House of Commons

Health Committee

# 2012 accountability hearing with the Care Quality Commission

## Seventh Report of Session 2012–13

*Volume I: Report, together with formal minutes and oral and written evidence*

*Additional written evidence is contained in Volume II, available on the Committee website at www.parliament.uk/healthcom*

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## The Health Committee

The Health Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department of Health and its associated bodies.

### Membership

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Rosie Cooper MP (*Labour, West Lancashire*)
Andrew George MP (*Liberal Democrat, St Ives*)
Barbara Keeley MP (*Labour, Worsley and Eccles South*)
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The Committee is one of the departmental select committees, the powers of which are set out in House of Commons Standing Orders, principally in SO No 152. These are available on the Internet via www.parliament.uk.

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The Reports of the Committee, the formal minutes relating to that report, oral evidence taken and some or all written evidence are available in printed volume(s).

Additional written evidence may be published on the internet only.

### Committee staff

The staff of the Committee are David Lloyd (Clerk), Martyn Atkins (Second Clerk), David Turner (Committee Specialist), Stephen Aldhouse (Committee Specialist), Frances Allingham (Senior Committee Assistant), and Ronnie Jefferson (Committee Assistant).

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1 Mr Stephen Dorrell was elected as the Chair of the Committee on 9 June 2010, in accordance with Standing Order No. 122B (see House of Commons Votes and Proceedings, 10 June 2010).

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## Report

# Summary

The Care Quality Commission (CQC) has been subject to sustained criticism in the period 2011–12. This criticism emanated not only from this Committee, but also from the House of Commons Public Accounts Committee and from within the CQC's own board. The failures of the CQC prompted the Department of Health to undertake a performance and capability review which produced recommendations ranging from suggestions regarding the constitution of the board to the process of conducting inspections.

*Management and governance*

The decision by CQC board member Kay Sheldon to give evidence as a whistleblower to the Mid Staffs Public Inquiry added to the controversy surrounding the CQC. She identified serious failings within the management, organisation, functions and culture of the CQC. Kay Sheldon's concerns were legitimate and it is unacceptable that the CQC failed to address and act on them before she felt compelled to approach the public inquiry.

*Purpose*

We held our second annual accountability hearing with the CQC with the backdrop of the controversy surrounding Kay Sheldon's whistleblowing evidence, Dame Jo Williams's resignation, the appointment of David Behan as Chief Executive and the publication of a new strategy document. It is clear from the evidence presented by the CQC's outgoing Chair, Jo Williams, and recently appointed Chief Executive, David Behan, that the regulator is aware of the reforms that must be implemented. The CQC has developed a much keener focus on patient safety and has a better appreciation of what it exists to do, but we remain to be convinced that the CQC has successfully defined its core purpose.

The Committee concluded that the CQC's primary focus should be on ensuring that the essential standards it enforces can be interpreted by the public as a guarantee of acceptable standards in care. We do not believe that the CQC's essential standards in their current form succeed in this objective. As a result, patients, residents and relatives do not have confidence in the CQC's standards or the outcomes of inspections.

*Inspection*

There are indications that the CQC is developing its regulatory model to try and address this failing. The inclusion of clinical expert advisors to support the inspection process is a positive step and we are confident that this will enhance the inspection process. As yet, however, the CQC has failed to demonstrate how they will ensure that this expertise is deployed where it is most necessary. Equally, the CQC must be far more diligent in communicating the outcomes of inspections, especially to residents in social care and their immediate family. Residents of care homes and their relatives are entitled to be made aware of how their home performs in inspection. Expecting residents or relatives to scour the CQC website for inspection reports or chance upon a local newspaper report is, in our view, an insufficient communication strategy.

*Whistleblowing*

We were told that the CQC had learned from the serious failings it had previously experienced in relation to whistleblowing. There is evidence to bear this out, but we believe the CQC can do even more to support the most vulnerable workers to come forward and report their concerns. Professional staff concerned with standards of care should initially raise those concerns at their place of work, but it is essential that proper procedures are established to support whistleblowers who report cases to CQC In the long-term, however, we believe that the CQC has a role to play in facilitating a culture of challenge and response across health and social care so that identifying and addressing failings becomes a standard process for staff and management. Providers must support staff in raising concerns in order for those staff to meet their own professional duties. Those organisations who fail in this obligation should be refused registration by the CQC.

*Primary care registration*

Primary care registration is a major challenge for the CQC and will test the degree to which the CQC has managed to implement learning from its previous experience with dental registration. The CQC was able to demonstrate that it had made a positive start to this process and it is welcome that they emphasised the extent to which they have cooperated with third parties in designing the system. Given the magnitude of primary care registration we will, in 2013, examine carefully how successful the CQC has been in streamlining registration and limiting the bureaucratic burden on GPs.

# 1 Introduction

## Background

1. The Care Quality Commission (CQC) is a non-departmental public body, responsible for the registration, review and inspection of health and adult social care services. It also monitors the operation of the Mental Health Act 1983 and Mental Capacity Act 2005 in England.

2. Since we published our report on 14 September 2011 following the accountability hearing of 28 June 2011, the CQC has registered 8,112 primary dental care providers and 250 private ambulance services. In September 2012 the CQC commenced the registration of 8,500 GP practices with the process set to be completed by 31 March 2013.

3. Cynthia Bower resigned as Chief Executive of the CQC in February 2012 following the publication of the Department of Health's performance and capability review of the CQC. David Behan joined the CQC in July 2012 as the new Chief Executive. In September 2012 Dame Jo Williams announced her resignation as Chair but agreed to stay in post until a replacement was appointed. We held a pre-appointment hearing with the Government's preferred candidate, David Prior, on 5 December, on which we have reported separately.

## Conclusions from the 2011 accountability hearing

4. This report follows the second annual accountability hearing we held with the Care Quality Commission. The first hearing held in June 2011 produced a number of conclusions and recommendations which are summarised below. On Tuesday 11 September 2012 we held our second annual accountability hearing with the CQC with the objective of assessing the CQC's performance in the last 12 months. To aid this process, we sought to analyse the CQC's progress in implementing the committee's recommendations from 2011.

5. The principal concern expressed in our report of 2011 was that the CQC had failed to properly balance the demands of registering health and social care providers with the need to rigorously inspect hospitals and care homes. Inspections fell by 70%, a figure we deemed to be "unacceptable"[2] and we concluded that the CQC had failed to:

- understand its own priorities and objectives;
- analyse the resource implications of registering primary and social care providers;
- test the registration model.

6. We found that CQC had launched dental registration "without undertaking adequate proving of the registration model."[3] It was recommended that "each future extension of scope of registration should be preceded by a properly planned and executed piloting

2 Health Committee, Ninth Report of Session 2010–12, *Annual Accountability Hearing with the Care Quality Commission*, HC1430, para 15

3 HC (2010–12) 1430, para 25

exercise."[4] The emphasis placed on registration was regarded by the committee as "a distortion of its priorities"[5] and the process regarded as inflexible and excessively time consuming and complex.

7. We concluded that the CQC had failed to recruit adequately leaving long-standing vacancies for inspectors. We noted that the delay in recruiting frontline staff was indicative of an organisation which did not recognise the urgency of the problems they were seeking to address.

8. The CQC requested an additional 10% of resources to fund its inspection regime. The evidence put before the Committee did not convince us that the problems faced by the CQC would be resolved by additional funding as there was no clear strategy for how additional resources would be deployed.

9. We described the CQC's response to the Winterbourne View whistle blowing episode as "woefully inadequate".[6] This prompted our recommendation that the CQC should ensure that it is able to follow up all relevant communications from potential whistleblowers. In the case of Winterbourne View, the CQC acknowledged that it did not act on the information it had received, nor did it contact the whistleblower.

10. We expressed concern that the CQC monitoring and inspection process had become too reliant on Quality and Risk Profiles (QRP). The use of QRP data to help assess risk was not in itself regarded as a concern but the committee noted that the data is "limited in reliability and coverage".[7] Consequently, we warned that CQC inspectors must not become over-reliant on QRP data as "such a tool could only ever present a patchy picture of the quality of care".[8]

4 HC (2010–12) 1430, para 25

5 HC (2010–12) 1430, para 6

6 HC (2010–12) 1430, para 58

7 HC (2010–12) 1430, para 43

8 HC (2010–12) 1430, para 49

# 2 Management and governance

11. In November 2011 a CQC non-executive board member, Kay Sheldon, gave evidence to the second Mid Staffordshire NHS Foundation Trust public inquiry. This event, and the fallout from it, has focused public attention on the CQC. In her evidence submitted to this inquiry, Ms Sheldon repeated a number of criticisms regarding the management and culture of the CQC that she made in evidence to the Mid Staffs public inquiry. Ms Sheldon summarised her concerns by saying she was alarmed about:

> [a] lack of strategic direction, numerous lapses in governance, continuing under-performance and the culture (particularly reports of bullying and oppressive behaviour) of the organisation.[9]

12. Ms Sheldon's evidence to the Mid Staffs public inquiry itemised her complaints and criticisms in more detail. At the heart of her critique was the accusation that the CQC Board was incapable of properly scrutinising the work of the Executive (especially former Chief Executive Cynthia Bower) because of poor leadership by the Chair, Jo Williams. Ms Sheldon's statement made a number of serious accusations, including:

- The CQC did not properly consider the role it should play in health and social care regulation and failed to create a strategy to achieve a definable goal;
- Key decisions related to the inspection regime and prioritisation of registration were made and implemented by the executive without effective scrutiny by the Board;
- Jo Williams's poor leadership did not challenge Cynthia Bower and resulted in Board meetings lacking direction. As a result the Board could only rubber-stamp decisions rather than scrutinise them;
- Due to a lack of training CQC inspectors were not equipped with the skills or knowledge to undertake their tasks effectively;
- A culture of bullying had undermined staff morale.[10]

13. In her evidence to the committee Jo Williams acknowledged that some of Ms Sheldon's concerns have been proved to be correct.[11]

14. **The new Chair must, as a matter of urgency, overhaul the governance structures of the CQC. The Board must provide proper strategic direction to the organisation and hold the Executive effectively to account for their performance against defined objectives. The Chair must ensure that all members of the Board are encouraged to contribute fully to the operation of the Board and that they are always able to enjoy open and free access to the Chair. Board procedures should provide for regular assessments of its own effectiveness and they should also provide a clear process by which a Board Member can express concerns about the performance of the Chair.**

9 Ev 51

10 Kay Sheldon, Mid Staffs public inquiry, witness statement, November 2011

11 Q 71

# 3 Purpose of the CQC

## Regulatory approach

15. The question of the CQC's core purpose has not been resolved since the regulator was established in 2008. Memoranda we received from the NHS Confederation and the Foundation Trust Network addressed this matter, but there was no consensus on what the fundamental role of the regulator should be. The NHS Confederation said that:

> The Government should amend the CQC's statutory duties to reflect that its primary role is to assure essential standards, and that it has a limited role to play in driving improvements in the quality of care.[12]

The NHS Confederation added that the CQC's role in driving up quality is "through effective regulation and registration against its essential standards".[13] This view contrasts with that of the Foundation Trust Network, whose evidence agrees that the CQC should concentrate on essential standards but adds that CQC should be a "thought leader in the health system, analysing the data it holds to unpack the drivers behind standards and inform best practice."[14]

16. The Department of Health's performance and capability review of the CQC recommended that "CQC's strategy needs to be revised, explaining what role and impact its regulatory action is intended to have in specific sectors over time."[15] In its memoranda to the committee the CQC says that its purpose is to "drive improvements in the quality of care",[16] but in itself, we were not satisfied that this would address the serious criticism contained in the performance and capability review that "strategic prioritisation of essential standards is not understood at all levels within the Commission."[17]

17. In failing to understand its essential purpose, the CQC risks undermining its own attempts to realign its strategic priorities following a period of sustained criticism and review. In evidence the CQC's new Chief Executive David Behan told us that the CQC's "unique contribution [...] is that we measure the national standards of quality and safety."[18]

18. The CQC must work closely with other regulators and commissioners working in health and social care. There is an urgent need for all these organisations to define their role and purpose in order to achieve organisational focus and to avoid duplication.

19. **We agree that the CQC's fundamental purpose is to ensure that health and social care providers meet those essential standards which ensure patient safety. The Committee remains concerned that the role and duties of the CQC are not sufficiently**

12 Ev 37

13 Ev 38

14 Ev 33

15 Department of Health, *Performance and Capability Review: Care Quality Commission*, 2012, p 7

16 Ev 43

17 CQC Performance and Capability Review, p 21

18 Q 139

**clear. Responsibility for patient safety lies at the root of high quality patient care, but is in danger of being obscured by other competing priorities. This is a particular concern given that the Government has abolished the National Patient Safety Agency and absorbed it in to the NHS Commissioning Board. We recommend that the Secretary of State should urgently work with the statutory regulators and commissioners of health and social care in order to simplify and clarify their respective roles. We further recommend that the Secretary of State should reconsider whether prime responsibility for patient safety should reside with the CQC.**

## Essential standards and raising the bar

20. Significant concern exists that the CQC's essential standards do not guarantee acceptable levels of care in residential social care. The Relatives and Residents Association say in their memorandum to the Committee that "the experience of [...] poor quality care is not exceptional"[19] and they argue convincingly that levels of risk and the degree of safeguarding necessary in residential care are inherently greater than other care settings because of the simple fact that a care home doubles as a person's home.

21. In her evidence, Jo Williams told us that the CQC was:

> increasingly focusing on what has been the experience of people living in that environment: how have they experienced it, are they happy with the way in which they are treated as an individual and the services they all receive.[20]

This is welcome if the CQC can demonstrate that a renewed focus improves the process of registration and inspection to address the concerns of relatives and residents.

22. **In relation to social care there is too often a disconnect between the essential standards measured by the CQC and the experiences of residents in social care. In too many cases residential care homes which meet the CQC's essential standards are regarded as unsatisfactory by carers, relatives and residents. In reviewing their regulatory model the CQC must ensure that the 'essential' standards they enforce align with the expectations and experiences of patients, residents and relatives. We look to the new management team to work from the principle of 'first do no harm' and focus on this core issue with a much greater sense of urgency.**

23. Dame Jo told us that the CQC's objective is to turn today's quality standards into tomorrow's essential standards. The CQC must recognise that the public has little confidence that the essential standards the CQC enforces guarantee an acceptable standard of care. On too many occasions providers who meet these standards have subsequently been found to be delivering severely substandard care.

24. **The first priority for the CQC is to apply its existing standards consistently and effectively. When the CQC is able to command public confidence that it has achieved this objective, the Committee will seek a progress report on this issue and on plans for the progressive raising of these standards in line with public expectation.**

19 Ev 30

20 Q 20

## Purpose of inspection

25. The purpose of CQC inspections is to establish whether the quality of care provided in an organisation meets acceptable quality standards. CQC reports are relied upon both by statutory commissioners in the NHS and social services departments, and by individuals and families making choices about their own care – whether it is self-funded or funded by the taxpayer. In recent years there have been too many examples for comfort of care standards falling below acceptable levels, sometimes by an extraordinarily wide margin. The fact that this has happened in care settings which have been registered as satisfactory by the CQC only serves to emphasise the importance of developing more effective processes.

26. It is, however, important to be clear where primary responsibility lies. When care standards fail, it is the care provider that is responsible.

27. Furthermore, when commissioners have commissioned care from a provider who fails to deliver service of an acceptable quality, the commissioners should expect to face questions about the effectiveness of their commissioning processes. Commissioners exist to secure good value for the taxpayer and high quality for patients and residents; while they are not themselves inspectors, commissioners should be expected to provide themselves with sufficient information about the cost and quality of care provided to allow themselves to make properly informed decisions. Failures to do so—of which there have been too many examples—constitute culpable failures by commissioners to act with due diligence. **Commissioners ought to be able to turn to the CQC for evidence of the quality of care provided. The CQC Board and management need to show that they use the resources at their disposal effectively to deliver the necessary assurance to commissioners, patients and their families. The record shows that it has not so far been able to provide such assurance.**

28. **We welcome the fact that the CQC has undertaken a consultation with its stakeholders about the scope and purpose of the organisation. In view of its unhappy history, we believe that it needs to do more. We believe it should consult with stakeholders about effective means as well as desirable ends. We therefore recommend that before the accountability hearing in 2013 the CQC should undertake an open consultation designed to develop a clearer understanding of effective regulatory method.**

29. There have been too many reports of CQC inspections which focus on easily measurable inputs, rather than the essential quality of care provided. The organisation has sometimes seemed to be an illustration of the dangers of the principle that 'what gets measured gets managed'.

30. In particular we would encourage the CQC to require its inspectors to ask themselves about the culture of care within an organisation. There is abundant evidence that organisations with closed and autocratic cultures do not deliver consistently high quality care. Similarly the professional obligation of clinical staff to accept responsibility not just for the care they provide themselves, but for the context in which it is provided, is inconsistent with an organisational culture which discourages dialogue and challenge.

31. **We recommend that, as part of a general consultation about regulatory method, CQC should consult in particular on how to assess the culture of a care provider – in order to satisfy itself that a healthy open culture prevails amongst professional staff.**

# 4 Registration and inspection

32. A significant number of memoranda we received, and a substantial proportion of the hearing with the CQC, were dedicated to examining the process and outcomes associated with registration and inspection. These two functions are central to the CQC's core purpose and they must be executed effectively if the CQC is to achieve its objectives of accurately measuring providers against the essential standards and protecting patients from harm.

