Review of CQC's single assessment framework and its implementation

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1. Summary

This review has been commissioned by the board of the Care Quality Commission (CQC) to complement the report by Dr Penny Dash, by looking at changes that CQC made following the publication of its new strategy in 2021 and their impact. Importantly, this review makes recommendations on solutions to CQC's current problems.

The transformation programme that followed the 2021 strategy had 3 key elements:

- A major organisational restructure.
- The introduction of a single assessment framework across all the sectors that CQC regulates (hospitals, mental health services, ambulances, primary and community care services and adult social care).
- The development of a new IT system, named the regulatory platform.

These 3 initiatives are clearly interlinked, but this review has shown that all 3 have failed to deliver the benefits that were intended, despite being initially welcomed by providers. This has had the following major adverse consequences:

- CQC has been unable to fulfil its primary purpose "to ensure health and care services provide people with safe, effective, compassionate high-quality care and to encourage these services to improve". Far fewer inspections have been carried out than in previous years; publication of inspection reports have been seriously delayed, and providers have expressed serious concerns about both the inspection process and the quality of the reports.
- Staff involved in inspections have become demoralised and angry that their concerns about the changes have not been listened to by senior leadership. This has led to considerable numbers of staff leaving the organisation, further compounding the problems relating to assessments, inspections and enforcement. However, I found that many of the remaining staff remain committed to the purpose of CQC and are desperate to see things improve.
- The structural re-organisation has resulted in separation of those responsible for developing policy and strategy related to regulation from those responsible for operational delivery. Operational reality has therefore not been reflected in policy and strategy.
- Clinical leadership and oversight of the inspection programmes has been lost as Chief Inspectors are no longer directly responsible for the inspections in their own sector and are less available and visible to support those at the front line. For the past 2 years, CQC has only had 2 Chief Inspectors (both of whom are currently interim), rather than the 3 as set out in legislation.
- The single assessment framework, while having some positive elements derived from the previous assessment approach, is far too complex and, as currently constituted, does not allow for the huge differences in the size, complexity and range of functions of the services that CQC regulates. One size does not fit all. Some elements of the quality statements are causing confusion both to CQC inspectors and to providers. In addition, the evidence categories and scores are causing major delays to report writing.

- The regulatory platform has had a serious adverse impact on the working lives both of CQC staff and of those working in provider organisations who are expected to upload information onto a 'provider portal'. People who use the platform say that there are, as yet, no signs that these problems are being resolved.
- Staff morale is low, especially among inspection staff, as seen in the results of the most recent staff survey. Sickness levels have risen over recent years, especially among inspection staff.
- Staffing levels in the inspection teams are currently insufficient to undertake the duties of the regulator within reasonable timescales. Staff remain concerned that they are unable to respond to emerging risks in a timely way. Insufficient induction and training has been given to new staff.
- While recognising the independence of the regulator, providers across health and social care report that the previous sense of partnership with CQC to develop effective approaches to assessment of quality has been lost.
- Progress on the use of data to inform assessments of hospital services has been at best very modest over the past several years. In some respects, the intelligence available to inspection teams is less useful than it was pre-pandemic. This has a particularly negative impact on assessments of outcomes for people using services.
- Processes to ensure consistency of judgements and the adequacy of relevant evidence – which is vital to good regulation – have been adversely affected by the downgrading and dilution of quality assurance processes.
- Over the past 2 to 3 months, CQC has started to take steps to mitigate some of the problems identified in this report. However, the organisation needs to go much further.

2. Key recommendations

2.1. A fundamental reset of the organisation is needed. This needs to be akin to the reset in 2012/13, following the problems related to the regulator that were revealed by the report of the public inquiry into Mid Staffordshire NHS Foundation Trust (the Robert Francis inquiry) and the BBC investigation of Winterbourne View.

2.2. The previous organisational structure should be re-instated as soon as reasonably possible. Chief inspectors should lead sector-based inspection teams at all levels. These teams can be brought together to assess integration of care across a local area, while retaining focus on their own specialism.

2.3. The current Operations directorate should be disbanded and reformed into sector-based inspection directorates. Many of the staff currently working in the regulatory leadership directorate should be re-assigned to the relevant inspection directorate.

2.4 At least 3 permanent Chief Inspectors should be appointed as soon as reasonably possible to lead the sector-based inspection directorates. Serious consideration should be given to the appointment of a fourth Chief Inspector to lead regulation of mental health services and to oversee inspections under the Mental health Act.

2.5 Ongoing relationships between inspection staff with relevant skills and experience and providers should be re-instated as soon as possible. Regular dialogue coupled with appropriate levels of support and challenge in respect of required improvements has been sorely missed both by CQC staff and by health and social care providers.

2.6 Aspects of the single assessment framework could be retained – with some modifications. Other aspects should be suspended and almost certainly scrapped, including the evidence categories and scoring system. More work needs to be done to define what good looks like in different services.

2.7 Decisions on the future of the regulatory platform are outside the scope of this review. However, it is possible that simplifying the assessment framework (e.g. by scrapping evidence categories and scoring) may make it easier to resolve the problems with the IT system, but expert advice will be needed on this.

2.8 The use of data to inform judgements should be given much higher priority than at present. Existing datasets already collected by NHS England and associated bodies should be incorporated into assessments of hospitals and primary care services as soon as possible. New data sharing agreements between national bodies should be instituted as soon as possible. Uniform availability of high-quality data/intelligence would reduce the burden on both CQC staff and providers.

2.9 Staffing levels and pay scales within the inspection directorates should be reviewed as a matter of urgency. There are currently too few staff working in the hospital and primary care inspection programmes to undertake the duties of the regulator within reasonable timescales. The gap between NHS and CQC pay scales has almost certainly contributed to the loss of inspection staff.

2.10 Priorities for inspection within the healthcare sectors need to be reviewed, given current staffing levels. Possible approaches to prioritisation are discussed in greater detail in later sections of this report.

2.11 CQC should work closely in partnership with leaders of health care and adult social care to design improved approaches to assessment and inspection. This would be welcomed by those being regulated. They would also welcome a return to a larger element of peer review in the process.

2.12 Further work to determine how the current backlogs in registration can be reduced or eliminated is urgently required.

2.13 During the course of this review, the issue of “one-word ratings” was raised on numerous occasions by providers. Further consideration should therefore be given to this issue. In particular, the level at which ratings makes sense to people using services should be considered.

3. Introduction and context

This review was initially proposed by the leadership of CQC before the publication of the interim report by Dr Penny Dash.[1] Coincident with that publication in late July 2024, the Secretary of State for Health and Social Care announced that I would be conducting a rapid review of CQC and, in particular, to consider whether the single assessment framework introduced in late 2023 is fit for purpose.

