CARE ENGLAND

Representing independent care providers

# THE SINGLE ASSESSMENT FRAMEWORK REVIEW

A summary of Sir Mike Richard's investigation

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# Overview of the Professor Sir Mike Richards Review

The Professor Sir Mike Richard's review of CQC's single assessment framework and its implementation concluded that all 3 outlined initiatives:

- 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.

have failed to deliver on the benefits they intended and hindered the CQC's ability to fulfil its primary purpose, with the following adverse critical issues outlined:

- **CQC has failed to fulfil its purpose** of ensuring safe, high-quality care. Inspections have decreased, report publications are delayed, and providers are concerned about the inspection process and report quality.
- **Staff morale is low**, and many inspectors have left, feeling ignored by senior leadership. However, remaining staff are committed and eager for improvement.
- **Separation of policy and operational teams** means operational realities are not reflected in regulatory policy and strategy.
- **Clinical leadership in inspections has weakened**, with fewer Chief Inspectors than required, leading to a loss of direct oversight and visibility in the inspection process.
- **The single assessment framework is overly complex**, not fitting the diverse range of services CQC regulates, causing confusion and delays in report writing.
- **The regulatory platform has caused significant problems** for both CQC staff and providers, with no signs of improvement in its usability.
- **Staff morale is low, especially among inspectors**, with rising sickness levels and insufficient staffing to meet regulatory demands.
- **Staffing levels in inspection teams are inadequate**, leading to delays and an inability to respond to risks effectively. New staff have not received adequate training.
- **The partnership between CQC and providers has deteriorated**, with providers feeling that collaboration has been lost.
- **Progress on using data for assessments has been minimal**, leaving inspection teams with less useful intelligence compared to pre-pandemic times.
- **Consistency in judgements and quality assurance has been compromised**, leading to a reduction in the reliability of regulatory decisions.
- **CQC has begun to address some issues**, but more substantial changes are needed to fully resolve the problems.

The review sets forth thirteen key recommendations:

1. A **fundamental reset** of the organisation, akin to the reset in 2012/13
2. The previous organisational structure to be re-instated as soon as possible, with **Chief inspectors** leading on sector-based inspection teams at all levels with an emphasis on their respective specialisms
3. The current **Operations directorate** should be disbanded and reformed into sector-based inspection directorates, with several staff re-assigned to the relevant inspection directorate

4. At least 3 **permanent Chief Inspectors** should be appointed. The appointment of a fourth Chief Inspector to lead regulation of **mental health services** and to oversee inspections under the Mental health Act requires serious consideration
5. Ongoing **relationships** between inspection staff with relevant skills and experience and providers should be re-instated
6. Modifications to **SAF** should reflect what good looks like in different services
7. Decisions on the future of the **regulatory platform** are outside the scope of this review however the simplification of **SAF** may make it easier to resolve the IT issues
8. Prioritise the use of **data** to inform judgements
9. Urgently review **staffing** levels and **pay** scales within the inspection directorates
10. CQC to work closely in **partnership** with leaders of **health** and **adult social care** (ASC) to design improved approaches to assessment and inspection
11. Further work to address the current **backlogs** in registration
12. Further consideration of "**one word ratings**" , informed by what ratings make sense to individuals using services

## The issues in depth

### The single assessment framework

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- In practice, **not all 34 quality statements are assessed on any inspection**.
    i. *In ASC, 5 quality statements were initially selected for inspection, though this has now typically increased to 10-12.*
- Six evidence categories have been identified relating to each of the 34 quality statements that are meant to be given equal weighting however, the **relative importance of different evidence categories may vary between different services** and key questions.
    i. *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.*
    ii. *The availability of data varies widely between sectors.*
- It is unclear where judgement and moderation should prevail amidst the **4 point scale metric.**
- A total of 1,379 inspections of providers were undertaken between December 2023 and September 2024 using the SAF methodology, with a majority of these in ASC).
    i. *CQC personnel working in each of the sectors do not feel that SAF works for their services.*
    ii. *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 **wording** of the 34 quality statements is lengthy and some require modification, separation and being moved to a different and more relevant key questions. Some of the quality statements overlap with each other and there is insufficient emphasis on **outcomes**.
- Uploading of evidence from assessments of individual quality statements to the **regulatory platform** is time-consuming and can **delay** publication of reports.
- There was virtually **no support** for the use of scoring for each evidence category.
- The **ratings** given by applying **SAF** do not give an accurate view of the quality of care in some services.
    i. In ASC, the scoring system can give a rating of good, even though there are sometimes multiple breaches of the regulations.

ii. *Over 96 assessments using SAF (around 10% of the total number undertaken to date) have been rated as "good with a breach".*
iii. *A large number of interviewees advocated going back to the previous approach based on the 5 key questions and prompts/KLOEs.*

- CQC has only recently started to assess **local authorities** (LAs) in relation to their role as commissioners of ASC.
- The **regulatory platform is not being used for LA assessments**.
  i. *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.*
- The **demand for registration** of health and social providers has increased by around 33% between 2020/21 and 2023/24.
  i. *Largely driven by a increase in applications related to domiciliary care agencies.*
  ii. ***Backlogs** have thus significantly increased – 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.