## Morecambe Bay

33. Evidence from the registration of University Hospitals of Morecambe Bay Foundation Trust (UHMBFT) suggests that the CQC's registration process was not effective in ensuring essential standards were met. David Behan acknowledged that there is concern regarding the registration of UHMBFT[21] and he told us that as a result Grant Thornton will independently review the process which led to UHMBFT's registration.[22]

34. We believe an independent investigation of this nature is urgently needed to begin to identify the serious failings which allowed UHMBFT to be registered without CQC expressing any major concerns. In her written evidence, Kay Sheldon notes a conversation she had with the CQC's Director of Operations, Amanda Sherlock, in January 2012 in which Ms Sherlock claimed that the CQC's registration and inspection of UHMBFT was "a robust piece of work."[23] This is very disturbing, particularly as UHMBFT apparently relied on this evidence to tell Monitor that, having been registered by the CQC without any conditions, there were no problems with its maternity services.[24]

35. **It is failures such as those witnessed at Morecambe Bay which undermine public confidence in the CQC's essential standards. Registration should be a challenging process for providers and not simply a bureaucratic formality. The CQC must undertake registration with the intention of finding shortcomings where they exist and ensuring that service providers swiftly address their failings.**

## Cooperation between regulators

36. At the heart of the failures connected to the registration of UHMBFT is the suggestion that the CQC failed to act independently in its assessment of the trust. Kay Sheldon reported in written evidence that she had seen evidence that the CQC was aware of the problems at UHMBFT as early as 2010 but still found the trust to be compliant with essential standards. Ms Sheldon alleges that the Parliamentary and Health Service Ombudsman, Ann Abraham, agreed not to investigate UHMBFT in 2009 after Cynthia Bower (then CQC Chief Executive) assured her that the CQC would take "robust action".[25]

21 Q 31

22 Q 32

23 Ev 54

24 Uncorrected transcript of oral evidence taken before the Health Committee on 30 October 2012, HC (2012–13) 652-i, Q30

25 Ev 56

Ms Sheldon says that it was not until "late 2011/early 2012 when the extent of the problems re-surfaced that CQC suddenly decided to launch an investigation."[26]

37. Working closely with other regulators is desirable and the CQC is correct to emphasise that it cannot fulfil its obligations without close liaison with its counterparts. We welcome the fact that Memoranda of Understanding are being drafted between the CQC and Monitor and the CQC and the National Commissioning Board, as these should help to provide clarity and transparency to a cluttered and opaque regulatory environment.[27]

38. The exchange of information between regulators is necessary if the system is to succeed in prioritising patient safety with minimal bureaucracy. It is welcome that David Behan acknowledged that the CQC's ability to act independently to judge the quality of services against essential standards depends on an interdependent relationship with other regulators and commissioners.[28]

39. **Without joined up working the regulatory landscape will be burdensome and dysfunctional, but there is also an acute danger that 'when everyone is responsible, no-one is responsible'. There is an urgent requirement to define the role and responsibility of the CQC; within that definition of its role the CQC must operate autonomously of the other health and social care regulators and be accountable to Ministers and Parliament for its actions.**

## Inconsistency in inspection

40. It is accepted by the CQC that despite a more regimented system for undertaking inspections, inconsistency remains a substantial problem that has yet to be resolved. David Behan and Jo Williams said that there was inconsistency in the way inspections were conducted both within and between the English regions in which the CQC operates. Mr Behan said that this is "probably the most often-quoted issue to me"[29] by providers and this is reinforced by evidence from the Foundation Trust Network (FTN) which cites "variability in the quality and consistency of reports and judgements".[30]

41. Providers such as the FTN highlight that inconsistency in the approach to inspection is often accompanied by variable quality and they, along with other providers, have questioned whether CQC inspectors have the necessary skills to properly carry out inspections. Recommendation 20 of the Department of Health Performance and Capability Review said that inspectors should have greater access to expertise during inspection.[31] This conclusion acknowledged the inherent limitations of employing an inspection workforce consisting of regulatory rather than clinical experts.

42. The Relatives and Residents Association has questioned whether CQC inspectors have the knowledge to perform an accurate assessment of a provider's services against essential

26 *Ibid*

27 Q 16

28 *Ibid*

29 Q 90

30 Ev 34

31 CQC Performance and Capability Review, p.24.

standards.[32] Exploiting the knowledge and experience of expert clinical advisors is central to addressing this, and we expect the number of inspections in which this support is accessed to increase dramatically. For as long as suspicion remains that inspectors do not have the ability to measure services against essential standards the CQC will struggle to convince patients and the public that their standards ensure a safe, acceptable service.

43. David Behan told us that the CQC's bank of approximately 100 national clinical advisors "is a reservoir, which is there to be drawn on appropriately"[33] and in their additional evidence the CQC say that:

> Inspectors will make a decision about whether they need someone to provide advice, which may be advice by email or phone, or to accompany the inspector on an inspection.[34]

44. **The Committee welcomes the greater use and availability of clinical expertise to support the work of inspectors. We note, however, that 87% of inspections carried out since this resource became available did not use it. We recommend that the CQC should develop a consistent methodology for their inspectors to follow which would help to regulate when and how clinical experts are allocated to inspection. We also recommend that the CQC should monitor the effect of the deployment of this resource on the quality and consistency of its inspections in order to ensure that its practice evolves in the light of experience. We will examine these issues again at the next accountability hearing and seek a progress report on the balance between generic and specialist inspection.**

## Allocation of resource

45. In 2011 we recommended that the CQC recruit additional staff to alleviate the problem as last year:

> the average inspector's caseload has increased from approximately 50 locations per compliance inspector as at 1 April 2010 to 62 locations per inspector on 1 April 2011.[35]

In their evidence to the committee the Royal College of Nursing said that their members are still dealing with caseloads "well in excess of 50 organisations and also providing cover for vacant post or absent colleagues regularly adding a further 40 organisations to this workload."

46. The CQC is now in the final stages of recruiting additional inspectors. The CQC's underspend on staff expenditure alone for 2012/13 will reach £4.8 million[36] and it has been allocated a further £10 million grant in aid funding from the Department of Health to help

32 Ev 31

33 Q 12

34 Ev 49

35 Health Committee, Ninth Report of Session 2010–12, *Annual Accountability Hearing with the Care Quality Commission*, HC1430, para 31

36 Ev 48

meet its recruitment needs.[37] David Behan told us that in the last year the CQC had sought to recruit an additional 255 inspectors and that all the vacant positions would have been offered by the end of the calendar year.[38] Striking the correct balance between recruiting quickly and ensuring that the best possible candidates are selected is vital in this process, but we welcome the fact that the CQC is taking action to increase its ability to carry out its core function.

47. In March 2012 the CQC was requested by the Department of Health to undertake urgent inspections of termination services after evidence was discovered that as many as one-fifth of clinics were pre-signing consent forms for terminations. This had a substantial impact on the CQC's scheduled work and by acceding to this request the CQC reports that it had to delay 580 other inspections.[39] We do not believe it unreasonable for the Department of Health to make ad hoc requests of this nature to the CQC but it is concerning that such disruption should be caused as a result. **We recommend that the Executive Management of CQC should be tasked to ensure that its inspection planning includes sufficient resilience to be able to accommodate unexpected peaks of work, whether they result from the requests of Ministers or from other causes.**

37 Q 96

38 Q 11

39 Q 98

# 5 Communicating with patients and the public

## Informing patients, residents and relatives

48. We received evidence arguing that there should be a formal mechanism for informing patients, residents, their carers and family members of the outcomes of inspection reports in cases where compliance failures are identified.[40] We agree with this view and it is noteworthy that public commissioners of care services (local authorities and the NHS) are made aware formally of the outcomes of inspection by the CQC but privately paying commissioners (the general public) are not.[41]

49. This is of particular significance in relation to social care where providers are not simply providing an episode of care with a finite end date but offering residents a permanent home combined with life-long care. In such cases it is not sufficient to assume that people, many of them elderly, will regularly monitor the CQC website to check if their care home or the home of a loved one has been the subject of an inspection report

50. Similarly, it is not sufficient for patients, residents and relatives to discover the outcome of a critical inspection through the published media. A press and PR strategy is no substitute for targeted communication with patients, residents and relatives who rely on the CQC to inform them of the quality of the services they receive. We believe in the swift communication of the results of inspections to patients, residents and their families although the methods by which the CQC communicates the outcomes of inspections will be different for a large hospital as compared to a small care home. We therefore recommend that the new Chair should explore how the CQC can more effectively communicate with residents of care homes and their relatives about the outcomes of inspections.

## Online publication and media reporting

51. The CQC's approach to communicating the results of its inspections and assessments of providers relies on the public accessing the CQC website. Jo Williams told us that formal actions such as the issuing of a warning notice would be published on the website.[42] David Behan explained that:

> a huge amount of work has been done[...] on improving the website, so our reports are there and available for people to read, whether that is public or private-sector organisations.[43]

40 Ev w2

41 The CQC publication *The state of health care and adult social care in England: An overview of key themes in care 2011/12* , reported that 'an estimated 45% of care home places in England are occupied by people who are self-funding, meaning their costs are met privately rather than by the state.'

42 Q 24

43 Q 29

We welcome this commitment by the CQC to provide a user-friendly and accessible website.

52. The FTN claims that when publishing reports the CQC pursues a "sensationalist media approach that has unnecessarily damaged the reputation of organisations".[44] Four Seasons Healthcare, in their evidence, add that critical inspection reports are "almost invariably the subject of a press release by the CQC" and these press releases do not reflect improvements that may have been made in the intervening period between an inspection which highlighted failings and the eventual publication of a report.[45] This provider complains that the period between inspection and publication "means that commissioners and service users or potential service users to not have appropriate timely information on which to base decisions."[46]

53. **We recommend that the CQC should develop clearer guidelines for communicating the results of its inspections to interested parties. When inspections are complete, patients, operators, residents and relatives are all entitled to effective access of the results, both positive and negative which is prompt, accurate and complete.**

44 Ev 34

45 Ev 29

46 *Ibid.*

# 6 Whistleblowing

## Managing incidents of whistleblowing

54. Since the events at Winterbourne View first emerged the CQC has strengthened its arrangements for dealing with whistleblowing by health and social care professionals. The CQC has established a team of call handlers trained to deal with whistleblowing calls. This team is responsible for ensuring that concerns are passed to the appropriate local inspectors for assessment and consideration.[47] Importantly, this team will also track cases through to a satisfactory conclusion. This should help to ensure that decisions to act on whistleblowing reports are not made by any one individual without scrutiny from elsewhere within the CQC. In their evidence, the Department of Health says that the CQC's system should ensure that all whistleblowing concerns are tracked from receipt through to conclusion[48] and it is essential that, in practice, the system operates in this manner.

