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.