CARE ENGLAND

Representing independent care providers

THE DASH REVIEW

An executive summary of the Dr. Penny Dash Review into the CQC.

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Overview of the Dr. Penny Dash Review

The Dr. Penny Dash's review into the operational effectiveness of the CQC concluded that there were several critical issues, including:

1. **poor** operational performance
2. **significant challenges** with the provider portal and the regulatory platform
3. **poor** presentation of reports and **delays** in their production
4. **loss of credibility** within the health and care sectors **due to the loss of sector expertise** and wider restructuring, resulting **in lost opportunities** for improvement
5. concerns around the single assessment framework (SAF)...
    a. *...[in] the way in which the SAF is described is **poorly laid out** on the CQC website and not well communicated internally or externally.*
    b. *...[that] 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.*
    c. *...[that] the data used to understand the user voice and experience is **not sufficiently representative** of users and patients*
    d. *...[that] there is **limited reference to innovation** in care delivery*
    e. *...[that] there is **insufficient attention paid** to the effectiveness of care and a lack of focus on outcomes (including inequalities in outcomes)*
    f. *...[that] there is **no reference to use of resources** or efficient delivery of care in the assessment framework despite this being stated in section 3 of the Health and Social Care Act 2008*
    g. *...[that] there is **little reference to, or acknowledgement of**, the challenges in balancing risk and ensuring high quality care across an organisation or across a wider health and care system*
6. lack of clarity regarding **how ratings are calculated** and concerning use of the outcome of previous inspections (often several years ago) to calculate a current rating
7. There are **opportunities to improve** CQC's assessment of local authority care act duties
8. Integrated Care System (ICS) assessments are in early stages of development with a number of concerns shared
9. CQC **could do more to support** providers to improve quality across the health and care sector
10. There are opportunities **to improve the sponsorship relationship** between CQC and the DHSC

The report notes that these issues have which have led to a substantial loss of credibility within the health and social care sectors, a deterioration in the ability of CQC to identify poor performance and support a drive to improved quality and a direct impact on the capacity and capability of both the health and social care sectors to deliver much needed improvements in care.

The review has heard that many people within CQC tried to raise concerns about the changes made over the last few years; and members of CQC's staff forum, trade union representatives at CQC, senior professional advisors and a number of executives all raised concerns about the changes being implemented but did not feel listened to.

The scale and consistency of comments received from former CQC staff is striking. The review received more than 125 emails providing a consistent account of the last couple of years and has seen two letters from the recognised trade unions of CQC to former Secretaries of State to Health and Social Care informing them of significant issues.

Several areas have been brought to the attention of the review team but have yet to be examined in detail. **These include:**

1. One-word ratings
2. Finances within CQC - both how CQC is funded and the costs of running the organisation efficiently and effectively
3. The need to ensure the Federated Data Platform results in a single "data lake" across the health and social care sectors

4. The wider regulatory landscape and the burden of regulation including the relationship between CQC and NHS England oversight framework

The review sets forth seven key recommendations:

1. **Rapidly improve operational performance**, fix the provider portal and regulatory platform, urgently address issues raised re managing safeguarding and serious untoward incidents, improve use of performance data within CQC and improve the quality and timeliness of reports.
2. **Rebuild expertise within the organisation** and relationships with providers in order to resurrect credibility.
3. **Review the SAF** to make it fit for purpose with clear descriptors, a far greater focus on effectiveness, outcomes, innovative models of care delivery and use of resources.
4. **Clarify how ratings are calculated** and make the results more transparent
5. Continue to **evolve and improve local authority assessments**
6. Formally **pause ICS assessments**
7. **Strengthen sponsorship arrangements** to facilitate CQC's provision of accountable, efficient and effective services to the public

The review sets out the following timeline for action and next steps after its publication:

Over the next 4 months, phase 2 of this work will report on proposed improvements to the wider regulatory landscape for quality of care, with a focus on patient safety.

Over the next 6 months, there needs to be rapid improvements to operational performance within CQC and significant steps taken to rebuilding expertise within CQC, and fostering stronger relationships with providers and the wider sectors in order to resurrect credibility.