55. The steps taken by the CQC to improve the ability of the organisation to react to whistleblowing are encouraging. It is imperative in these cases that the CQC not only prioritises patient safety but that it is able to justify the action it takes in relation to each referral. Auditing whistleblowing cases will allow the CQC to understand how well they react to these incidents and, most importantly, how effective their interventions prove to be.[49] As part of this process, we are pleased that the CQC has assumed the discipline of reporting outcomes of referrals to those whistleblowers that do not opt for anonymity.[50] This encourages accountability and transparency within the CQC and delivers a degree of confidence that referrals will not be ignored or treated with undue scepticism.

## Supporting whistleblowers

56. Publication of a set of joint principles with the BMA, RCN, NMC and GMC on whistleblowing is a positive step towards developing a coordinated approach between regulator and professional body.[51]

57. Doctors and nurses who report serious concerns to the CQC can typically expect support from their professional bodies and trade unions, but this is not always the case in social care.[52] Unqualified care workers do not have the same degree of professional support available to them as more senior colleagues and they are, therefore, more vulnerable and potentially less likely to refer concerns to the CQC. We would encourage the CQC to examine carefully what additional support they can offer to whistleblowers in this group.

47 Ev 27

48 *Ibid.*

49 Q 29

50 Qq 74–76

51 Q 72

52 In 2011/2012 the longitudinal Social Care Worker's Survey conducted by the King's College London Social Care Workforce Research Unit found that only 14 per cent of unqualified care workers were members of a trade union.

58. **While it is essential that proper procedures are established to support whistleblowers who report cases to the CQC, in most circumstances it will be important for staff in the first instance to raise issues through accessible procedures at their place of work. We have noted earlier in this report the importance which CQC inspectors should attach to making an assessment of the professional culture of organisations which provide health and social care. A key element of this assessment should be a judgement about the ability of professional staff within the organisation to raise concerns about patient care and safety issues without concern about the personal implications for the staff member concerned. An organisation which does not operate on this principle does not provide the context in which care staff can work in a manner which is consistent with their professional obligations. It should therefore be refused registration by the CQC.**

## Managing complaints from the public

59. The Committee welcomes David Behan's view that information received via complaints should be treated as "free intelligence."[53] We accept that the CQC should not treat every complaint from the public as a whistleblowing incident and it is not within the CQC's remit to investigate specific complaints. The CQC should, however, feed such 'free intelligence' into their risk profiles in order to ensure that they take comments and complaints made by the public seriously.

60. CQC inspectors and compliance managers should not ignore the fact that patients, residents and relatives will develop a detailed appreciation of what constitutes good care and will often be the first to observe non-compliance. The Relative and Residents Association argues that:

> any complaint which speaks to the fitness of the manager is CQCs business because it is an intrinsic part of their role to ensure that the staff, management and environment are fit for purpose and meet the registration requirements.[54]

We are sympathetic to this view and in the most serious cases the CQC must do more than simply listen to the public and incorporate comments into risk profiles. **If the CQC is to genuinely treat feedback from the public as free intelligence then it must show that it can act swiftly on intelligence when serious complaints are made.**

53 Q 78

54 Ev 31

# 7 GP registration

61. Following the criticisms that the CQC's dental registration process suffered in 2010–11, the Department of Health agreed to a request that registration of primary care providers should be postponed by twelve months until April 2013. Registration of 49 out-of-hours providers continued as planned in April 2012 and was successfully completed without attracting any substantial criticism. Formal registration of 8,500 GP practices commenced in September 2012.

62. Having recognised that elements of earlier registration processes were too burdensome for providers, the CQC has taken a number of steps which are intended to simplify and ease the registration process for GPs. For example, GPs can register via an online account and an electronic system for Criminal Records Bureau (CRB) checks whereby a GMC number is accepted rather than a CRB number.[55]

63. GP registration is taking place in four one-month windows from September to December 2012. The CQC reported that approximately 95% of practices had completed the initial pre registration process by September 2012.[56] This represented a positive start to registration and we welcome the fact that the CQC engaged with, amongst others, the British Medical Association, the Royal College of General Practitioners and the Family Doctor Association in order to minimise the burden registration places on primary care providers.[57] As part of this, we expect the CQC to have identified the data that can be shared between organisations to limit the degree of bureaucracy within the system. We were, however, concerned that the CQC had estimated in February 2012 that, on the basis of their pilot programme, 25% of GP practices may be non-compliant with at least one essential standard.[58] We acknowledge that the CQC has established a specific team to assess whether site visits are necessary and to conduct inspections. At next year's accountability hearing with the CQC we shall be keen to understand the results of this experience and the extent of any resource implications for the CQC of its extended inspection remit.

55 Ev 27

56 Q 118

57 Q 125

58 Ev 49

# Conclusions and recommendations

## Management and governance

**1.** The new Chair must, as a matter of urgency, overhaul the governance structures of the CQC. The Board must provide proper strategic direction to the organisation and hold the Executive effectively to account for their performance against defined objectives. The Chair must ensure that all members of the Board are encouraged to contribute fully to the operation of the Board and that they are always able to enjoy open and free access to the Chair. Board procedures should provide for regular assessments of its own effectiveness and they should also provide a clear process by which a Board Member can express concerns about the performance of the Chair. (Paragraph 14)

## Regulatory approach

**2.** We agree that the CQC's fundamental purpose is to ensure that health and social care providers meet those essential standards which ensure patient safety. The Committee remains concerned that the role and duties of the CQC are not sufficiently clear. Responsibility for patient safety lies at the root of high quality patient care, but is in danger of being obscured by other competing priorities. This is a particular concern given that the Government has abolished the National Patient Safety Agency and absorbed it in to the NHS Commissioning Board. We recommend that the Secretary of State should urgently work with the statutory regulators and commissioners of health and social care in order to simplify and clarify their respective roles. We further recommend that the Secretary of State should reconsider whether prime responsibility for patient safety should reside with the CQC. (Paragraph 19)

## Essential standards and raising the bar

**3.** In relation to social care there is too often a disconnect between the essential standards measured by the CQC and the experiences of residents in social care. In too many cases residential care homes which meet the CQC's essential standards are regarded as unsatisfactory by carers, relatives and residents. In reviewing their regulatory model the CQC must ensure that the 'essential' standards they enforce align with the expectations and experiences of patients, residents and relatives. We look to the new management team to work from the principle of 'first do no harm' and focus on this core issue with a much greater sense of urgency. (Paragraph 22)

**4.** The first priority for the CQC is to apply its existing standards consistently and effectively. When the CQC is able to command public confidence that it has achieved this objective, the Committee will seek a progress report on this issue and on plans for the progressive raising of these standards in line with public expectation**.** (Paragraph 24)

## Purpose of inspection

5. Commissioners ought to be able to turn to the CQC for evidence of the quality of care provided. The CQC Board and management need to show that they use the resources at their disposal effectively to deliver the necessary assurance to commissioners, patients and their families. The record shows that it has not so far been able to provide such assurance. (Paragraph 27)

6. We welcome the fact that the CQC has undertaken a consultation with its stakeholders about the scope and purpose of the organisation. In view of its unhappy history, we believe that it needs to do more. We believe it should consult with stakeholders about effective means as well as desirable ends. We therefore recommend that before the accountability hearing in 2013 the CQC should undertake an open consultation designed to develop a clearer understanding of effective regulatory method. (Paragraph 28)

7. We recommend that, as part of a general consultation about regulatory method, CQC should consult in particular on how to assess the culture of a care provider – in order to satisfy itself that a healthy open culture prevails amongst professional staff. (Paragraph 31)

## Morecambe Bay

8. It is failures such as those witnessed at Morecambe Bay which undermine public confidence in the CQC's essential standards. Registration should be a challenging process for providers and not simply a bureaucratic formality. The CQC must undertake registration with the intention of finding shortcomings where they exist and ensuring that service providers swiftly address their failings. (Paragraph 35)

## Cooperation between regulators

9. Without joined up working the regulatory landscape will be burdensome and dysfunctional, but there is also an acute danger that 'when everyone is responsible, no-one is responsible'. There is an urgent requirement to define the role and responsibility of the CQC; within that definition of its role the CQC must operate autonomously of the other health and social care regulators and be accountable to Ministers and Parliament for its actions. (Paragraph 39)

## Inconsistency in inspection

10. The Committee welcomes the greater use and availability of clinical expertise to support the work of inspectors. We note, however, that 87% of inspections carried out since this resource became available did not use it. We recommend that the CQC should develop a consistent methodology for their inspectors to follow which would help to regulate when and how clinical experts are allocated to inspection. We also recommend that the CQC should monitor the effect of the deployment of this resource on the quality and consistency of its inspections in order to ensure that its practice evolves in the light of experience. We will examine these issues again at the

next accountability hearing and seek a progress report on the balance between generic and specialist inspection. (Paragraph 44)

