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on the day BRIEFING

NHS Providers

Interim report into the operational effectiveness of CQC

Today, the Department of Health and Social Care (DHSC) published an interim report from Dr Penny Dash into the operational effectiveness of the Care Quality Commission (CQC). Dr Dash's full report will be published in the autumn. The Secretary of State for Health and Social Care responded to the report announcing steps the department and CQC would take immediately as a result. CQC's interim chief executive also issued a response.

This briefing sets out an overview of Dr Dash's interim findings, the government's and CQC's responses, and NHS Providers' view of the report.

Introduction

Dr Dash, chair of North West London Integrated Care Board, was commissioned to undertake this review of CQC's operational effectiveness in May 2024 by the previous government as part of an assessment of public bodies under the Cabinet Office Public Bodies Review Programme. On assuming the office of Secretary of State for Health and Social Care, Wes Streeting asked Dr Dash to produce an urgent interim report.

Dr Dash has conducted interviews with around 170 senior managers, caregivers and clinicians across the health and care sector, as well as more than 40 senior managers and national advisers at CQC. She has met NHS Providers as part of these discussions. Interviews with patients and service users are scheduled and will take place prior to the publication of the more detailed final report to ensure the final recommendations reflect their needs. The interim report is therefore a 'high-level summary of emerging findings'. The review will consider CQC's approach to assessing local authorities and integrated care systems in its final report but does not do so here.

The interim report sets out five emerging findings, and articulates six concerns about the single assessment framework (SAF). It then makes five recommendations. There are five appendices setting out supplementary data, quality and safety history and context, the terms of reference of the review, a participants list, and an overview of CQC's assessment model before the SAF was introduced.

Emerging findings and recommendations

The five emerging findings are:

1. Poor operational performance
2. Significant challenges with the provider portal and regulatory platform
3. Considerable loss of credibility within the health and care sectors due to the loss of sector expertise and wider restructuring
4. Concerns around the SAF
5. Lack of clarity about how ratings are calculated and the use of previous inspection outcomes

The review recommends:

1. Rapidly improve operational performance
2. Fix the provider portal and regulatory platform
3. Rebuild expertise within the organisation and relationships with providers in order to resurrect credibility
4. Review the SAF to make it fit for purpose
5. Clarify how ratings are calculated and make the results more transparent particularly where multi-year inspections and ratings have been used

These are set out in more detail below.

1. Poor operational performance

The report identifies evidence of poor CQC performance, including:

- Less than half the number of inspections were carried out in 2023-24 compared to 2019-20.
- The average 'age' of current provider ratings is 3.7 years, and the oldest rating for an NHS hospital is from June 2014.
- At year end 2023/24, 54% of pending provider registration applications were more than ten weeks old.
- Reports and ratings could take several months following an inspection, losing time in which quality improvements could have been made.
- One in five of the locations the CQC has the power to inspect have never been inspected.

Recommendation: rapidly improve operational performance

The report finds the interim chief executive is making progress already, bringing in more staff. CQC should agree performance targets in key areas, in conjunction with DHSC, to drive and track progress. Given delays starting ICS assessments, those staff might move to other teams.

2. Significant challenges with the provider portal and regulatory platform

The deployment of new systems designed to improve operations and communication with providers had resulted in significant issues for users. It was not easy to upload documents and took too long to receive password resets, causing providers considerable frustration and lost time.

Recommendation: fix the provider portal and regulatory platform

CQC should set out how and by when, and work with providers to seek feedback.

3. Considerable loss of credibility within the health and care sectors due to the loss of sector expertise and wider restructuring

When the CQC was restructured, sectoral knowledge was removed from assessment and inspection teams, placing far more reliance on generalists. The current executive team, the report says, lacks healthcare experience and should reflect the balance between health and social care. Lack of sector expertise means providers do not trust the outcomes of inspections nor have the chance to learn from experts in their fields.

Regular, welcome interaction between chief inspectors and senior leaders in health and care had been lost, and at a local level relationship-building with regular inspection teams was not taking place. This had previously built confidence, and enabled early awareness of emerging problems and the wider sharing of good practice.