Over the next 12 months, the SAF needs to be fundamentally enhanced with a review of quality statements, far greater emphasis on effectiveness, outcomes, innovation and use of resources and clear descriptors for each quality statement or evidence category.

The issues in depth

Poor Operational Performance

- Just 6,700 inspections and assessments were carried out in 2023 to 2024 partly due to the roll-out of the SAF. This compares to 15,800 inspections conducted in 2019 to 2020.
    i. *CQC's business plan for 2024 - 2027 includes a target for 16,000 assessments to be carried out in 2024 to 2025.*

- There is a backlog in registrations of new providers. According to CQC's 'Corporate performance report (2023/24 year end), at the end of 2023 to 2024, 54% of applications pending completion were more than 10 weeks old.
    i. *CQC has a key performance indicator (KPI) to reduce this proportion, but it increased from 22% at the end of 2022 to 2023.*

- The review heard from some stakeholders that re-inspection of social care providers after awarding a 'requires improvement', or 'inadequate' rating does not happen in a timely manner, leaving providers "stuck in requires improvement" despite making the changes required.
    i. *Data from CQC shows that the time taken to carry out a re-inspection after an 'inadequate' rating has increased from 87 days in 2015 to 136 days in 2024, and the time to carry out a re-inspection following a 'requires improvement rating' has risen from 142 days to 360 days in the same time frame.*
    ii. *Interviewees told the review that this could result in hospital discharge teams refusing to discharge people to them, or LAs refusing to contract with providers, impacting on capacity, staff morale, and overall ability of providers to operate sustainably.*

- Data provided by CQC suggests that the oldest rating for a social care organisation is from February 2016 (over 8 years old) and the oldest rating for an NHS hospital (acute non-specialist) is from June 2014 (around 10 years old).

- When inspections have been carried out, they are increasingly limited to a few service areas or quality domains. Of inspections carried out at 646 locations between 1 January 2024 and 30 July 2024, 43% were assessments were under the new SAF, over a third were focused and one fifth comprehensive. In 2023, 52% had focused and 48% had comprehensive inspections. This compares to years 2015 to 2019 when over 90% of locations had "comprehensive" inspections.

- Data provided by CQC estimates that the average age of current location ratings 'overall' is 3.9 years.
    i. *Further, of the locations CQC has the power to inspect, CQC estimate that around 19% have never been rated.*

- Care home quality leads told the review they end up relying on local authority provider assessment and market management solution reports to provide an objective view of quality.

- Providers told the review that they can wait for several months to receive reports and ratings following assessments.
    i. *This increases the burden on, and stress of, staff and results in lost time when quality improvements could have been made.*

- The performance of CQC's call centre is poor. Data from CQC shows the average time for calls to be answered between January and June 2024 was 19 minutes.

- CQC does have a KPI to achieve a 60% to 80% response rate on its national customer service centre call lines and this was achieved in 2023 to 2024 with a response rate of between 63% to 76% across the 4 lines. This means that between a quarter and a third of calls were dropped before they were answered.

- More recent results with data shared by CQC for 2024/25 year-to-date call centre data showed that 79% of general enquiry-related calls were answered before the caller rang off and 76% of those related to mental health.
    i. *For calls related to registrations, this had the lowest percentage answered at 66% and the greatest percentage of calls abandoned at 34%, equivalent to nearly 19,000 calls.*

- Almost a third of safeguarding-related calls were abandoned despite an average wait of only around 7 minutes.

The review has concluded that poor operational performance is impacting CQC's ability to ensure that health and social care services provide people with safe, effective, compassionate care, is negatively impacting the opportunity to improve health and social care services, and, in some cases, for providers to deliver services at all.

Significant challenges with the provider portal and the regulatory platform

- The review heard the deployment of new systems resulted in significant problems for users, which takes staff away from delivering or supporting front-line care and causes considerable frustration.

- The review heard of a number of issues with how the new system and regulatory platform is managing safeguarding concerns and reports of serious untoward incidents.