To do this, it is necessary to consider both the single assessment framework and the approach to its implementation. I have also taken account of the comments related to CQC in Lord Darzi's recent report on the NHS.[2]

The importance of an effective regulator of the quality and safety of care has been re-emphasised in Dr Penny Dash's report and has been further confirmed by multiple providers of health and care services who participated in the current review. Effective regulation can identify failings in the delivery of care and can assist providers in making improvements. Examples of such improvements in hospitals, primary care and adult social care have previously been published by CQC.[3, 4, 5]

4. Approach to this review

To undertake this review, I have:

- Taken full account of the findings in the interim report by Dr Penny Dash.
- Reviewed multiple documents available on CQC's website or provided to me by CQC staff.
- Reviewed recent reports of providers published using the single assessment framework.
- Interviewed over 50 current or former members of CQC staff individually. These involved people working across different sectors/directorates, including hospitals, mental health, primary care, adult social care, registration, policy and strategy, data and insight and finance.
- Participated in 15 group meetings or internal workshops with CQC staff. These ranged in size from 6 to over 200 people.
- Corresponded with over 40 members of CQC staff at all levels and across sectors.
- Held meetings with the leaders of representative bodies of NHS and adult social care providers, including NHS Providers, the NHS Confederation, the National Care Forum, Care England and the Homecare Association, and with the Chairs of the Royal College of General Practitioners and the British Medical Association.

- Participated in workshops arranged by these representative bodies. These were attended by senior personnel (CEOs or their representatives) of well over 100 provider organisations across health and social care.
- Interviewed a further 12 individuals external to CQC, but with a major interest in regulation.
- Spoken with senior representatives of NHS England.
- Attended 2 meetings of the advisory group established by Dr Penny Dash.
- Participated in 2 'all colleague' calls with CQC staff, where I presented my findings and initial thoughts on the way forward. The first of these meetings involved over 1,500 people. The second involved just under 800 people.

I have considered all this information in the light of my previous involvement with CQC as Chief Inspector of Hospitals between 2013 and 2017. During that time, CQC introduced its 5 key questions (safe, effective, caring, responsive and well-led) and new approaches to assessment, inspection and rating across all health and care sectors it regulated.

While I was responsible for hospitals (including mental health services, community health services and ambulance services, and covering both NHS and independent sector organisations), 2 chief inspector colleagues were responsible for adult social care and primary care services. As Chief Inspectors, we were responsible for developing and overseeing the delivery of inspections and ratings in our respective sectors, under the overall leadership of Sir David Behan as Chief Executive and with the support of colleagues in CQC's other directorates. Over a period of a little more than 3 years, almost all regulated services were inspected and rated.

Given this background, I was clearly very interested to assess changes in the past 7 years and to what extent these might be related to the current challenges faced by CQC.

5. CQC's 2021 strategy and the transformation programme

In 2021, CQC published 'A new strategy for the changing world of health and social care – our strategy for 2021'.[6] This confirmed CQC's purpose "*To ensure health and care services provide people with safe, effective, compassionate, high-quality care and to encourage those services to improve*". The new strategy set out ambitions under 4 themes:

- People and communities
- Smarter regulation
- Safety through learning
- Accelerating improvement

With 2 core ambitions running through each of these themes:

- Assessing local systems
- Tackling inequalities in health and care

The strategy set out a large number of benefits that it was intended to deliver, but without clear (indeed any) statements on how each of these would be achieved. The strategy did, however, list 12 broad outcomes that CQC would achieve:

People and communities

1. Our activity is driven by people's experiences of care.
2. We clearly define quality and safety in line with people's changing needs and expectations. This definition is used consistently by all people and at all levels of the health and social care system.
3. Our ways of working meet people's needs because they are developed in partnership with them.

Smarter regulation

4. We are an effective, proportionate, targeted and dynamic regulator.
5. We provide an up-to-date and accurate picture of quality.
6. It is easy for health and care services, the people who use them and stakeholders to exchange relevant information with us, and the information we provide is accessible, relevant and useful.

Safety through learning

7. There is improvement in safety cultures across health and care services and local systems that benefit people because of our contribution.
8. People receive safer care when using and moving between health and social care services because of our contribution.

Accelerating improvement

9. We have accelerated improvements in the quality of care.
10. We have encouraged and enabled safe innovation that benefits people or results in more effective and efficient services.

Core ambitions

11. We have contributed to an improvement in people receiving joined-up care.
12. We have influenced others to reduce inequalities in people's access, experiences and outcomes when using health and social care services.

While these outcomes are aspirational, the strategy does not provide any indication of how its vision might be achieved. Nor are there any metrics against which progress towards the stated outcomes might be measured. The findings outlined in

Penny Dash's interim report suggest that limited or no progress has been made on the majority of these outcomes, despite the strategy being published 3 years ago.

Subsequent to the publication of the strategy, a transformation programme was initiated, with 3 key components:

- The development of a single assessment framework.
- Major changes to the structure of the organisation, with the establishment of an operations directorate separate from regulatory leadership.
- Major changes to the IT systems used by CQC, with a new regulatory platform and provider portal to replace the existing (and ageing) customer relationship management (CRM) system.

6. The single assessment framework

6.1 Rationale for the single assessment framework

The rationale for the new framework is set out in 'Our new single assessment framework' published by CQC in July 2022.[7] This states that:

"There are three main reasons why we need to change:

- *We need to make things simpler so that we can focus on what really matters to people.*
- *We need to better reflect how care is actually delivered by different types of service as well as across a local area.*
- *We need one framework that connects our registration activity to our assessments of quality."*

While the 5 key questions and 4 quality ratings would remain central to CQC's approach, the existing key lines of enquiry (KLOEs) and underlying prompts would be replaced with new 'quality statements'. The aim of these changes was to reduce the duplication in the 4 previous separate assessment frameworks, which would allow a focus on specific topic areas under each key question, and would link to the relevant regulations and associated external guidance to make it easier for providers.

From discussions I have had with members of CQC staff, their understanding was that the aim of the single assessment framework was to provide:

- consistency of approach across sectors
- consistency of judgements
- applicability to local health and care systems as well as to providers

- simplicity
- emphasis on people's experiences.