## Allocation of resource

**11.** We recommend that the Executive Management of CQC should be tasked to ensure that its inspection planning includes sufficient resilience to be able to accommodate unexpected peaks of work, whether they result from the requests of Ministers or from other causes. (Paragraph 47)

## Online publication and media reporting

**12.** We recommend that the CQC should develop clearer guidelines for communicating the results of its inspections to interested parties. When inspections are complete, patients, operators, residents and relatives are all entitled to effective access of the results, both positive and negative which is prompt, accurate and complete. (Paragraph 53)

## Supporting whistleblowers

**13.** While it is essential that proper procedures are established to support whistleblowers who report cases to the CQC, in most circumstances it will be important for staff in the first instance to raise issues through accessible procedures at their place of work. We have noted earlier in this report the importance which CQC inspectors should attach to making an assessment of the professional culture of organisations which provide health and social care. A key element of this assessment should be a judgement about the ability of professional staff within the organisation to raise concerns about patient care and safety issues without concern about the personal implications for the staff member concerned. An organisation which does not operate on this principle does not provide the context in which care staff can work in a manner which is consistent with their professional obligations. It should therefore be refused registration by the CQC. (Paragraph 58)

## Managing complaints from the public

**14.** If the CQC is to genuinely treat feedback from the public as free intelligence then it must show that it can act swiftly on intelligence when serious complaints are made. (Paragraph 60)

# Formal Minutes

## Tuesday 18 December 2012

Members present:

Mr Stephen Dorrell, in the Chair

| | |
|---|---|
| Barbara Keeley | David Tredinnick |
| Grahame M. Morris | Dr Sarah Wollaston |
| Mr Virendra Sharma | Valerie Vaz |

Draft Report (*2012 accountability hearing with the Care Quality Commission*), proposed by the Chair, brought up and read.

*Ordered*, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 63 read and agreed to.

Summary agreed to.

*Resolved*, That the Report be the Seventh Report of the Committee to the House.

*Ordered*, That the Chair make the Report to the House.

*Ordered*, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

Written evidence was ordered to be printed with the Report.

Written evidence was ordered to be reported to the House for publishing on the Internet.

[Adjourned till Tuesday 8 January at 9.30 am

# Witnesses

**Tuesday 11 September 2012**

*Page*



# List of printed written evidence



# List of additional written evidence

(published in Volume II on the Committee's website www.parliament.uk/healthcom)

# List of Reports from the Committee during the current Parliament

The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

**Session 2012–13**

| | | |
|---|---|---|
| First Report | Education, training and workforce planning | HC 6-I |
| Second Report | PIP breast implants: web forum on patient experiences | HC 435 |
| Third Report | Government's Alcohol Strategy | HC 132 |
| Fourth Report | Annual accountability hearing with the General Medical Council | HC 566 |
| Fifth Report | Appointment of the Chair of the Care Quality Commission | HC 807 |
| Sixth Report | Appointment of the Chair of the National Institute for Health and Care Excellence | HC 831 |
| Seventh Report | 2012 accountability hearing with the Care Quality Commission | HC 592 |

**Session 2010–12**

| | | |
|---|---|---|
| First Report | Appointment of the Chair of the Care Quality Commission | HC 461-I |
| Second Report | Public Expenditure | HC 512 (Cm 8007) |
| Third Report | Commissioning | HC 513 (Cm 8009) |
| Fourth Report | Revalidation of Doctors | HC 557 (Cm 8028) |
| Fifth Report | Commissioning: further issues | HC 796 (Cm 8100) |
| First Special Report | Revalidation of Doctors: General Medical Council's Response to the Committee's Fourth Report of Session 2010–11 | HC 1033 |
| Sixth Report | Complaints and Litigation | HC 786 (Cm 8180) |
| Seventh Report | Annual accountability hearing with the Nursing and Midwifery Council | HC 1428 (HC 1699) |
| Eighth Report | Annual accountability hearing with the General Medical Council | HC 1429 (HC 1699) |
| Ninth Report | Annual accountability hearing with the Care Quality Commission | HC 1430 (HC 1699) |
| Tenth Report | Annual accountability hearing with Monitor | HC 1431 (HC 1699) |
| Eleventh Report | Appointment of the Chair of the NHS Commissioning Board | HC 1562-I |
| Twelfth Report | Public Health | HC 1048-I (Cm 8290) |
| Thirteenth Report | Public Expenditure | HC 1499 (Cm 8283) |
| Fourteenth Report | Social Care | HC 1583-I (Cm 8380) |
| Fifteenth Report | Annual accountability hearings: responses and further issues | HC 1699 |
| Sixteenth Report | PIP Breast implants and regulation of cosmetic interventions | HC 1816 (Cm 8351) |

# Oral evidence

## Taken before the Health Committee

## on Tuesday 11 September 2012

Members present:

Mr Stephen Dorrell (Chair)

Rosie Cooper
Andrew George
Barbara Keeley
Grahame M. Morris
Mr Virendra Sharma
Chris Skidmore
David Tredinnick
Valerie Vaz
Dr Sarah Wollaston

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**Examination of Witnesses**

*Witnesses:* **Dame Jo Williams DBE**, Chair, and **David Behan**, **CBE,** Chief Executive, Care Quality Commission, gave evidence.

**Q1 Chair:** Can I begin by welcoming you to the Committee, both Dame Jo Williams and David Behan? I do not think either of you need introducing to the Committee. You will not be surprised to hear that there is a broad of range of subjects the Committee wants to cover this morning; issues that have been raised by your board member Kay Sheldon—

***Dame Jo Williams:*** Indeed.

**Q2 Chair:** There are more general issues of whistleblowing and other specific issues in the performance of the CQC but, rather than going into those at the beginning, we would like to start by standing back. The organisation has been subject to extensive criticism over quite a long period from this and other parliamentary Committees. There has obviously now been the change in chief executive and there is the imminent change in the chair. The Committee would like to begin by asking whether you believe the organisation has understood why it has been criticised. What is your view about why it has been criticised and what has been the reaction of the organisation? The key question is: can the public now have confidence that the CQC is fit for purpose?

***Dame Jo Williams:*** Thank you very much, Chairman. There are a lot of questions there. Perhaps I should begin by saying that I think the CQC has had a very tough year but during that year has made significant progress. To illustrate my point, I would say that last year we conducted 18,000 inspections, largely unannounced. Our processing centre in Newcastle received well over 200,000 calls. Over 90% were dealt with within 30 seconds. But, of course, the real issue is: what about the impact of those calls, those communications with the CQC? It is clear that we are following through, auditing and looking at the impact of those calls. We have done a lot of work in preparing for primary care registration. We have had great involvement with the sector and are confident that those processes—we have learned from what has gone before—are fit for purpose. In addition to that, we established a team in Newcastle that would respond to whistleblowing calls, people raising concerns, and we have had significant numbers—500, on average—a month.

What do I believe about the CQC now? I think it is an organisation that recognised last year that there were many things that had to change. We put in process the means of doing so. What I have tried to illustrate in the last minute or so is some of the ways in which we have made progress. That is not to say we are complacent. There is still a great deal to do.

On the appointment of David Behan as the new chief executive, we put out last week a consultation document looking at our next three years. We have begun to be much more future-focused. The feedback from organisations that we work with is that the foundations are now there and we have to move forward. Within our strategy, we are quite clear that we are part of a system that requires commissioners, providers, other regulators and the public to work together to make sure that services are safe and of an appropriate quality.

My reflection is—and, as you have said, I will be going when my successor is appointed—that the CQC had a very poor start and was probably given a task that was almost impossible. The preparation and the foundations were not properly in place. When I look back, I probably underestimated the challenge and the task, but over the three or four years that I have been involved, we have got to grips with that. We understand our part and our purpose now and I am certainly feeling that we will move forward. We have a work force central to what we do who are as passionate as David and I are about bringing about safe, quality services for everyone who uses them, whether it is in a hospital or in a care home.

**Q3 Chair:** But you used the phrase, Dame Jo, "We know what we are there for." I am not quoting you directly, but, "We know what we are there for." In response to the question, you talked about the call centre, the processes and about unannounced visits. What I still do not get is a clear single answer to what is the CQC there for? Why does the public pay £150 million a year for the CQC?

***Dame Jo Williams:*** It is there so that we play our part in driving improvement in health and social care

services. We do that through regulation, using our powers and, where necessary, taking action against those services that do not measure up to the essential standards.

**Q4 Chair:** But there is a tension, even in that, isn't there, between a regulator who provides a minimum standard—
***Dame Jo Williams:*** Yes.

