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.

Note

[8] Changing our operational teams, November 2022, https://www.cqc.org.uk/news/changing-our-operational-teams