6.2. What is the single assessment framework and how does it differ from the previous approach?

The single assessment framework is intended to be one single framework that covers all the services (across health and care) that CQC regulates. It retains the 5 key questions and replaces the key lines of enquiry (KLOEs) that were previously used with 34 quality statements (Appendix 1). These quality statements have been mapped onto the 5 key questions as follows:

Safe

- Safety learning culture
- Safe systems, pathways and transitions
- Safeguarding
- Involving people to manage risks
- Safe environments
- Safe and effective staffing
- Infection prevention and control
- Medicines optimisation

Effective

- Assessing needs
- Delivering evidence-based care and treatment
- How staff, teams and services work together
- Supporting people to live healthy lives
- Monitoring and improving outcomes
- Consent to care and treatment

Caring

- Kindness, compassion and dignity
- Treating people as individuals
- Independence, choice and control
- Responding to people's immediate needs
- Workforce wellbeing and enablement

Responsive

- Person-centred care
- Care provision, integrity and continuity

- Providing information
- Listening to and involving people
- Equity in access
- Equity in experiences and outcomes
- Planning for the future

Well-led

- Shared direction and culture - Shared vision, strategy and culture
- Capable, compassionate and inclusive leaders
- Freedom to speak up
- Workforce equality, diversity and inclusion
- Governance, management and sustainability
- Partnerships and communities
- Learning, improvement and innovation
- Environmental sustainability – sustainable improvement

These 34 quality statements are broadly similar to the topics that were assessed in the previous hospital inspections and ratings. However, some are likely to be of greater importance in particular settings/sectors than others.

It could also be argued that some are identified under the wrong key question. For example, 'workforce wellbeing and enablement' is placed under the caring key question, while it might be better placed under well-led. In addition, some quality statements conflate concepts that would be better kept separate. For example, under the well-led key question, culture should be separated from vision (and strategy).

While the emphasis of people's experience of care is clearly of major importance, this does appear to downplay the importance of outcomes and proxies for outcomes. In healthcare settings, patients may report a good experience of care, while actually receiving treatment that is suboptimal and may affect their long-term morbidity or mortality. Patients under the care of breast surgeon Ian Paterson and GP Harold Shipman initially reported good experiences of care, but had disastrous outcomes.

In practice, not all 34 quality statements are assessed on any inspection. For example, in adult social care, 5 quality statements were initially selected for inspection, though this has now typically increased to 10-12. In primary care, 18 quality statements are now being advocated for inspection, and in A&E/emergency department inspections, experts are advocating using 21 quality statements. This begs the question as to whether this is a 'single' assessment framework.

If only some quality statements are assessed for a particular key question, it means it is not possible to give a rating for that key question (without relying on past assessments, which may be several years out of date). In addition, assessment of only a selection of quality statements may mean that an inspection does not cover all the fundamental standards set out in the regulations.

The currency and credibility of ratings is a key issue for providers and the public.

6.3. Evidence categories

Six evidence categories have been identified relating to each of the 34 quality statements. These are:

- People's experience of health and care services
- Feedback from staff and leaders
- Feedback from partners (e.g. commissioners and other local providers)
- Observation
- Processes
- Outcomes

Although these sources of evidence were used from the outset of CQC inspections and ratings, the single assessment framework makes them more explicit. Equal weighting is meant to be given to each evidence category for each quality statement. However, the relative importance of different evidence categories may vary between different services and key questions. For example, the effectiveness of a hospital service may largely be measured through processes and outcomes, while caring may largely be measured through people's experience and through observation. In addition, the availability of data varies widely between sectors (see Data and insight section).

6.4. Scores

The single assessment framework process involves scores being given to each of the relevant evidence categories for each of the quality statements on a 4-point scale (where 1 is worst and 4 is best).

While this might be thought to provide greater consistency and allow for automated aggregation of scores to provide an overall rating, this would depend on clear criteria being set out for each score for each evidence category and for each quality statement in all services. It is unclear where judgement and moderation should prevail in this approach, especially where aggregated scores are at the borderline between ratings (e.g. good versus requires improvement).

6.5. The single assessment framework in practice: CQC staff perspective

A total of 1,379 inspections of providers were undertaken between December 2023 and September 2024 using the single assessment framework methodology. The breakdown by type of sector is as follows:

Sector	No. of inspections
Adult social care	885
Primary care	350
NHS and independent hospitals	47
Mental health	97

This is far fewer than would have been done in a comparable period before the Covid pandemic but is sufficient for staff in each sector to have formed clear views on the new methodology.

The views of CQC staff across all sectors who have been using the single assessment framework for assessments can be summarised almost unanimously as follows:

Views on quality statements and evidence:

- The concept of a single assessment framework is superficially attractive, but it doesn't take account of the major differences in size, complexity or function between services/organisations, or in the nature of the information necessary to assess a service.
- CQC personnel working in each of the sectors do not feel that the single assessment framework works for their services.
- CQC staff in both the Operations Directorate and in Regulatory Leadership continue to find the 5 key questions helpful and are glad these have been retained.
- The 34 quality statements are broadly acceptable as they are little different from the topics previously used. However, the wording of the statements is lengthy and some statements would benefit from modification, separation and being moved to a different and more relevant key question. Some of the quality statements overlap with each other, leading to confusion and duplication.
- The rationale for the selection of 'priority quality statements' for assessing different service types is unclear and confusing.
- There is insufficient emphasis on outcomes. These cannot be adequately measured for hospitals and primary care through people's experiences. Much more informative datasets are available but are not being used.
- The insistence on assessing several evidence categories for any individual quality statement is causing major difficulties, both in the assessment process and in report writing. This precludes writing a narrative report that would make sense either to a provider or to people trying to get information about a service.
- Uploading of evidence from assessments of individual quality statements to the regulatory platform is extremely time-consuming and can delay publication of reports by several months. This is having a serious adverse impact on the overall number of inspections being undertaken.

Views on producing scores and ratings:

- There was virtually no support for the use of scoring for each evidence category. Although scoring may seem superficially logical, it precludes the use of judgement about the rating of a whole key question, or even for a quality statement. It was described to me as a 'pseudoscience'. It also creates a risk of gaming to get the 'right' overall rating. Scores that are at a borderline (e.g. between good and requires improvement) can feel unfair, especially if the negative findings could be corrected and validated rapidly (e.g. between inspection and report).
- Evidence that has previously been successfully developed for primary care inspections and has been welcomed by GPs, CQC inspectors and specialist professional advisers (SPAs) cannot be accommodated within the current single assessment framework, so assessments are considered less valid than previously. GP inspectors and SPAs found the use of templates for evidence and a narrative report much more meaningful. Comparison of ratings between around 150 primary care practices recently assessed using the old methodology and around 150 using the single assessment framework showed major differences in ratings.
- The single assessment framework has made assessment of the well-led key question at NHS trust level more complex – not simpler. Assessment of multiple evidence categories for each quality statement, combined with equal scoring of each evidence category, is making the task almost impossible, especially when combined with the problems of uploading evidence to the regulatory platform. The previous framework for assessing well-led in trusts was developed jointly by CQC and NHS England/Improvement and worked well.
- If only a limited number of quality statements relating to a key question are assessed, it is difficult – if not impossible – to determine a reliable current overall rating for that key question. This is especially true if previous ratings were given several years ago.
- The ratings given by applying the single assessment framework do not give an accurate view of the quality of care in some services. In adult social care, the scoring system can give a rating of good, even though there are sometimes multiple breaches of the regulations (Appendix 2). This is not a rare occurrence, as over 96 assessments using the single assessment framework (around 10% of the total number undertaken to date) have been rated as "good with a breach". A member of the public might see a rating of good and not be aware of the breach, unless they read the full report. Under the old methodology if a service was in breach of one of the fundamental standards, it would not be rated as good. In addition, the use of ratings limiters supported consistency in judgements.
- Combining new ratings for individual quality assessments with old ratings (some of which were awarded several years ago) does not make sense. In some cases, this can make it impossible to upgrade a rating of a key question even when there has been improvement.

In summary:

- The single assessment framework is not simpler than the previous approach and does not accurately reflect the quality of care delivered – which were 2 of its key objectives.
- CQC staff feel that the single assessment framework was introduced without sufficient testing and training.
- As one correspondent put it (and many others would agree): “It takes longer to look at less”.
- A large number of people I spoke to advocated going back to the previous approach based on the 5 key questions and prompts/KLOEs.

6.6 Application of the single assessment framework to local authority assessments

CQC has only recently started to assess local authorities (LAs) in relation to their role as commissioners of adult social care. These assessments are being undertaken as part of CQC’s relatively new duties to reflect how care is delivered across a local area. In due course, it is anticipated that integrated care systems (ICSs) will also be assessed, though these assessments have not been commenced as yet.

A dedicated team has been established to undertake the LA assessments. LAs are given 6 weeks’ notice of an inspection, with a substantial amount of information being requested before a site visit is undertaken. To date, 26 of the 153 LAs have been inspected, with reports published for 9 of these, and 58 LAs have started the process with information having been requested. The teams for inspection are made up of around 14 personnel, around 40% of whom are external expert reviewers. Case tracking forms part of the process.

Nine quality statements are assessed, with 4 of the 6 evidence categories being used for each. Although the quality statements cover several of the key questions, rating at key question level is not part of the process. A single overall rating is given with sub-scores for the 9 quality statements. The regulatory platform is not being used for LA assessments.

It is still too early to assess how well these assessments are working or the value of the reports. However, although the quality statements used come from the single assessment framework, it is questionable whether the move to a single assessment framework was needed to undertake these reviews. As with other assessments being undertaken using the single assessment framework, inspection teams report that scoring has been unhelpful, as it can drive towards a rating that is not felt to be appropriate.

6.7. Registration and the single assessment framework

Registration of health and social care providers is one of the key functions of CQC. All new locations from which services are to be provided have to be registered by law and certain changes to registered services have to be agreed with CQC.

When a provider wishes to register a service/location, they complete a standard application form. Following initial checks, this is passed to dedicated registration inspectors who review documentation, conduct interviews with the provider and manager and decide whether an on-site visit is needed. The assessment is conducted against regulations and is based on intent, as delivery of services will not have started.

Demand for registration increased by around 33% between 2020/21 and 2023/24. This has largely been driven by a major increase in applications related to domiciliary care (homecare) agencies. I was told that many of these applications are ultimately rejected.

Backlogs have increased markedly. In June 2022, 23.2% of registrations were waiting more than 10 weeks to be processed, but by May 2024 this had risen to 61.6%. Recruitment of additional staff on fixed term contracts has now been undertaken to tackle these backlogs, but given the time needed for induction and training, backlogs are likely to remain for some time. This has a serious impact on providers who may have invested substantial funds in developing a new service, but cannot start to recoup these through delivery of services.

Although one of the stated aims of the single assessment framework was to connect registration activity to assessments of quality of service delivery, registration managers report that there is no evidence of this happening.

6.8. Oral health and the single assessment framework

CQC regulates around 11,500 dental locations with a dedicated team of around 33 inspectors (i.e. around 500 locations per inspector). These services are deemed compliant or not compliant with regulations, but CQC has not been given the powers to rate dental services. CQC aims to inspect around 10% of dental practices each year. Overall, around 85% of practices are found to be compliant.

Seven quality statements are used for dental inspections, 3 of which relate to the safe key question (staffing, environment and infection prevention and control), with one quality statement each for the other 4 key questions. Initially, 22 evidence categories were used across these 7 quality statements, but this has now been reduced to 15. Each inspection typically requires one or two inspectors (depending on the size of the practice) and one specialist professional adviser (SPA).

The large majority of oral health inspectors wish to come off the regulatory platform and would wish to dispense with evidence categories, as these (as in other sectors) impede the flow of a report. Previously, dental practices had to submit a provider information report (PIR) before an inspection, but this has currently lapsed. This did

give an indication of risk. Better data/intelligence is wanted by inspectors, who believe that large corporate providers have such intelligence that could support more effective assessment of quality and risk pre-inspection.

7. Organisational re-structure

7.1. Current and previous structure

CQC's strategy, launched in 2021, set out an ambition to regulate in a smarter way. To do this "*Changing our operational teams*", published in November 2022[8], stated that CQC needed to change the way it worked to enable it to:

- look at the quality of health and care services across a local area
- give a more up-to-date view of quality
- be more efficient, consistent and effective
- provide more tailored support to health and care providers.

To achieve these aims, it was decided to bring together 3 sector teams (adult social care, hospitals, primary medical services) into one Operations group.

The previous 4 regions (North, Central, London, South) were changed into 4 regional 'networks' (London and East of England, Midlands, North, South).

Director roles replaced Deputy Chief Inspector (DCI) roles. The 4 'networks' are each led by a single Director, who is responsible across adult social care (ASC), hospitals and primary care. Previously, each of the 4 regions had 3 DCIs, one for each sector, so just 4 Network Directors have replaced 12 DCIs.

The 4 Network Directors are each supported by Deputy Directors (equivalent to previous Heads of Inspection).

The Deputy Directors line manage Operations Managers (equivalent to previous Inspection Managers), who do not necessarily have experience related to each of the 3 sectors.

Operations Managers, in turn, manage local teams with a mix of expertise and experience. One of the aims was to give the best view of services across an area.