**The review concluded that whilst some aspects of SAF can be retained, the ideological commitment to this form of assessment cannot be justified, given the diversity of services the CQC inspects and regulates.**

## Organisational Restructure

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- CQC staff explained that **credibility** with providers has been lost.
- CQC staff also explained the loss of the previous **'relationship owner'** role.
- The 4 Network (regional) Directors have **unsustainable workloads** and responsibilities across all 3 sectors and for a wide population.
- 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 individuals who do not have an in-depth knowledge of the sector being inspected.
- **Separation of the inspector and assessor roles** has made report writing much more difficult with assessors writing reports on services they haven't inspected.
  i. *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).*

**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.**

## Challenges with the regulatory platform

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- Full assessment of the **regulatory platform** is beyond the scope of this review.

- However, the challenges associated with the regulatory platform have a direct impact on both CQC staff and on providers, and are deeply linked with the SAF and its implementation.
- Repeated feedback showed the use of evidence categories and scoring complicates and **delays** the production of reports, stopping a meaningful narrative to arise for providers or the wider public.

**Provider perspective on the single assessment framework and its implementation**

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Views on implementation:

- There has been no action taken on concerns raised by several of the umbrella organisations in health and social care.

Views on trust and confidence:

- There has been widespread and severe loss of **confidence** and sense of **partnership** in CQC by providers and LA commissioners of social care.
- The current approach's emphasis on what is going wrong rather than what works well is impediment to **innovation**.

Impact on providers:

- **Delays in registration** are having an adverse impact especially on independent health and ASC providers.
- CQC is currently undertaking **too few inspections and re-inspections**, which has serious adverse financial impacts on independent sector providers.
- Providers feel they are not getting **value for money**.
- **Delays** in contacting 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**.

**The review concluded that the current approach by CQC lacks credibility, supported by both health and social care organisations expressing extreme dissatisfaction with the regime.**

Specific views on SAF:

- The selection of only a **sample** of quality statements for an inspection and then combining with **old ratings** is deemed unproductive and unreliable.
- **Process measures** are over-emphasised.
- **Delays** in getting reports out are far too long.
- **Scoring** has increased (not decreased) inconsistency.
- **Quality assurance** of reports appears to have been lost.
- The loss of the **provider handbook** contributes to a loss of **transparency**.

Specific views on the organisational structure:

- The loss of **relationship owners** is a severe retrograde step as providers no longer knowing who their **point of contact** is.
- 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.
    i. *This contributes to the lack of consistency between inspections, which is observed by corporate providers in both independent health and ASC.*

## Data and insight

- For NHS hospitals, mental health services and primary care services, several national datasets and surveys are collected. **Equivalent national datasets are not generally available for care homes**, which are required to notify CQC each time various adverse events occur.
- There are several obstacles to using data under **SAF**, including work on incorporating datasets into assessments of services has been hampered by the slow progress with the **new regulatory platform**.

## Levels of activity, staffing, and funding

- *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.*

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.
- 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.

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, with **ASC providing 41% of fee income**.
- 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**.

## Staff satisfaction

- The staff survey undertaken between January and February 2024 showed a **decline in all items regarding their experiences** with executive/senior members, if they are proud of their work, and if they feel their work helps improve care.
- Almost all items showed a decline since the previous full survey in 2021, with **11 items declining by more than 10%.**
- The largest decline was among **operational staff**, followed by concerns for how people are treated by leaders, not being listened to, concerns going unaddressed, and change not implemented effectively.

## Conclusions

The review by Professor Sir Mike Richards complements that by Dr Penny Dash, aligning completely with her findings.

- **Operational performance is poor**, with far fewer inspections carried out than in earlier years.
- There is a **serious backlog in processing registrations**.
- Some providers have not been **re-inspected** for several years.
- Patients, residents, 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** and contributing to major delays in report publication.
- The re-structuring has had a negative impact on some of the organisation's **key functions.**
- The **SAF** is certainly not proving to be beneficial for hospital and primary care inspections or in ASC.

## Recommendations in depth

### Structure

1. **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 SAF** and ensure it is fit for purpose in each sector. 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.

## Assessment framework

1. **Abandon** the concept of a **SAF**.
2. **Retain the 5 key questions** across all sectors, though some simplification might be desirable.
3. Retain the **I statements**. 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.
5. Routine use of **all evidence categories** for all quality statements should be abandoned.
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.
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 ASC.
9. The **evidence** that should be sought for each quality statement should be defined and a **handbook of rating characteristics** should be developed.
10. **Immediate feedback** should be given at the end of inspections.
11. **'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.
12. **Quality assurance** processes for reports and ratings should be reviewed by CQC.
13. **Reports** must provide a narrative that can be understood both by the provider and by the public.
14. **Training** in the use of the simplified assessment framework recommended above should be given very high priority.

## Data and insight

1. **Available data should be used more effectively.**
2. Measures of **patient experience** collected by hospitals and GP practices should be standardised, so that evidence on this is comparable between providers and Review of CQC's SAF and its implementation is available on much larger numbers of service users. This could potentially also be applied to the ASC sector.
3. Retain the **'clinical searches'** approach that has been developed for primary care. However, this should be able to be done centrally.

## Staffing

1. An **urgent review of staffing** within the current operations and regulatory leadership directorates should be undertaken.
2. The role of **Deputy Chief Inspector** should be reinstated.
3. An increase in the number of **inspection team staff.**
4. **Pay bands** should also be compared with comparable roles in the NHS and ASC.

5. An emphasis on **Recruitment** will almost certainly be needed.

## Prioritisation of future inspections

In all sectors: The use of **evidence categories** and **scoring** should be suspended, and **narrative reports** should be re-commenced to avoid further delays. **Close working** with partner bodies may be valuable in identifying organisations with highest risk that need the most urgent inspections.

In ASC: 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).