- The new system distributes most referrals to the National Customer Service Centre (NCSC) rather than through a CQC employee. This has led to a high proportion of referrals not containing adequate information for the local authority to act on.

The review has concluded that poorly-performing IT systems are hampering CQC's ability to roll out the SAF and appropriately manage concerns raised with CQC and cause considerable frustration and time loss for providers and CQC staff.

Poor quality of reports and delays in producing them

- The review has heard multiple comments about poor quality reports - these have come from providers and from members of the public. Specific issues raised include:

    i. *Poor structuring of reports which are hard to read and follow*

    ii. *Different messages in summaries than in the main report*

    iii. *Some sections copied from other providers*

    iv. *Disparity between the tone and evidence used in a report and the subsequent rating awarded*

    v. *Difficulty for users in understanding assessment reports, lacking explanation of type of residents, and limited information on number of beds*

    vi. *Lack of clarity in dates of assessments e.g. providing a recent date for an update yet information gathered by CQC often years before, without clear explanation*

vii. A lengthy and complicated scoring system which is not easy to understand

The review has concluded that poor quality reports hamper users' ability to access information and limit the credibility and impact of assessments for providers.

Loss of credibility within the health and care sectors due to the loss of sector expertise and wider restructuring, resulting in lost opportunities for improvement

- The review heard that "the new structure may result in situations where there is an isolated single person, with a mental health background or knowledge of mental health, on an inspection team looking at a mental health unit." - Senior executive at CQC

- While the review recognises that prior experience of a sector is not a prerequisite for someone to be a credible assessor and that experience does not, in itself, bring credibility, the review has heard consistently from providers about a reduction in expertise and seniority of inspection teams over the last couple of years.

- The lack of sector expertise results in providers not trusting the outcomes of reviews and not feeling they have the opportunity to learn from others, especially from highly-regarded peers.

- This lack of expertise has been compounded by a reduction in ongoing relationships between CQC staff and providers.

The review has found that the current model of generalist inspectors and a lack of expertise at senior levels of CQC, combined with a loss of relationships across CQC and providers, is impacting the credibility of CQC, resulting in a lost opportunity to improve health and social care services.

Concerns around the single assessment framework (SAF)

- Typically there are between 5 and 12 priority quality statements assessed depending on the sector or sub sector being assessed. The review found that the average number of quality statements currently used on inspection is 9.2 or just under a third of the total 34 quality statements.

- The review identified 7 concerns with the SAF:

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

- The SAF is instead described on CQC's website in a way that the review found confusing. Poorly-laid-out papers lack structure and numbering and do not have a summary.

- The review has found that across the executive team, few were able to describe the 34/6 framework (34 quality statements and 6 evidence categories), the rationale for prioritising particular quality statements in each sector, the rationale for which evidence categories are used for different quality statements, the way in which ratings are calculated and so on.

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.

- There is a lack of a description regarding what 'good' looks like for each quality statement and evidence category.

- The lack of a description of what 'good' or 'outstanding' looks like does not support organisations to improve.

- The review also heard that inspectors struggled to articulate the SAF and the definitions they should be working to.

- Many providers referred to subjectivity and a lack of consistency in ratings awarded to providers. Those who work across multiple sites, for example a large care home provider with multiple sites or a large group of GP practices, report ratings differing from one site to another, when they know that the differences are not as being reported.

The data used to understand the user voice and experience is not sufficiently representative of users and patients.

- The review found it hard to build a clear picture of exactly what data is looked at and how this feedback is used to prioritise inspections, with further consideration taking place in a second review.

- The review has not found any published description of the statistical analysis applied by CQC to these, what response rate is required and how representation across users, patients and staff is ensured.

- The review heard from users, patients and their representative groups that CQC is open to receiving feedback on services but that it doesn't seem to be used in a meaningful way.

There is limited reference to innovation in care delivery

- The review did not find evidence of a systematic consideration of how well organisations are innovating care delivery.