Recommendation: rebuild expertise within the organisation and relationships with providers in order to resurrect credibility

Urgently appoint senior clinicians as chief inspector of hospitals and chief inspector of primary care, and work with them and national professional advisers to rapidly rebuild sector expertise in all teams, as well as ensuring the leadership team rebuilds relationships and shares progress. The review also recommends CQC consider a reward programme where top performing managers along with carers and clinicians are appointed as assessors for a few weeks per year.

4. Concerns around the SAF

The report describes the rollout and approach of the SAF, and then sets out six concerns the review has identified, with further explanations against each of them:

1. There is no description of what 'good' or 'outstanding' care looks like, resulting in a lack of consistency in how care is assessed and a lost opportunity for improvement.

Providers struggle to know what inspectors are looking for, are not learning from them, and so do not know what to do to improve. Many providers told the review about a lack of consistency in ratings awarded.

2. There is a lack of focus on outcomes (including inequalities in outcomes).

While there is an evidence category for outcomes in the SAF, the review found little evidence of assessments and inspections considering the outcomes of care in practice, and when they were considered there only a very narrow set of metrics had been reviewed. The report notes various data sets that are currently available that could be used by CQC but are not, and there was no reference to outcomes by different population groups.

3. The way in which the SAF is described is poorly laid out on the CQC website and not well communicated internally or externally.

The website was found to be confusing and senior CQC employees could not adequately describe how the framework should work.

4. The data used to understand the user voice and experience, how representative the data is, and how it is analysed for the purpose of informing inspection, is not sufficiently transparent.

Dr Dash acknowledges CQC's intention to place greater emphasis on people's experience of care, but found it difficult to establish what data CQC looked at and what was considered a relevant, representative sample. She noted that CQC does currently assess providers on actively hearing from those who are more likely to have a poorer experience of care or face barriers accessing services.

5. There is no reference to use of resources or efficient delivery of care in the assessment framework which is a significant gap despite this being stated in section 3 of the Health and Social Care Act 2008.

Information on use of resources can be requested by CQC from NHS England but the review found that this was rarely done. The review highlights that efficiency is within the scope of the CQC and suggests recognised metrics for measuring efficiency and good use of resources.

6. The review had found limited reference to innovation in care models or ways of encouraging the adoption of these.

The review did not find CQC systematically considered how well providers were innovating, for example in the use of technology or setting up elective care centres. This was a missed opportunity. The review compares CQC unfavourably with Ofsted (the education regulator) in this respect.

Recommendation: review the SAF to make it fit for purpose

The SAF should be reviewed to address each of the concerns articulated above.

5. Lack of clarity about how ratings are calculated and the use of previous inspection outcomes

The review finds that it 'cannot be credible or right' that overall ratings for a provider may be calculated by aggregating inspection outcomes over several years. Because the CQC is not doing enough inspections to update ratings, the intention of the CQC to phase this practice out over time has not been achieved. The report says the CQC intends to mitigate this by using individual quality statement and domain scores instead of aggregated ratings, and by assessing more quality statements.

Providers had told the review they did not understand how ratings are calculated: CQC needed to be credible and transparent. The review states CQC was seeking to bring greater clarity.

Recommendation: clarify how ratings are calculated and make the results more transparent particularly where multi-year inspections and ratings have been used

The approach should be clear to all providers and users, and the use of multi-year assessments in calculating ratings should be reconsidered, with greater transparency given to how these are used in the meantime.

Next steps

The final report will contain more data and detail, more analysis, and include the perspectives of patients and service users who were not interviewed due to the pre-election period. Local authority and ICS assessments will also be considered.

The review recommends that DHSC should enhance its oversight of CQC, to include more regular (monthly) performance review conversations, ideally with relevant directors general present.

Government and CQC responses

DHSC issued a press release setting out four immediate actions it and CQC would take:

- The appointment by CQC of Professor Sir Mike Richards (a former hospital physician and CQC's chief inspector of hospitals 2013-2017) to review CQC assessment frameworks.
- Improving transparency in how the CQC determines its ratings for health and social care providers.
- Increased government oversight of CQC, with CQC regularly updating the department on progress, to ensure that the recommendations in the final review are implemented.
- Asking Dr Dash to review the effectiveness of all patient safety organisations.