Teams were to contain a mix of:

- assessors (essentially off-site evidence collectors and report writers)
- inspectors (gatherers of evidence on site)
- co-ordinators
- regulatory officers (inspection planners and administrative officers).

A separate Regulatory Leadership directorate was established, which effectively separates clinical leadership (including Chief Inspectors) and others, including senior specialists, from the operations directorate. Chief Inspectors no longer have direct line management for assessments/inspections or enforcement in their sectors.

This structure effectively divorces strategy from operations, though senior specialists would still be available to offer advice to inspection teams when requested.

For providers, it was stated that "you will still be assessed by CQC colleagues who are experts in your service type". Despite this, I have been told that inspecting has been regarded by some senior personnel at CQC as a generic skill, so that someone with a social care background should be able to inspect a hospital, or vice versa for care homes. In practice, this reduces operational efficiency because inspectors are less clear what to look for. The current resource challenges also mean that people who are not specialists are used to support inspection in other sectors. This can lead to less pertinent evidence being collected to inform judgements. This in turn reduces confidence and credibility among providers.

Following the resignation of the Chief Inspector of Primary and Community Care in mid-2022, no successor has been appointed, but the role of Chief Inspector of Hospitals has been extended to include primary care, and is now called Chief Inspector of Health Care. The 2 current Chief Inspectors are both interim appointments.

Inspectors report that it is difficult being managed by an operations manager who is not someone from your sector.

The previous inspector role has been divided into 2 – with assessors and inspectors. The assessor's role is to manage the evidence relating to individual providers and to write a report once the inspector has inspected and fed back. In other words, the assessor writes a report without ever having been to the service being assessed. This division of roles has already been recognised as not working and is being reversed.

One of the potential advantages of establishing a single operations directorate was to ensure closer working across sectors. This may be a particular advantage for assessment of integrated care systems (ICSs), though these have not yet been rolled out. In addition, CQC staff have suggested various alternative ways of ensuring that cross-sector working can be achieved without forming a single operations directorate. Local authority assessments relate largely to commissioning of adult social care.

7.2. Impact of re-structuring

CQC staff perspective

The views of CQC staff working in hospitals, primary care and adult social care about the impact of re-structuring on the assessment, inspection and rating of providers can be summarised as follows:

- Credibility with providers has been lost, as people with backgrounds in social care are inspecting hospitals without ever having worked in them.
- The loss of the previous ‘relationship owner’ role, which hospital (and mental health) inspectors and inspection managers had with individual trusts, has had a serious negative impact in terms of ongoing engagement and early recognition of issues.
- Engagement between chief inspectors or their deputies with senior executives in provider organisations has been lost, which is a major problem when serious issues are found.
- The 4 Network (regional) Directors have unsustainable workloads and responsibilities across all 3 sectors and for a wide population. These roles were previously covered by 12 Deputy Chief Inspectors. It is unsurprising that they cannot engage externally to the extent that is needed.
- Ensuring consistency between inspection teams is one of the key challenges for a quality regulator. However, under the new structure, quality assurance of reports and ratings has been devolved to lower levels. This can mean that quality assurance is being overseen by someone who does not have an in-depth knowledge of the sector being inspected.
- There is currently insufficient senior level input to inspections of the well-led key question in NHS trusts.
- Separation of the inspector and assessor roles has made report writing much more difficult with assessors writing reports on services they haven’t inspected. Inspectors are expected to provide evidence to the assessor to write a report, contributing to delays (although the problems with the regulatory platform have also contributed). Previously, inspectors would have been responsible for the initial draft of a report on a service they had inspected.
- Supervision of hospital and primary care inspectors by a line manager who is not familiar with their specialism is suboptimal. Operations managers often lack experience and insight of the sectors for which they are responsible.
- Processes for checking the validity of reports and the ratings that are being assigned are unclear. Quality assurance of reports and ratings by personnel with knowledge and experience of the relevant area has been lost.

8. Challenges with the regulatory platform

Full assessment of the regulatory platform is beyond the scope of this review. However, the problems related to the regulatory platform are having a significant adverse impact on both CQC inspection staff and on providers, and are interlinked with the assessment of the single assessment framework and its implementation.

I have been repeatedly told that the use of evidence categories and scoring complicates and delays the production of reports and does not allow for a meaningful narrative that makes sense to providers or the wider public.

Providers have confirmed this and have emphasised the difficulties they have in uploading information needed for the single assessment framework through the provider portal.

As one inspector told me: “I would go back to CRM in a heartbeat”.

9. Provider perspective on the single assessment framework and its implementation

9.1. General comments across sectors

To gain insights into the views of providers concerning the single assessment framework and its implementation, I have spoken with leaders of several major representative organisations. These include:

- NHS Providers
- The NHS Confederation
- The Independent Health Providers Network (IHPN)
- Care England
- The National Care Forum
- The Homecare Association
- The Royal College of General Practitioners
- The British Medical Association
- The Shelford Group of NHS Trusts

Information they have provided has been supplemented by surveys of members of several of these organisations and from large group meetings with their members.

Provider organisations have clear views on the overall impact of CQC’s transformation programme, but they may not always be clear whether the problems lie with the single assessment framework itself, or with its implementation. They are all clear on the major problems related to the regulatory platform. It is also clear that problems relating to the single assessment framework and its implementation are common to hospitals and adult social care.

General comments relating to the transformation programme can be summarised as follows:

Support for the approach:

- There was widespread support from providers when the transformation programme was first announced. CQC received several thousand responses to its consultation, which were broadly supportive. However, it is important to note that these positive comments were in response to the concept of a single assessment framework and were made before the single assessment framework had been developed. From the outset, staff within CQC expressed concerns about the concept. No formal consultation was undertaken once the single assessment framework had been developed, and very little piloting was undertaken before rollout in December 2023.
- As recently as 2023, the NHS Providers annual survey of regulation reported that “Trusts continue to be supportive of the direction of travel indicated by the regulators”. Around 8 out of 10 supported the changes initiated by CQC to deliver more risk-informed and responsive regulation. However, the survey also showed that “support for these principles contrasts with trust leaders’ experience of regulation at the frontline.”
- The need for high-quality regulation is recognised across all sectors: “We want good regulation”. In other words, the principle of a unified approach to assessment was welcomed, but the practice has fallen far short of what was anticipated. The need for change in the first place has now been questioned.

Views on implementation:

- Several of the umbrella organisations in health and social care had warned CQC against tackling all 3 elements of the transformation programme at one time. Their concerns had not been acted on.
- There had been too little piloting and no evidence of learning or change as a result of the pilots that had been carried out.