- CQC has attempted to support digitisation of social care records by including the adoption of records as a measure of best practice in the single assessment framework However, this has been undermined by the varied levels of digital maturity, skills and confidence of inspectors - with some inspectors requesting for printouts of digital records

There is insufficient attention paid to the effectiveness of care and a lack of focus on outcomes (including inequalities in outcomes)

- Of the assessments carried out using the single assessment framework up until July 2024, 75% of assessments have focused on the safe domain with only 38% looking at effectiveness. 90% of social care assessments looked at 'safe' with this only being 22% in primary care.

- Within the framework there is an evidence category for outcomes data but surprisingly little attention given to the outcomes of care. For example, within primary care, only 2 of the 99 quality statements and evidence categories considered refer to outcomes of care.

- A number of providers commented that inspections tended to concentrate on more trivial issues. For example, at a primary care providers roundtable, the review heard that the failure to calibrate 1 out of 15 sets of weighing scales was reported on. Other providers referred to an over focus on documentation of things like fire safety or employment practices which, while being important, should not be done at the expense of assessing all quality domains/key questions.

- The review was similarly to see the lack of measures of outcomes in independent sector providers, particularly given the emphasis on this in the Paterson Inquiry Report.

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

- The review was asked to consider how efficient delivery of care is assessed. However, within the SAF there is no quality statement that considers use of resources.

- The review understands that inspectors are encouraged to discuss staffing levels with providers before making an assessment but there appears to be a disconnect between CQC policy on this issue and providers' experience of inspections

- It is not clear how the 'safe-staffing' levels in the guidance are set and whether they are grounded in an efficient model of care or promote scenarios where technology, scale and optimal process management are used to best effect. CQC should clarify the evidence base or lack thereof.

- An independent regulator should not be assessing against provider-stipulated inputs but would be better to focus on overall outcomes for patients and users and challenge provider capture, as can be seen in other national regulators such as OFGEM

There is little reference to, or acknowledgement of, the challenges in balancing risk and ensuring high quality care across an organisation or across a wider health and care system

- The review has heard from a number of providers - and commissioners of care - about the lack of recognition within the SAF to the challenges in balancing risk in the health and care sectors.

- Providers have referred to a number of examples of where one aspect of care is assessed in isolation of the consequences for other areas of care and, therefore, other patients and users.

- Across health and care systems, the review heard of care homes refusing to accept users after 4pm as "it will be marked down by CQC" but this then leading to further time in hospital with implications for the user themself and then a knock-on impact on people awaiting admission to hospital.

Lack of clarity regarding how ratings are calculated and concerning use of the outcome of previous inspections (often several years ago) to calculate a current rating

- The review has been concerned to find that overall ratings for a provider may be calculated by aggregating the outcomes from inspections over several years. This cannot be credible or right.
    i. *CQC intends to mitigate this by using individual quality statement and quality domain scores instead of aggregated ratings, and by assessing more quality statements to improve robustness.*

- Further, providers do not understand how ratings are calculated and, as a result, believe it is a complicated algorithm. This results in a sense amongst providers that it is “impossible to change ratings”.
    i. *CQC is seeking to bring greater clarity to how ratings are calculated and is developing materials to facilitate communication and build transparency.*

Ratings matter - they are used by users and their friends and family, they are used by commissioning bodies and so drive effective use of capacity in the sector and they are a significant factor in staff recruitment and retention. **Ratings need to be credible and transparent.**

There are opportunities to improve CQC's assessment of local authority care act duties

- The review found broad support for the assessment framework as it is designed, in line with a wider sector response. However, it also heard feedback that the assessment process and reporting could be improved.

- A particular gap noted was in the commissioning of social care. The review was told that ministers who initiated the review of local authorities had expected that CQC would look at how effectively they were commissioning services.

- It is not clear from current assessments how comprehensibly commissioning functions are assessed which misses an opportunity to improve commissioning capabilities and, as a result, quality of care.

- Given that the approach to re-assessment is still to be designed, it is difficult to comment on the role of CQC in local authority improvement. The review understands CQC is in the process of designing reassessment with the sector.