**Q5 Chair:** —and a responsibility for standards above the minimum, driving towards better care. Where does the CQC sit in that? Is it a guarantor of the minimum or is it a mechanism for driving quality higher?
***Dame Jo Williams:*** They are essential, not minimum and we believe and know that those standards will change over time as people's expectations, and services, change. So they are essential standards. Our interventions in a variety of different ways certainly are about making sure that those essential standards are maintained, but, importantly, through working with the sector, helping people. Increasingly, the central platform of our strategy for the future concerns being clear about highlighting for people what works well and how they can learn and encourage. David, do you want to come in on this?
***David Behan:*** If I may, Chair. It is a hugely important question and too often we have seen this as an "either/or" debate. Of course, the truth is that the 2008 Health and Social Care Act, which gives us our power, says that our job is to measure whether people are meeting these essential—as Jo said, not minimum—standards. That is an important issue. Then it goes on to say that we will do that for the purpose of encouraging improvements in services. So the very legislation that created the CQC gives a function which is to encourage improvement in the way that services take place. Holding up the light to services and saying, "This is how you compare to the standards that are set and this is where we issue warning notices," is an indication of where services need to improve and, of course, if services do not improve, we will take further action.
The other area where I think improvement takes place from the functions that the CQC is required to undertake through the legislation is in some of the reports we have produced. In the "Dignity and nutrition for older people" inspection report, which was published last year, one of the phrases that I came across during my induction in the CQC is "the bow-wave effect". What that means is that by publishing this report, those people not subject to an inspection are clear about what some of the essential standards are as to dignity and nutrition and have been able to take action on this.
This was illustrated quite vividly as part of my induction. I went on an unannounced "dignity and nutrition" inspection to a hospital here in London. We knocked on the door and said, "We are from the CQC. We have come to speak to you about dignity and nutrition." The hospital handled this very well, if I may say so. What was absolutely clear was that the director of governance in that hospital had already carried out some audit work based on the dignity and nutrition standards to check that it was meeting the standards we had set out in the "Dignity and nutrition for older people" report. So without the CQC going in to inspect, that organisation, which is a good organisation, had begun to act on the standards that had been set. That is an example of how, through our reports, we can drive improvements.
Indeed, I was flicking through the evidence that has been submitted to you, which your Clerk very kindly sent through to us last night. It was interesting to note the number of times the state-of-the-market report was commented on favourably by those people submitting evidence—there were other comments in there as well—as being a platform, a potential, to drive improvements more broadly across the sector. So I think we do it specifically in individual services through our regulatory activity and we do it through the reports that we publish which allow others that have not been subject to the inspection to consider how they compare against those essential standards.

**Q6 Chair:** One of the questions I remember asking Dame Jo some time ago was the extent to which your service, support and information are sought by the commissioners in the system who are supposed to be the people responsible for driving standards in their particular locality. Can you tell the Committee where that process has got to, in your view?
***David Behan:*** Yes, and it is important. It is not only the commissioners of service, I would argue, Chair, but also the providers that have a direct impact on quality. The information that we possess needs to be sought by both as we begin to go into an environment, a landscape, a context, which is changing quite dramatically with the advent of the Commissioning Board. One of the things I reviewed this week is the draft memorandum of understanding between the CQC and the Commissioning Board. One of the first three areas identified for priority activity is exactly this issue about the exchange of information to ensure that the information that we possess is shared with the Commissioning Board and the information that the Commissioning Board has is shared with us, so we can build that. As you are aware, Chair, it has also taken on the responsibilities from the National Patient Safety Agency, which is a valuable source of information to the CQC. We are keen to ensure that that information is available to us so we can prioritise the work that we do in terms of the inspections and use that to inform the way that our inspections take place and move forward.

**Q7 Valerie Vaz:** I have a quick question about the past and then we will move on to your future strategy. You probably know that the Committee criticised the fact that you focused on registration.
***Dame Jo Williams:*** Indeed.

**Q8 Valerie Vaz:** Can I put it to you that you got it wrong and that mainly you were registering dentists to get income in because you get £50 million grant in aid but £90 million from registration? Could you explain to us—because we have not had an opportunity—why you focused on registration?
***Dame Jo Williams:*** We focused on legislation because—

**Valerie Vaz:** Registration. You said legislation.
***Dame Jo Williams:*** I am sorry. We focused on registration because without registration it is not possible for us to regulate. So, if you like, registration is a licence which enables the provider to stay in business, to do business. The process is required within the law and we cannot follow up and look at whether or not the standards are being met unless that licensing, or registration, process has taken place. It was not about gaining income for the CQC. This was about carrying out our statutory duties.

**Q9 Valerie Vaz:** So you accept that you did not focus on inspection at the time?
***Dame Jo Williams:*** At the time, we had to register in order to, as I say, carry out our regulatory functions. With hindsight—and this is certainly an issue that has been discussed many times—the emphasis, the way in which we set that process up, meant that we were not following up and doing the inspections that our work force wanted to do. That, if I might say so, was out of kilter. It has completely shifted and changed this year, but also last year.

**Q10 Valerie Vaz:** What is the current vacancy rate at the organisation?
***Dame Jo Williams:*** I beg your pardon?
**Valerie Vaz:** The acoustics are not very good and if you do not mind I will talk loudly and slowly. What is the current vacancy rate at the organisation, because I think that was one of the criticisms?
***Dame Jo Williams:*** We have details of our vacancy rate and I will hand over to David.

**Q11 Valerie Vaz:** Is it better than previously? It was an issue.
***David Behan:*** Yes, it is. Really good progress has been made on this. There was an additional £10 million made available to the CQC from the Department. That was resource sufficient for an additional 255 inspectors. As of Friday afternoon, we currently have vacancies of 49 inspectors and 75 interviews are booked to take place over the next few weeks. All those inspectors, once selected, will go through an eight-week induction programme. So we are, from offer letters going out, eight weeks away from people starting being productive. But it is absolutely essential, Chair and Members, that we make the right decisions about selecting people, that we are clear about the standards we want. Therefore, there is a balance to be struck here about the speed at which we recruit to those vacancies and ensuring that we get the right people in.
We had 194 vacancies in April of this year and, as I say, as of Friday afternoon it was 49 inspector vacancies, predominantly in London and the south-east of England, interestingly enough, but we have a programme to get through that. I would calculate that by the end of this calendar year, we would be in a position where we have offered all those roles. We have about 4.5% turnover so there will be some attrition during that—it is a bit like the Forth Road Bridge in that as soon as you have it to full establishment some people will leave due to retirement, etc.—but that is where we are and we are making good progress in relation to that.

**Q12 Valerie Vaz:** Could you touch on this bank of 100 national clinical advisers? Who are they and what is it?
***Dame Jo Williams:*** We have recruited people from a variety of different backgrounds and David is looking for the detail of it as I speak. They are a resource to our inspectors. If, for instance, an inspector believes that they are in a situation where they need advice from a nurse or a doctor, they can tap into this. They are people who have put themselves forward because of their expertise, and we can draw on that list. I think we have the complete list of what their backgrounds are.
***David Behan:*** Yes, we have about 100, Valerie, and we went live with this in July. We have about 42 general nurses, nine nurses with expertise in mental health and learning disability, 14 midwives, nine doctors and two GPs. Interestingly, in terms of your question about dentists, we have 10 dentists, five allied health professionals, 12 social care people, four executives who are experts in QA systems and two clinical scientists for the laboratory work. In addition—and I think this is important—we have 300 experts by experience, people who use services, who have accompanied inspections.
On the dignity inspection I referred to earlier that was part of my induction, I was accompanied by an expert by experience who spoke to the people in the hospital and asked them how they were treated and who was, I have to say, a fantastically invaluable member of the team. We were assisted by a nurse from elsewhere in the south-east who added real professional value to the inspection. That is beginning to get traction in the organisation.
Since July, there have been 16 requests for advice and seven of those people have accompanied inspectors on routine inspections. It is a resource, a reservoir, which is there to be drawn on appropriately. Clearly, I would be looking for a greater traction in relation to that for inspectors who are going in where their own background is not of that particular service area either to speak to people before or perhaps be accompanied.

**Q13 Valerie Vaz:** If I could turn to this document, your next phase, you mention at page 15 "Building the evidence base". Could you explain about this evaluation, what it is about, how much it is going to cost and why you don't appear to have that information already within the organisation?
***David Behan:*** We do have some of it already and I think what is important, Chair, is that if you look across the world at the literature of what regulators do—whether you are looking in America, Australia, Canada, New Zealand or the Scandinavian countries—what is clear is that there is too little evidence internationally as well as nationally about what is effective in regulation. So I don't think we should beat ourselves up. I am certainly not beating myself up, coming to this job, about whether we are missing international evidence about what is effective in regulation. If that evidence, that research, is not there, then we need to create it. There needs to be a

debate about what academic research we need in relation to the evidence about the effectiveness of regulation.

We also need to be clear about the way that we operate. What we are setting out in the strategy, quite importantly, in my view, is a clear statement that we want what we do to be based on the evidence of what we know works. One other question is that I had a positive feeling that the expert by experience really added value to the dignity inspection that I went on, but what is the evidence? Do they add value to everything that we do? If they do, should we be extending the way that we use experts by experience in what we do? Where we have outside experts assisting teams, what is the evidence of what difference they make, what value do they offer and should we have more or fewer of those? What we are setting out is a clear approach to generating the evidence ourselves in terms of what works and using that to inform the work that we do going forward.