Views on trust and confidence:

- There has been widespread and severe loss of confidence in CQC. This applies not only to providers, but also to local authority commissioners of social care. I heard that some local authorities are now conducting their own assessments before commissioning services because they have lost confidence in CQC.
- The sense of partnership between CQC and provider organisations has been lost.
- The loss of relationship owners is keenly felt. Providers need a point of contact.
- The current approach has a major emphasis on looking for what is wrong – not what is working well or is innovative. This is an impediment to innovation.
- The new approach is difficult for providers to understand and is not clearly set out by CQC. The National Care Forum had found it necessary to produce a ‘mega-briefing’ to help its members understand the new approach.
- The current approach lacks credibility. Both healthcare and adult social care organisations expressed extreme dissatisfaction with the current regime.

Impact on providers:

- Delays in registration are having an adverse impact especially on independent health and adult social care providers. In one instance, the provider was not informed for a month even though registration had been successfully completed.
- CQC is currently undertaking too few inspections and re-inspections. This has a serious adverse financial impact on independent sector providers (health and social care) who have a previous rating of requires improvement.
- Providers feel they are not getting value for money, considering the fees they pay to CQC.
- Delays in getting through to the CQC helpline are causing major frustration for providers.
- Final reports frequently bear little relationship to the feedback given immediately at the end of an inspection.

Headline findings from surveys conducted by umbrella organisations are shown in Appendix 3.

9.2 General views on the transformation programme from adult social care providers

Specific comments made by leaders of adult social care providers (care homes and/or homecare) included:

- *"My organisation has had 6 inspections. All were different. They had no clue what they were looking for."*
- *"Did CQC need to change? They were respected. Scrap what we've got now."*
- *"The provider information request (PIR) takes hours, and then we get no feedback."*
- *"We are not getting value for money".*
- *"Total disaster. Huge damage."*
- *"Some inspectors don't have knowledge about things that matter in care homes – dementia, learning disabilities, rehabilitation."*
- *"The evidence categories are a nonsense."*
- *"We need sector handbooks."*
- *"How do we get to outstanding?"*
- *"The number of people who are spoken to on site should be standardised. Otherwise, inspectors may not get a balanced view."*
- *"The report structure is awful."*

Some individuals also felt that an independent body should be established to oversee CQC and to hear appeals.

9.3 General views on the transformation programme from NHS trusts

The views of NHS chief executives on the new approach can be summarised as follows:

- Inspection teams sometimes lack credibility, without adequate knowledge of the sector, and lack seniority especially for assessment of the well-led key question at trust level.
- The culture among inspection teams has changed for the worse. There is now no sense of partnership. Inspectors are only looking for what is wrong – not for evidence of what is good or innovative. Inspection teams can instil fear, warning that if findings are challenged, the outcome will be worse.
- CQC is on a downward spiral and should revert to what was working previously.
- Judgements are inconsistent.
- Some senior staff in trusts are no longer willing to take part in inspections due to a feeling that objectivity had been lost and that outcomes appeared pre-determined.
- Some trust CEOs noted the difficulty in approaching CQC's senior team and felt that it had become detached from the sector.

9.4 Specific views on the single assessment framework

There were specific comments relating to the single assessment framework across all sectors:

- The selection of only a sample of quality statements for an inspection and then combining with old ratings is widely thought to be unhelpful and inappropriate.
- Combining old and new ratings gives an unreliable picture of current quality and safety and can be unfair to providers.
- The initial selection of 5 quality statements for adult social care inspections had been greeted with incredulity, though this has now been increased to 12 to 14.
- Process measures are over-emphasised. More emphasis should be given to outcomes or proxies for outcomes in all sectors. CQC should work with providers and academics to devise outcome measures, where these are not currently available.
- Delays in getting reports out are far too long.
- When a report does arrive, it is of very limited value and bears little relation to what was found on the day of inspection.
- Scoring has increased (not decreased) inconsistency.
- Quality assurance of reports appears to have been lost.

- Rating characteristics should be brought back. The loss of the provider handbook contributes to the loss of transparency.

9.5 Specific views on the organisational restructure

Specific issues relating to the organisational restructure include:

- The loss of relationship owners is seen as a severe retrograde step. Providers no longer know who they should contact when things go wrong.
- The loss of inspectors who have knowledge and experience of the relevant sector contributes to the loss of confidence and credibility in CQC's current approach. This also contributes to the lack of consistency between inspections, which is observed by corporate providers in both independent health and adult social care.

10. Data and insight

The evidence CQC uses in assessments relies on data from both on-site activity and reviewing information published by external sources.

It is important to recognise that the data CQC receives are markedly different for NHS hospitals, primary care and adult social care. For NHS hospitals, mental health services and primary care services, several national datasets and surveys are collected. Some of these are run by NHS England (e.g. NHS Staff survey, Hospital Episode Statistics giving information on waiting times and the GP patient Satisfaction survey), while others are run by CQC. Equivalent national datasets are not generally available for independent hospitals or care homes, which are required to notify CQC each time various adverse events occur.

CQC continues to run several national surveys. These cover inpatients, maternity, children and young people, urgent and emergency care, and community mental health services. These provide useful information that can be compared between organisations. However, because of their limited size (63,000 in the case of the inpatient survey) they are only able to identify major outliers with statistical reliability. The maternity survey is now run annually.

The datasets that CQC uses relating to secondary health care enable outliers to be tracked, to support prioritisation of assessments. They should also contribute to the information packs needed for hospital and primary care inspections, and therefore to assessments, but this does not appear to be happening routinely.

Data sharing between national bodies has not been optimal, limiting the use of data by CQC.

Other potential sources of data are being explored by CQC. These include:

- The 32 national clinical audits commissioned by the Healthcare Quality Improvement Partnership (HQIP). CQC currently has access to data from 21 of these and work has started on a further 9.
- Indicators developed by Getting it Right First Time (GIRFT). CQC started to consider these in 2019/20, but these have not yet been incorporated into assessments/inspections.
- Information available from the Private Healthcare Information Network (PHIN) for independent acute hospitals. This includes Patient Reported Outcome Measures (PROMs), infection rates, never events and readmission rates. Independent sector hospitals also have a statutory duty to report to CQC on deaths, readmissions, transfers to NHS providers and re-operations.
- Electronic staff record (ESR) information on staff numbers, turnover and absence for all NHS trusts. However, it is unclear how this is being used in assessments.
- CQC is currently working with NHS England to re-develop indicators of patient safety following the introduction of the Learn from Patient Safety Events (LFPSE) service, which replaced the National Reporting and Learning System (NRLS) in June 2024.
- CQC is now close to having data from Hospital Episode Statistics and Mental Health Service datasets and is working with NHS England to pilot access to their analytical platform.