Integrated Care System (ICS) assessments are in early stages of development with a number of concerns shared

- CQC developed a methodology for these assessments, which was tested in pilots but wider roll out has been paused. The concerns are:
  i. *ICSs have four objectives but the assessment process has not particularly focused on these objectives and it is not clear how progress against them will be measured.*
  ii. *lack of descriptors as to what does good look like, particularly recognising different structures/arrangements across ICSs*
  iii. *questions as to what specific data (metrics) should be considered to enable a meaningful assessment of leadership, integration and quality across an ICS*
  iv. *concerns around duplication of provider assessments - some data requests related to provider data which could/should have been considered in provider assessments rather than ICS assessments*
  v. *the need for CQC to recognise the challenges of clinical risk management in working effectively across multiple providers*
  vi. *difficulties in meaningfully hearing from residents about their views of quality of care across a whole system*
  vii. *the time taken to prepare for the CQC assessment and the associated costs - both direct (CQC fees) and indirect (time of staff), given this is on top of the costs for providers within an ICS*
  viii. *the need for CQC to recognise the challenges of clinical risk management in working effectively across multiple providers*

CQC could do more to support improvements in quality across the health and care sector

- The review heard a consistent comment that CQC should not be an improvement body per se, but, at the same time, could do more to support the health and care sectors to improve.

- There are opportunities for far more than this. Specifically:
  i. *the description of best practice, of good and outstanding delivery of care should be central to any inspection*
  ii. *reports need to be clearer with opportunities to improve set out and encouragement to develop clear action plans.*
  iii. *Inspection teams should inspire, as much as instruct - helping organisations to understand where there are opportunities for improvement and setting out what a better model of care could look like.*

iv. *many organisations, both within and outside the health and care sectors, take a very proactive approach to the collection of, and use of, user feedback*
v. *governance structures within organisations are key to improvement - with clear roles, responsibilities, and accountabilities, all aimed at continuously innovating and improving.*

There are opportunities to improve the sponsorship relationship between CQC and the DHSC

- The review has found that DHSC could do more to ensure that CQC is sponsored effectively, in line with the Government's Sponsorship Code of Good Practice. The *DHSC should do more*
  i. *To ensure that CQC is meeting its KPIs in key areas of operational performance*
  ii. *hold the CQC to account through regular discussion of timely management information linked to those KPIs*

- The National Quality Board (NQB) could/should play a key role in agreeing definitions of high-quality care, how to measure and quantify quality of care, how to think about effectiveness and use of resources, how to assess trade-offs/balance of risk considerations.

- The NQB had an initial presentation on the SAF in 2021, but this was high level and there was no further discussion beyond this. It is not clear how the NQB is working to:
  i. *ensure that recognised clinical outcomes metrics, national clinical audits and GIRFT analyses are used to a far greater degree in assessing quality of NHS providers or independent sector providers.*
  ii. *consider innovation in care delivery and how to embed that into providers through CQC.*
  iii. *consider use of resources and identifies how and where limited public funds could be spent more effectively*
  iv. *agree how to quantify use of resources to support optimal allocation of resources to improve health and wellbeing, and optimal deployment of resources within providers.*

Other areas for further consideration

One-word ratings

- Matters of one word ratings should consider complexity of a provider (number of different service lines), the variation in ratings across those different service lines, the variation in scores by quality domain/key question
- (and hence the representativeness of a single word rating) and the need for a simple narrative to be accessible for users and patients.

CQC Finances

- The current funding model presents a number of challenges, namely:
  i. *How to ensure efficient and effective service delivery from CQC when providers are obligated to pay*
  ii. *How to decide on fee levels*
  iii. *How to ensure that resources available match the requirements of CQC - while still remaining efficient and effective.*

  Greater consideration could be given to how to quantify the above - and where/how decisions re resourcing are made.

Single date lake across health and care sectors

- There is a significant opportunity to build a single repository of data on quality of care (including use of resources) across the health and care sectors. This would benefit CQC and would bring a more streamlined and efficient approach to performance management and improvement across all services.

- The Federated Data Platform was established to create a "single version of the truth" approach to data within healthcare.

- Consideration should be given to how best to build on this to have a common set of data about quality of care (across all domains) which could be used.