The Secretary of State said "When I joined the department, it was already clear that the NHS was broken and the social care system in crisis. But I have been stunned by the extent of the failings of the institution that is supposed to identify and act on failings. It's clear to me the CQC is not fit for purpose".

CQC's interim chief executive, Kate Terroni, said CQC accepted the findings and recommendations in full and the organisation was "working at pace and in consultation with our stakeholders to rebuild trust and become a strong, credible, and effective regulator of health and care services".

She also highlighted work that was already underway at CQC to improve the use of their new regulatory approach (single assessment framework), increase the number of people working in provider registration, fix their provider portal, and to design other solutions with providers.

NHS Providers view

This interim report highlights significant concerns about operational effectiveness, loss of credibility and a lack of consistency at CQC and will be of great concern to providers of health and care, and to patients using those services. We welcome the report, its emerging findings and its recommendations.

Trusts have been concerned about many of the issues outlined here for a significant period of time, as set out in our annual regulation surveys and our recent Good Quality Regulation report.

Trusts will welcome the opportunity to work with CQC to rebuild relationships and restore faith in CQC. Regulation plays a crucial role in public services, especially in high-risk areas like the NHS, where strong leadership, effective processes, and robust governance are essential for ensuring safety. Trust leaders acknowledge that independent regulation and oversight are valuable for offering impartial assessments, constructive challenges, and ensuring transparency and accountability to both service users and taxpayers. Effective independent oversight also helps maintain focus on national priorities and provides necessary support and assistance for areas requiring improvement.

The role of the regulator enhances the functions of the trust board, but does not replace it. Trust boards remain crucial for offering strong leadership, ensuring good governance, and fostering the capacity and capability for self-reflection within the organisation. Regulation is mostly retrospective, focusing on evaluating past performance and rectifying identified issues. In contrast, trust boards are responsible for assuring the quality of care in the present and proactively seeking future improvements.

Trusts have consistently voiced concerns about the need for improved relationships with CQC, echoing the review's observations on the detrimental effects of separating sectoral knowledge from assessment and inspection teams. The move to a greater reliance on generalists, the lack of experience and skills on inspection teams, and the poor quality of subsequent reports, have damaged the confidence providers have in the regulator, and hindered opportunities for meaningful improvements.

The recommended reintroduction of sector-specific expertise is to be welcomed, but we would also recommend CQC continues to invest in improving the training, as well as the conduct and behaviour of its inspection teams.

We also agree with the findings of the review that there is a significant lack of clarity regarding the calculation of ratings, and that long gaps between inspections have left trusts unable to demonstrate improvements that have been made.

On the SAF, we recognise the implementation challenges for the regulator and we and our members would welcome further engagement as CQC works to improve.

A key recommendation in our Good Quality Regulation report is for the regulator to support providers to innovate, share best practice, and focus conversations towards improvement. We will

continue to advocate for this change in approach from CQC, recognising the potential of the regulator as a driver for improvement.

We are keen to continue to engage with CQC's leadership team on our members' behalf, including Professor Sir Mike Richards, and would welcome the opportunity to continue to work with Dr Dash during the subsequent phases of her review. We look forward to the final report and to continued engagement during implementation of recommendations.

NHS Providers press statement

Responding to the government's intervention in response to failings at CQC the chief executive of NHS Providers, Sir Julian Hartley, said:

"Trust leaders will welcome this announcement.

"Based on their clear and consistent feedback, we have been calling for urgent reform of the CQC.

"We fully agree with these recommendations.

"Winning back credibility for the CQC will take a lot of work.

"We recognise the important role of regulation in the NHS, but for that to really add value you need good behaviours, effective leadership, the right expertise and close attention to the issues that matter.

"Our recent report Good quality regulation underlined the need for the CQC to focus more on support and improvement.

"There are elements in the current approach to build on, but the key is always in the implementation.

"We welcome the return of Professor Sir Mike Richards and look forward to continuing our close dialogue with Dr Penny Dash."

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