However, there are several obstacles to using data under the single assessment framework:

- Work on incorporating datasets into assessments of services has been hampered by the slow progress with the new regulatory platform.
- Little progress has been made on data and insight that is used as evidence in assessing providers since 2017, with the exception of primary care, where ‘clinical searches’ are giving valuable information.
- The provider information request (PIR), which was previously sent to healthcare providers around 3 months ahead of an inspection was paused in March 2020 and has not been reinstated., though this continues in adult social care.

11. Levels of activity, staffing and funding

To provide context for this review of the single assessment framework and its implementation as part of CQC’s new approach, the following need to be considered:

11.1. Activity

- 10,356 inspections were undertaken in 2022/23 and 10,306 in 2021/22. This compares with more than 16,000 in 2019/20.

- Only around 7,000 assessments and inspections were carried out in 2023/24 and only around 100 inspections per month have been undertaken so far in 2024.

11.2 Staffing

- Overall headcount and full-time equivalents (FTE) within CQC fell by around 3% between March 2020 and March 2023, but had increased by March 2024 to 5% above March 2020 levels. Most of the recent increase relates to staff working for the Maternity and Newborn Safety Investigations (MNSI) programme becoming part of CQC and to staff related to local authority assessments.
- Taking operations and regulatory leadership figures together, there was virtually no change in FTE between March 2020 and March 2023. However, this masks a considerable fall in the numbers of inspection/operation assessors/inspectors and inspection/operation managers over the same period and a marked growth in regulatory officers and 'other' staff.
- The overall number of staff working in registration increased by around 15% between March 2020 and March 2023, largely due to an increase in 'other' staff. Registration inspector numbers had fallen by around 6% over the same period.

11.3 Income

- CQC receives the large majority (82% in 2023/24) of its funding through fees, with a much smaller proportion coming from Grant in Aid from the Department of Health and Social Care.
- Total fee income in 2023/24 was £223.3m. Adult social care provided 41% of fee income, with 32% coming from NHS trusts, 17% from GP practices, 5% from independent healthcare providers and 4% from dental practices.
- Provider fees have remained static since 2019/20. If they had risen in line with inflation, CQC would have received an additional £25.3m in 2023/24.
- Fee income from NHS trusts in 2019/20 represented 0.067% of their turnover.

12. Staff satisfaction

CQC undertook a People (staff) survey between 16 January and 6 February 2024. A total of 2,278 reposes were received, with a response rate of 78%. The headline findings were reported at the public board meeting in March 2024.

Almost all items showed a decline since the previous full survey in 2021, with 11 items declining by more than 10%. The table below shows percentages of positive responses for questions asked in 2021 compared with 2024.

	2021	2024	% Difference
Values and behaviours of executive leaders	55%	27%	-28%
Values and behaviours of senior leaders	64%	44%	-20%
My work helps to improve care	85%	66%	-19%
I am proud to work here	71%	56%	-15%

The largest declines were among operational staff.

Other concerns included:

- how people are supported by leaders
- not being listened to enough
- concerns not being acted on
- change not being implemented effectively.

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.

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.

Final comment

It is important to note that over a period of 3 years between 2013/14 and 2016/17, all acute hospitals, mental health services, community services, ambulance services, primary medical services and adult social care services were inspected and rated by CQC.

The task is possible, as long as an adequate number of inspection staff are recruited and trained and are working in sectors with which they have knowledge and expertise, and as long as the methodology used is fit for purpose. It can and must be done again now.

Appendix 1: The 34 quality statements

Safe key question

Safety is a priority for everyone and leaders embed a culture of openness and collaboration. People are always safe and protected from bullying, harassment, avoidable harm, neglect, abuse and discrimination. Their liberty is protected where this is in their best interests and in line with legislation.

1. **Learning culture**: We have a proactive and positive culture of safety based on openness and honesty, in which concerns about safety are investigated and reported thoroughly, and lessons are learned to continually identify and embed good practices.
2. **Safe systems, pathways and transitions**: We work with people and our partners to establish and maintain safe systems of care, in which safety is managed, monitored and assured. We ensure continuity of care, including when people move between different services.
3. **Safeguarding**: We work with people to understand what being safe means to them as well as with our partners on the best way to achieve this. We concentrate on improving people's lives while protecting their right to live in safety, free from bullying, harassment, abuse, discrimination, avoidable harm and neglect. We make sure we share concerns quickly and appropriately.
4. **Involving people to manage risks**: We work with people to understand and manage risks by thinking holistically so that care meets their needs in a way that is safe and supportive and enables them to do the things that matter to them.
5. **Safe environments**: We detect and control potential risks in the care environment. We make sure that equipment, facilities and technology support the delivery of safe care.
6. **Safe and effective staffing**: We make sure there are enough qualified, skilled and experienced people, who receive effective support, supervision and development. They work together effectively to provide safe care that meets people's individual needs.
7. **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.
8. **Medicines optimisation**: We make sure that medicines and treatments are safe and meet people's needs, capacities and preferences by enabling them to be involved in planning, including when changes happen.

Effective key question

People and communities have the best possible outcomes because their needs are assessed. Their care and support and treatment reflects these needs and any protected equality characteristics. Services work in harmony, with people at the centre of their care. Leaders instil a culture of improvement, where understanding current outcomes and exploring best practice is part of everyday work.

9. **Assessing needs**: We maximise the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.
10. **Delivering evidence-based care and treatment**: We plan and deliver people's care and treatment with them, including what is important and matters to them. We do this in line with legislation and current evidence-based good practice and standards.
11. **How staff and teams work together**: We work effectively across teams and services to support people. We make sure they only need to tell their story once by sharing their assessment of needs when they move between different services.
12. **Supporting people to live healthier lives**: We support people to manage their health and wellbeing so they can maximise their independence, choice and control. We support them to live healthier lives and where possible, reduce their future needs for care and support.
13. **Monitoring and improving outcomes**: We routinely monitor people's car and treatment to continuously improve it. We ensure that outcomes are positive and consistent, and that they meet both clinical expectations and the expectations of people themselves.
14. **Consent to care and treatment**: We tell people about their rights around consent and respect these when we deliver person-centred care and treatment.

Caring key question

People are always treated with kindness, empathy and compassion. They understand that they matter and that their experience of how they are treated and supported matters. Their privacy and dignity is respected. Every effort is made to take their wishes into account and respect their choices, to achieve the best possible outcomes for them. This includes supporting people to live as independently as possible.