**Q14 Valerie Vaz:** How much is it and when will it come to an end?

***David Behan:*** We will do that from within our current resources. We are working with Professor Kieran Walshe from Manchester University who has some knowledge and expertise in these areas and he will provide that link to the academic and research world, although he will also actively get engaged. I can write to you, Chair, if you want, as to what those original costs will be, but this is an ongoing programme. Being clear about what we do that is effective is something we will do year on year and not a one-off event that will come through. It needs to be part and parcel of the way that we become a high-performing organisation. As to your question earlier on whether we have listened to what people have said in terms of your recommendations last year, the Public Accounts Committee, the NAO and the Department's own capability review, I have to say that coming into the organisation I have been impressed by the openness with which the organisation has demonstrated its receptiveness to the challenges that it has received. It is perhaps the most scrutinised public service organisation in the past 12 months.

The scrutiny review—there is a copy of that review and an update on progress on our website—has been used to drive the evaluation process that Valerie Vaz is raising with us now. I hope what we are doing in that is demonstrating that we have listened to the comments that have been made. One of the queries that was made in relation to effectiveness is whether we should regulate in exactly the same way a small three-bedded care home for people with autism, a dental practice and a multi-site multi-million-pound teaching hospital here in London. Perhaps the same values and principles can be used, but a number of people have said to us that you cannot use exactly the same evaluation process.

**Q15 Valerie Vaz:** The differential regulation.

***David Behan:*** We need to differentiate. We want that differentiation to be based on the evidence.

**Q16 Valerie Vaz:** Absolutely. I want to move on. Thank you for that very helpful answer. One of the key areas you said you were going to look at in the future is how you are going to deal with other organisations, say, for example, Monitor. Some of the evidence that we have in, particularly from the Foundation Trust Network, said that clarification is needed on the role of Monitor and you because there is an overlap, isn't there? There is a case where Monitor stepped in and found out there was something wrong and you didn't pick it up. The Relatives and Residents Association has said that some local authorities and other commissioners undertake their own inspections because they have no confidence in the CQC's rigour. Could you address those two points about Monitor and why other regulators have to step in?

***David Behan:*** Yes. This goes back to the Chair's question, I think, of whether we have listened to what has been put at CQC's door over the past 12 months. I believe we have. In the past four weeks since I began I have had regular conversations with David Bennett at Monitor. I have described the memorandum of understanding that we are developing with the Commissioning Board. We will have similar MOUs with Monitor so we and it can be absolutely clear about what its role is. It is moving into a new space and developing its new role as a result of the Health and Social Care Act.

As I said, I read the submissions that you had kindly shared with us yesterday evening. There were no antibodies in relation to the issues that were being raised by the Foundation Trust Network or by the Relatives and Residents Association. We need to embrace some of those comments. What you will have seen earlier this month is the publication by the National Quality Board of a document which Dame Jo has signed on behalf of the CQC, David Bennett, I think, has signed on behalf of Monitor, and other key actors and players in the system have signed, which is a clear statement of their roles. As a beginning, it will set out what the distinct and unique contributions are that we all make. I think we have a unique contribution and I think this plays, Chair, to your question to Dame Jo at the opening. What we do that nobody else does is check that people are meeting those essential standards. Nobody else in the system will do that. In order to do that effectively—and I think this goes to the heart of your question, Chair—we will need to share information with those organisations and they will need to share that information with us.

The case you were referring to is that of Morecambe Bay, and one of the issues in Morecambe Bay is whether the right amounts of information were being shared at the right time. The CQC has been very open about that and we are setting out very clearly in our strategic review that our ability to be the independent regulator of quality in the system—so we can arrive at independent judgments about the quality of services—means that we have to be interdependent because we will work with others to discharge those responsibilities.

**Q17 Valerie Vaz:** Finally, is there any reason why Monitor and HFEA have been left off your list of participating organisations?
***David Behan:*** You need to draw a line somewhere otherwise you end up with a very long list. What we are doing is drawing a distinct difference between the organisations which we know now we have to work with—and we are calling those strategic partners—Monitor, the professional regulators, but the consultation is still out in relation to HFEA. That matter has not been determined by Government. In fact, we have not yet set out our response.

**Q18 Valerie Vaz:** I am talking about your document and list of participating organisations. Could it have been an error? Monitor is keen and you have been having a chat with them. I wondered why you drew the line and left those two important institutions aside.
***Dame Jo Williams:*** It must be an oversight. Quite clearly—

**Q19 Valerie Vaz:** That is all I wanted to know.
***Dame Jo Williams:*** If that is the case, I am sorry about that.

**Q20 Barbara Keeley:** Can I take you back, Dame Jo, to what you said about this question of "essential, not minimum" standards? You said a curious thing, I think. You said that "this will change as people's standards change." I have to tell you, as a constituency MP, that it is not unusual to find family members and carers who have had very bad experience over the last number of years, for instance, and particularly in things like using nursing homes for respite care, to the point where a family member would remove somebody halfway through a respite care week because the standards of a home that you had passed as being acceptable were so poor. That is where we are.
It is not a question, I think, of looking forward to a future where people will start to expect higher standards. In my experience, in my constituency, people are unhappy with standards now. This is particularly borne out in the written evidence from the Relatives and Residents Association. Focusing quite a deal on care homes, it says that the CQC does not have sufficient expertise in the care-home sector, and your focus on selected standards only is negligent. It makes the point that, differently from registering dentists and the other things we have been talking about, care homes are places where people live. You are not just there for a couple of weeks. If the standards are low, this is the quality of your life all of the time, 24/7 all year round. I would like to take you back to that because I don't think we are in a situation where we are looking at people currently thinking standards are acceptable but that they might go higher. That is not the case.
***Dame Jo Williams:*** I do not wish in any way to deny anything that you have said. I absolutely agree that if someone is experiencing a care service, it should be acceptable to them. We all have individual standards but, basically, it must be acceptable to that individual and their family. The essential standards which we operate against are the means by which we are able to say whether or not a service is compliant. We are increasingly focusing on what has been the experience of people living in that environment: how have they experienced it, are they happy with the way in which they are treated as an individual and the services they all receive? If there is additional information that a service is not meeting the needs of an individual, we would wish to know about that and follow up.

**Q21 Barbara Keeley:** Before you go any further with that point, let me say that I am not talking about exceptions. I have, on occasions, sat down with a group of carers at a carers' drop-in, who would run through the list of nursing homes we have locally and find only one or two of them of an acceptable standard. That is where we are. When they are trying to find a nursing home following the deterioration of a loved one and their increasing need for care, people are horrified at the existing standards. This is a crucial point.
I am talking about my local experience, but the Relatives and Residents Association gathers a lot of experience in from its members. It is saying that in terms of purpose and where you are going, its belief is that you do not have sufficient expertise; you are focusing, negligently, only on selected standards; and that you are not doing an adequate job in terms of inspecting care homes. That would entirely tie in with my experience of talking to people in my constituency about their local experience. It is not always a question of saying that at some point in the future standards have to improve. This is an issue now. As we discussed, Chair, on the purpose of the CQC, it is important that you recognise and accept that. If you do not, there is an issue.
***Dame Jo Williams:*** I would not wish to say in any way that we wouldn't take seriously what you have said. I know from my own experience that it is very variable. If there are significant shortcomings in the service, we must know about that and we will follow it up. We have been working with the Residents and Relatives Association very closely, asking it to pass on information. Since the beginning of this financial year, we have had an agreement with it. The information that it has passed to us is very limited. That is a matter that we must take up with it. We have only had, I think, somewhere in the region of 35 direct referrals. We need to hear from you and from the public about those unacceptable services and standards. It is our job to go in and regulate against those standards. Quite rightly, people's expectations should change. My point about standards improving is not to deny that we must make sure, right now, for everyone experiencing services, that those services meet with those standards.

**Q22 Rosie Cooper:** Dame Jo, please let me ask this and I am sorry to interrupt. I heard what you said and there will be people agog at it. When you last gave evidence you talked about minimum standards. This time, you are talking about essential standards. You are saying that, when alerted, you will go to it. So what happened at Winterbourne View? What happened at Mid Staffordshire? You were alerted many times. We have had people here giving

evidence. If what you are saying is true, why didn't it work then? Why did you fail so miserably on so many occasions?

***Dame Jo Williams:*** First of all, may I say that if I did talk about "minimum standards" rather than "essential", I am surprised by that and I apologise. It has always been "essential standards". We have looked long and hard at what happened at Winterbourne View. As a result of that, we have made very significant changes within the CQC. We carried out our own internal management review and contributed to the serious case review. It was an extraordinarily painful process for everyone concerned and horrifying to see and understand that people were in that situation. But what the serious case review author said was that the CQC had been refreshingly honest in looking at what had gone wrong and putting in place measures to move forward. That is my point, that we have absolutely listened to, understood the messages and taken steps to improve.

**Chair:** Rosie, we are coming back, if I may say so—

**Q23 Rosie Cooper:** Winterbourne View was a while ago. What happened to Morecambe Bay? That is recent.

***Dame Jo Williams:*** As David has said, we have looked at that. In fact, we have established a further investigation into that. We want to understand why we made the judgments that we did.

**Q24 Grahame M. Morris:** My point essentially follows on from a point that was originally put to you, Dame Jo, by my colleague Valerie Vaz in relation to the dissemination of information following an inspection and how the information that is collected by the CQC is made available to the general public and to other stakeholders. We have received evidence from individuals documenting their concerns. Without mentioning those specific cases that colleagues have already referred to—just in the generality of it—could you clarify for my benefit, what happens in the case of a private care home where the CQC does an inspection and finds that the services that are delivered do not meet the required standard? If that was a local authority care home, the CQC would share that information with the local authority and it would be in the public domain, but if it is a private care home, those individuals who fund their services privately are not notified of it, are they? Why is that, in terms of what do we do with the information that the CQC collects?

