executive level in CQC.

- The re-structuring has had a negative impact on some of the organisation's key functions.
- The concerns around the single assessment framework identified by Penny Dash have repeatedly been brought to my attention. The single assessment framework is certainly not proving to be beneficial for hospital and primary care inspections or in adult social care.

It is difficult to separate out the separate detrimental impacts of the 3 key elements of CQC's transformation programme – re-structuring, single assessment framework and IT – as there are problems with each element and these have an impact on each other. However, I would make the following comments:

13.2 Structural changes

- CQC will never be able to deliver on its objectives if the current structure is maintained. It is essential that the inspection and rating programmes for the different sectors are led by at least 3 highly credible Chief Inspectors and that they are supported by deputies with credibility in their sectors and sector-specific individuals at Deputy Director/Head of, and Operation/Inspection manager levels. The current separation of assessors and inspectors should be reversed as soon as possible.
- Consideration should be given to the appointment of a fourth Chief Inspector to lead the assessment of mental health services and to oversee the work of CQC related to the Mental Health Act. This is a large and complex area covering a wide range of community and inpatient mental health services delivered to people of all ages.

- No-one has yet given me a persuasive rationale for regulatory leadership being separated from operations. I understand that there may be some specific pieces of work unrelated to day-to-day assessment, inspection and rating that need senior people with experience of individual sectors. In such circumstances, individuals within the relevant directorates should be given time to take on these functions. This has been successfully undertaken in the past under the previous structure.
- Integration between people working in the different sectors is clearly important and especially for assessment of systems. However, I believe this can be achieved through networking across the 3 (or 4) proposed directorates.
- Reversal of the structural changes was seen as the highest priority by the majority of CQC staff I have met.

13.3 The single assessment framework

- Some aspects of the single assessment framework can probably be retained, but ideological commitment to a single assessment framework cannot be justified, given the very different services that CQC inspects and regulates.
- The 5 key questions have stood the test of time and should be retained. Indeed, I have not heard any suggestion that these should be changed.
- The 34 quality statements are wordy, but are broadly very similar to the (much shorter) topic areas that were previously considered under the 5 key questions. Further consideration should be given to the content of specific quality statements and where they fit best. For example, in addition to 'equity of access', surely timeliness of access should also be assessed? Similarly, workforce wellbeing and enablement is clearly of major significance, but I would argue that this applies across all key questions and would be better assessed under the well-led key question rather than under caring.

- I have not heard a clear rationale for selecting a limited number of quality statements across different key questions for any one inspection. I recognise that inspection resource is limited, but this feels like a scattergun approach. It might well be better to look at all the quality statements relating to an individual key question, so that a reliable rating can be assigned.
- Ideally, I would recommend that whole services should be inspected and rated at the same time. This would eliminate the problems relating to combining legacy and current ratings. This may, of course, mean that fewer services can be inspected and rated, though it is important to remember that CQC previously managed to inspect and rate all hospitals, mental health services, primary care services and adult social care services over a 3-year period.
- I have heard major concerns about the application of the 6 evidence categories and the scoring system. This part of the single assessment framework had not been adequately piloted. In the short term, I would recommend that this approach is suspended. Ultimately, I believe they should be scrapped. In addition, the use of evidence categories and scores is increasing the problems relating to the new IT system.
- Modelling is urgently needed to assess how many inspections are needed each year and the resource that is likely to be required to deliver these, once an effective structure is in place and once the problems with the IT systems have been resolved.
- As a starting point, it should be possible to assess what resource was required to undertake a single core service assessment and an inspection of the well-led key question at trust level in a hospital, using previous experience. The same could be done for an average sized care home.

13.4 The new regulatory platform

It is not within my remit or expertise to make recommendations on how to improve the IT platform. However, it would also be remiss of me not to comment on the adverse impact that this is having both on providers and CQC staff. This is exacerbating the challenges of using data effectively and of preparing timely reports. It would be helpful to know whether simplifying any aspects of the single assessment framework could make the task of improving the IT easier.