15. **Kindness, compassion and dignity**: We always treat people with kindness, empathy and compassion and we respect their privacy and dignity. We treat colleagues from other organisations with kindness and respect.
16. **Treating people as individuals**: We treat people as individuals and make sure their care, support and treatment meets their needs and preferences. We take account of their strengths, abilities, aspirations, culture and unique backgrounds and protected characteristics.
17. **Independence, choice and control**: We promote people's independence, so they know their rights and have choice and control over their own care, treatment and wellbeing.
18. **Responding to people's immediate needs**: We listen to and understand people's needs, views and wishes. We respond to these in that moment and will act to minimise any discomfort, concern or distress.
19. **Workforce wellbeing and enablement:** We care about the wellbeing of our staff, and we support and enable them to deliver person-centred care.

Responsive key question

People and communities are always at the centre of how care is planned and delivered. The health and care needs of people and communities are understood and they are actively involved in planning care that meets these needs. Care, support and treatment is easily accessible, including physical access. People can access care in ways that meet their personal circumstances and protected equality characteristics.

20. **Person centred care**: We make sure people are at the centre of their care and treatment choices and we decide, in partnership with them, how to respond to any relevant changes in their needs.
21. **Care provision, integration, and continuity**: We understand the diverse health and care needs of people and our local communities, so care is joined-up, flexible and supports choice and continuity.
22. **Providing information:** We provide appropriate, accurate and up-to-date information in formats that we tailor to individual needs.
23. **Listening to and involving people:** We make it easy for people to share feedback and ideas or raise complaints about their care, treatment and support. We involve them in decisions about their care and tell them what's changed as a result.
24. **Equity in access:** We make sure that everyone can access the care, support and treatment they need when they need it.
25. **Equity in experiences and outcomes:** We actively seek out and listen to information about people who are most likely to experience inequality in experience or outcomes. We tailor the care, support and treatment in response to this.
26. **Planning for the future**: We support people to plan for important life changes, so they can have enough time to make informed decisions about their future, including at the end of life.

Well-led key question

There is an inclusive and positive culture of continuous learning and improvement. This is based on meeting the needs of people who use services and wider communities, and all leaders and staff share this. Leaders proactively support staff and collaborate with partners to deliver care that is safe, integrated, person-centred and sustainable, and to reduce inequalities.

27. **Shared direction and culture**: We have a shared vision, strategy and culture. This is based on transparency, equity, equality and human rights, diversity and inclusion, engagement, and understanding challenges and the needs of people and our communities in order to meet these.
28. **Capable, compassionate and inclusive leaders**: We have inclusive leaders at all levels who understand the context in which we deliver care, treatment and support and embody the culture and values of their workforce and organisation.

They have the skills, knowledge, experience and credibility to lead effectively. They do so with integrity, openness and honesty.

29. **Freedom to speak up**: We foster a positive culture where people feel that they can speak up and that their voice will be heard.
30. **Workforce equality, diversity and inclusion**: We value diversity in our workforce. We work towards an inclusive and fair culture by improving equality and equity for people who work for us.
31. **Governance, management and sustainability**: We have clear responsibilities, roles, systems of accountability and good governance. We use these to manage and deliver good quality, sustainable care, treatment and support. We act on the best information about risk, performance and outcomes, and we share this securely with others when appropriate.
32. **Partnerships and communities**: We understand our duty to collaborate and work in partnership, so our services work seamlessly for people. We share information and learning with partners and collaborate for improvement.
33. **Learning, improvement and innovation**: We focus on continuous learning, innovation and improvement across our organisation and the local system. We encourage creative ways of delivering equality of experience, outcome and quality of life for people. We actively contribute to safe, effective practice and research.
34. **Environmental sustainability, sustainable development**: We understand any negative impact of our activities on the environment and we strive to make a positive contribution in reducing it and support people to do the same.

Appendix 2: Regulations most relevant to assessment of providers

Health and Social Care Act 2008 (Regulated activities) Regulations 2014:

ABBREVIATED COMMENTS ONLY.

Regulation 9: Person centred care – Care and treatment must be appropriate, meet their needs and reflect their preferences.

Regulation 10: Dignity and respect – Privacy, autonomy, independence and protected characteristics.

Regulation 11: Need for consent – Care and treatment of service users must only be provided with the consent of the relevant person (unless they lack capacity to do so).

Regulation 12: Safe care and treatment – Assessing risks to health and safety of service users; mitigating risks; ensuring competence of staff; premises; equipment; medicines; infection prevention and control; care planning for transfers of care.

Regulation 13: Safeguarding service uses from abuse and improper treatment: Systems and processes; restraint; not depriving liberty without lawful authorisation.

Regulation 14: Meeting nutritional and hydration needs

Regulation 15: Premises and equipment – (Clean, secure, suitable, properly used and maintained, appropriately located.

Regulation 16: Receiving and acting on complaints.

Regulation 17: Good governance – Systems and processes to assess, monitor and improve the quality and safety of the services provided; mitigate risks; maintain records of service users.

Regulation 18: Staffing – Sufficient numbers of suitably qualified, competent, skilled and experienced person; support, training and development for staff; staff meeting professional standards.

Regulation 19: Fit and proper persons employed – Persons of good character; qualifications, competence, skills and experience; able to perform the tasks required (subject to reasonable adjustments).

Regulation 20: Duty of candour – A health service body must act in an open and transparent way as soon as is reasonably practicable after a notifiable safety incident has occurred, including an apology. Reasonable support must be given to the service user. A written record must be kept.

Appendix 3: Survey findings related to transformation programme

1. Care England survey (April 2024)

This survey received 67 responses from adult social care providers representing 85,000 beds (around 20% of adult social care beds)

Statement: I believe that:	**Agree/agree strongly**	**Disagree/disagree strongly**
CQC treats all ASC providers consistently and fairly	12%	68%
CQC support the wellbeing of staff during an assessment	17%	54%
Current routes to challenge an assessment are fair and proportionate	11%	63%
The work CQC does with ASC providers improves the quality of care and promotes…	29%	40%
CQC inspectors have the appropriate skills and training to fulfil their role to a satisfactory level	15%	58%
I feel satisfied with the frequency of inspections/ratings	14%	72%

Percentage of responses to the question:

What quality rating would you give CQC?

Inadequate	41%
Requires improvement	52%
Good	6%
Outstanding	0%

2. Homecare association survey (August 2024)

Care quality Commission: Regulatory performance in home care. Jane Townson OBE for the Homecare Association.

75 responses regarding satisfaction with CQC

Dissatisfied	44 (58%)
Somewhat dissatisfied	15 (20%)
Neither satisfied nor dissatisfied	11 (15%)
Somewhat satisfied	3 (4%)
Satisfied	2 (3%)

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