The wider regulatory landscape

- The wider regulatory landscape is extensive with a growth in the number of bodies over recent years. Overlapping responsibilities of these bodies can create confusion for providers and create an unhelpfully large burden of regulation

- A mapping of the regulatory landscape of healthcare identified over 100 organisations which exert some regulatory influence on NHS provider organisations and recommended a review to ensure more effective and responsive regulation.

Recommendations

Rapidly improve operational performance, fix the provider portal and regulatory platform, urgently address issues raised re managing safeguarding and serious untoward incidents, improve use of performance data within CQC and improve the quality of reports

- CQC should agree operational performance targets or KPIs in key areas, in conjunction with DHSC, to drive and track progress.

- CQC will need to set out how, and by when, it will make the changes required to the provider portal and regulatory platform.

- CQC should also ensure that there is far more consideration given to working with providers to seek feedback on progress.

- Urgent action is needed to ensure timely and appropriate response to concerns raised around safeguarding and serious untoward incidents.

- The quality of reports needs to be significantly improved with clear structure, labelling and findings.

Rebuild expertise within the organisation and relationships with providers in order to resurrect credibility.

- There is an urgent need to appoint highly-regarded senior clinicians as chief inspector of hospitals and chief inspector of primary and community care.

- Working closely with the chief inspectors and the national professional advisors, there should be rapid moves to rebuild sector expertise in all teams.

- Consideration should be given to a programme whereby the top performing managers (from across health and social care) along with carers and clinicians are appointed or apply to become assessors for 1 to 2 weeks a year with high accolade being given to being accepted on the programme.

- The leadership team of CQC - which should include the 3 chief inspectors - should rebuild relationships across the health and care sectors, share progress being made on improvements to CQC and continually seek input.

Review the SAF to make it fit for purpose with clear descriptors, a far greater focus on effectiveness, outcomes, innovative models of care delivery and use of resources.

- There needs to be a wholescale review of the SAF to address the concerns raised. Including:
    i. *Defining clear standards for 'outstanding', 'good', 'requires improvement', and 'inadequate' for each evidence category and quality statement.*
    ii. *Consulting credible sector experts to reassess and prioritize quality statements and how they should be measured.*
    iii. *Placing greater emphasis on the effectiveness domain and outcome measures (e.g., GIRFT, national clinical audits, social care equivalents).*
    iv. *Strengthening the focus on resource use within the "well-led" domain and building assessment capabilities.*
    v. *Recognising and balancing risks across organizations and adapting the SAF.*
    vi. *Enhancing the quality of documentation on the CQC website.*
    vii. *Ensuring staff are fully trained in conducting inspections under the SAF.*
    viii. *Improving transparency and data robustness regarding user and staff experience.*

ix. *Integrating knowledge of healthcare and social care innovation, including new models of care, into quality assessments.*

Clarify how ratings are calculated and make the results more transparent

- The approach used to calculate ratings should be transparent and clearly explained on CQC's website. It should be clear to all providers and all users.

- The use of multi-year assessments in calculating ratings and in reports should be reconsidered and greater transparency given to how these are being used in the meantime.

Continue to evolve and improve local authority assessments

- CQC should consider feedback they have received, alongside the findings in this review in order to improve the process of assessment, continuously improving its robustness and the experience of local authorities.

Formally pause ICS assessments

- Given the difficulties to date in agreeing how best to assess ICSs, a need to ensure alignment with NHS England oversight framework and considerable challenges within CQC, it is recommended that ICS assessments be paused for now with the nascent ICS assessment team redeployed within CQC.

Strengthen sponsorship arrangements to facilitate CQC's provision of accountable, efficient and effective services to the public

- DHSC should strengthen its arrangements for sponsorship of CQC, reaching an advanced level of maturity against the Sponsorship Code of Good Practice.

- This should be underpinned by more regular performance reviews between DHSC and CQC to reinforce and check progress against the recommendations in this report.

- Metrics for performance review should be enhanced with clear performance targets set for the next 6-12 months. Meetings should include senior civil servants at DHSC, ideally the relevant directors general, and should take place on a monthly basis.

- Service level agreements could be considered between providers and CQC to further reinforce accountability.