14. Recommendations

14.1 structure

1. The organisational re-structure has had a serious negative impact. **CQC should revert to the previous structure**. Separate sector-based inspection directorates led by **Chief Inspectors** should be re-established and the Regulatory Leadership directorate should be re-integrated with the inspection directorates.
2. **Cross-directorate working** can still be achieved either for thematic or strategic work by giving relevant people responsibility for this as part of their job plans. Similarly, integration between sector inspection teams can be maintained by giving dual responsibilities for integration at a local (perhaps ICS level) and specialism/sector responsibility for a wider geography (perhaps 2 or 3 ICSs depending on population size) to staff at Deputy Director or 'head of' level.
3. **Simplify the single assessment framework** and ensure it is fit for purpose in each sector, rather than slavishly expecting a single approach to work well across all sectors and for systems assessments. As a start, remove the evidence categories and scoring at evidence category level.
4. **Model the resource needed** to undertake inspections at reasonable intervals, both with comprehensive inspections and with a more limited approach (see below).
5. Re-establish **relationship owner** roles for all sectors.
6. Remove the separation between the roles of **assessors and inspectors**.

14.2 Assessment framework

1. Abandon the concept of a **'single assessment framework'**. The services that CQC regulates are diverse and it has not proved helpful in practice.
2. Retain the **5 key questions** across all sectors. They have stood the test of time, though some simplification might be desirable.
3. Retain the **I statements** as these are liked by many people I have spoken with. They can act as useful prompts when asking about people's experience of care.
4. Retain the **quality statements** but modify where necessary to avoid overlap and to make inspection simpler. Agree which quality statements are most needed for inspections in different sectors/services and then use consistently.
5. Routine use of all **evidence categories** for all quality statements should be abandoned. This is complicating the single assessment framework without benefit. The evidence categories should only be used as an aide memoire to ensure evidence is corroborated
6. **Scoring** at evidence category level should be abandoned.
7. **Key lines of enquiry (KLOEs)** relevant to the quality statements selected for inspection in a sector or service should be developed. For hospitals, these can largely be taken from the previous methodology.
8. **Standards** relating to the quality statements/KLOEs should be developed in conjunction with the National Quality Board, NHS England, Royal Colleges and representative bodies in adult social care. CQC's National Professional Advisers should take a leading role in this for individual services.
9. The **evidence** that should be sought for each quality statement should be defined and a handbook of rating characteristics should be developed.
10. **Peer review** should be encouraged at least for hospital inspections. This should build on the current role of the executive reviewer. All trusts should be expected to contribute to a pool of reviewers.

11. **Immediate feedback** should be given at the end of inspections, though with caveats that this may change on review of further evidence. At the very least, serious adverse findings should be brought to the attention of the relevant person in the provider and confirmed in writing.
12. **'Quick fixes'.** If minor negative findings are noted on an inspection, these should be included in a report. However, if these can be rectified swiftly (say within 2 weeks) and adequate assurance can be given that this has occurred, they should not affect ratings.
13. **Quality assurance** processes for reports and ratings should be reviewed by CQC. This is vital to help ensure consistency and should be undertaken by staff with expertise in the relevant sector.
14. **Reports** must provide a narrative that can be understood both by the provider and by the public. Suggested word lengths for different sections may be helpful, but a degree of flexibility should be allowed.
15. **Training** in the use of the simplified assessment framework recommended above should be given very high priority.

14.3 Data and insight

1. **Available data should be used more effectively**. High priority should be given to working with NHS England, Healthcare Quality Improvement Partnership (national clinical audits) and the Get It Right First Time (GIRFT) programme and others to develop a shared view of data required for assessments and ratings.
2. Measures of **patient experience** collected by hospitals and GP practices should be standardised, so that evidence on this is comparable between providers and is available on much larger numbers of service users. This could potentially also be applied to the adult social care sector.

3. Retain the **'clinical searches'** approach that has been developed for primary care. However, this should be able to be done centrally, reducing the time taken by SPAs on individual practice data. This would help to identify high or low risk practices before an inspection. It would also release SPAs to participate in inspections, adding to credibility.
4. The **NHS staff survey** has been demonstrated to be an effective measure of the culture of NHS trusts. Results from the survey should be incorporated into inspections of the well-led key question.

14.4 Staffing

1. An **urgent review of staffing** within the current operations and regulatory leadership directorates should be undertaken. This should assess the numbers of staff at different grades with expertise in the different sectors that CQC regulates.
2. The role of **Deputy Chief Inspector** should be reinstated, with additional posts being re-created. The current network director role is unsustainable.
3. An increase in the number of **inspection team staff** will almost certainly be needed at other levels, if CQC is to undertake appropriate numbers of inspections within reasonable timescales
4. **Pay bands** should also be compared with comparable roles in the NHS and adult social care.
5. Recruitment will almost certainly be needed in some areas.

14.5 Prioritisation of future inspections

It will take time to restructure and get CQC back to full activity, but experience from 2013/14 shows that, if there is sufficient will, this can be done reasonably quickly. More staff in specialist areas will be needed to replace those lost in recent years. It will take time to train them fully.

It will therefore be important to determine priority for inspections in different sectors. It is unlikely to be possible to undertake comprehensive inspections covering all 5 key questions for all of the previously determined 'core services' within a reasonable timescale.

In all sectors: The use of evidence categories and scoring should be suspended, and narrative reports should be re-commenced to avoid further delays.

In hospitals: National Professional Advisers have stressed the importance of assessing the 'safe' and 'well-led' key questions in NHS trusts in the first instance. They have also recommended starting with services that are most likely to carry high risk. These are A&E/ emergency departments, medical inpatients and maternity services. Abbreviated methodologies that were developed during the pandemic might also be valuable. For maternity services, the approach recently used to inspect and rate 131 services can act as a model. [9]

In primary care: National Professional Advisers have recommended that the 'safe' and 'effective' key questions should be given priority, with 'well-led' being inspected if significant issues were discovered in the first 2 key questions. The inclusion of the 'effective' key question reflects the significant improvements to inspection methodology using 'clinical searches'. If these could be done nationally, this would improve identification of high-risk practices and would reduce the burden on individual specialist professional advisers, who could then be available on site during inspections.

In adult social care: Priority should be given to reducing delays in registration and to re-inspecting services previously rated as requires improvement some years ago. Further consideration needs to be given to methodology (e.g. selection of a standard number of quality statements for each inspection).

In all sectors: Close working with partner bodies (e.g. local authorities, ICBs and NHS England) may be valuable in identifying organisations with highest risk that need the most urgent inspections.

Note

[9] National review of maternity services in England 2022 to 2024, CQC 19 September 2024, https://www.cqc.org.uk/publications/maternity-services-2022-2024