The other question related to that is, when we are talking about private care homes—and often private care homes will be part of a group—if there is an indication of a problem within the group or there is an indication that directors who own these companies are involved with other companies where there are similar failures in standards, does the CQC make that information available on its website so that people can make a judgment about where their relatives should be looking for the best standards of care?

***Dame Jo Williams:*** Your first question was about what we do if we find that a service is not compliant: that could lead to actions such as a warning notice, and that would certainly be published on the website. I take the point that you have made about would we go and talk to those individuals in the home. If it was significant and we felt that they were significantly at risk, of course we would work with the local authority whose responsibility it would be to make sure that they were kept safe and that alternative arrangements were made for them. That is a reflection of, yes, how do we do more to safeguard individuals who themselves are limited in the way in which they are not supported, if I can put it that way, by a local authority?

As to the question about large corporate organisations, we do recognise that. Particularly relating to issues to do with learning disability and Winterbourne View, we are looking at how we can work differently with the corporate organisations and what we can legitimately say to the public about that. That is a partial answer, I think, to the point that you are making.

**Q25 Grahame M. Morris:** Where there is a serious failure, would the CQC determine that, say, the director of a company where there is a history of this, or where there is a failure to comply, is not a fit and proper person to run such an establishment? When would you reach that point?

***David Behan:*** If I may, Chair? This is an important question and I think you yourself have raised it at other times.

**Chair:** I have.

***David Behan:*** It is a hugely important question. The Government have published a document on the operation of the market and this was very much post the events at Southern Cross. One of the issues that came out of that consultation was exactly this issue about how you determine fit and proper people. It was a question that was asked in the document and the Government have committed to publishing a further document in the autumn of this year. One can anticipate it any time soon, I suppose. I hope that will be the basis on which a further debate can take place about this important question that Grahame Morris is raising. At the minute, the CQC does not have power to act in that way around "fit and proper people" tests and therefore that is something on which there needs to be a broader debate and it is an important issue for members of the Committee to continue to raise.

**Q26 Mr Sharma:** Following on from Barbara's initial question, do you act only when the whistleblower or a family member of those residents in the care homes makes a complaint? You do not have any mechanism to visit and question.

***Dame Jo Williams:*** Indeed we do. Each inspector will have responsibility for a number of services. They are looking at those services for which they have responsibility. They will be talking to the local community, possibly local LINks, but they will be looking at local newspapers. If it is a care home, they may be talking to local nurses, gathering the information, sharing information with the local authority, making a judgment about that information and then deciding to make an unannounced inspection. On that basis—

**Q27 Mr Sharma:** How long is that period?
***Dame Jo Williams:*** If we received very worrying information from a particular source that suggested there was high risk to those people, we would act very quickly. Every inspector is looking at their responsibilities. If I could put it this way, they are doing a risk assessment on the basis of what they know—when they last visited and what others are telling them—and determining at what time they should go in.

**Q28 Mr Sharma:** Then why—and I am not going to name the places at this stage—even in my own constituency, has it taken years, not days, weeks or months, but years, before the CQC came to the decision to close down the care home when all that information was publicly available? The local authority was involved, a large number of families were directly involved, whistleblowers had provided the videos and all that information, but it still took years and many residents suffered and later the families suffered during that investigation. Is it the failure of the CQC, or do you think there is something else? And what actions would you take against any inspector who was responsible in that investigation?
***Dame Jo Williams:*** If I might say, I would be very pleased if you would perhaps give us information outside this Committee.

**Q29 Mr Sharma:** It is an old case, now closed. I am asking why it has taken such a long time when that information was available and if the organisation was, as you say, so effective.
***Dame Jo Williams:*** I obviously cannot respond to your particular point or example, but most certainly, if we learned that people were at risk, we would take action to make sure that they were safe. If it is not of that high risk but there are difficulties and non-compliance—if it were of such a nature—the first thing we would do would be to talk to the provider of the service about what they were going to do to put it right. We would follow that up. If they were not putting things right, we would determine what would be a suitable action. It could be that the first stage would be a warning notice. The point you ask about is, from that stage, how long does it take to bring about closure? It is a legal process and of course it doesn't happen overnight, but throughout that legal process our responsibility is to make sure that individuals are safe.
***David Behan:*** If I may add to that, Chair, it is an important question. The CQC has been publishing on our website performance data and one of the changes that have been made from this time last year to now is that we are trying to provide data as part of that. It is published on our website and anybody can go on and see it. The period to July is on the website now, but I want to check that. One of the pieces of information that we are putting out there is the length of time it takes us to complete certain activities. Then it is out, open and public and people can come back and challenge us in relation to it.
Obviously, the devil on all these cases is in the detail and not in an aggregate set of numbers. Your challenge right at the beginning was "What have we learned?" One of the things we have learned is to be much more open about the way we are publishing data on our performance, being much more transparent and allowing people to come back to us in relation to that. As I say, I commend the information that is on the website. The last period is period 4, to July 2012. We hope that information is accessible and presented in a way that people can make sense of in terms of our own performance. A huge amount of work has been done—to pick up on Grahame Morris's question—on improving the website, so our reports are there and available for people to read, whether that is public or private-sector organisations.
There is more still to do. We are not satisfied with the website. There is an active programme of engagement and I think, in terms of Virendra Sharma's question—and I think this plays to Rosie Cooper's challenge as well—we are getting about 500 whistleblowing referrals each month. Rosie herself has been up to look at the work that we do in Newcastle, and thank you very much for making yourself available to do that. It speaks well of your commitment to making this a system that is one that people can have confidence in.
We are also carrying out audits of the way those whistleblowing referrals come through. In our second audit—we are about to do one in September—we looked at 40 cases. Of those 40 cases, 22 were referred to local safeguarding teams and 17 triggered responsive inspections. That is an example of where people do blow the whistle, the information comes through and you are beginning to see us changing the way that we operate based on that information coming through. As Jo said right at the beginning, we are not complacent about any of this. This is a significant change in the way that we operate, but I share that information and the statistics that are behind that in a way that I hope enables you to begin to develop some confidence that this is an organisation which is changing, learning, growing and developing. We are determined, as an organisation—I am determined—that we will discharge our responsibilities in a way that people can have confidence in.

**Q30 Chair:** We would all welcome that, but perhaps you will understand the scepticism on the part of the Committee, and indeed beyond the Committee, given that this is not an old quote—or not that old, it is January 2012. Your director of operations Amanda Sherlock described the inspection of the Morecambe Bay Trust as a "robust piece of work". We do not understand, frankly, how the director of operations can describe the inspection of that trust as a robust piece of work given what happened following that inspection.
***Dame Jo Williams:*** Chairman, I have already said that we are looking back. We set up an independent review of what happened there and that information will be with—

**Q31 Chair:** It is a pity, isn't it, that the director of operations describes it as "a robust piece of work" before the review takes place?
***David Behan:*** It is important, Chair, to draw the distinction between the registration of Morecambe

Bay, which is where some of the concerns come from, and then the subsequent inspections in Morecambe Bay. The issue that sits at the heart of the Morecambe Bay case is whether we got the initial registration right and whether all the information—

**Q32 Chair:** With great respect, I doubt whether that distinction between registration and inspection would tell very strongly in the eyes of patients.

***David Behan:*** No, that is absolutely right. One of the consequences of, "Did we get it right in Morecambe Bay?"—one of the things I have agreed with Dame Jo—is that we should get an independent review. I have asked Grant Thornton to lead a review of that work, which is completely independent. Then, as to the issues that you are quite rightly raising, in the eyes of people using services in Morecambe Bay, I hope they will see that there is some element of independence in the review of the work that we did and the engagement that we have had. That is probably the most appropriate way to try to respond to those allegations, Chair.

**Q33 Rosie Cooper:** Mr Behan, how can the general public have great confidence when—and it is the point I was trying to allude to before—organisations get either a clean or reasonable bill of health and then later the most horrendous situation is found to have existed? It is not that you were not alerted to it. You were alerted many times and, as the Chair has described, Amanda Sherlock did say that that report was robust. I hear you saying repeatedly, "We are learning," but the public out there are screaming, "How long will it take?" How many people have to suffer before we start to get this right and we can trust that when you say it is robust, we don't need to go to Grant Thornton because we know it is robust? That is the bit by which you will be judged.

Perhaps I can also say something in your mitigation that I think is true as well. There is confusion in the hearts and minds of people outside because you say, "Please bring us your concerns. Please bring us any detail you have," and when people do give it to you, the immediate response is, "We are a regulator, we are not a complaints mechanism. Therefore, we will not investigate that complaint and get back to you." There is a complete mismatch between what you are asking people to do, what they think they are doing and what you are delivering. They want you to look at the complaint and you are saying, "Thank you very much for that information. We will feed it into our system." The fact that the Health Service has such an appalling complaints system often means that people feel that their complaints are not dealt with properly. You, the regulator, become the point of last resort and when it all goes wrong, you have allowed it to happen. So there are other parts of this system which are wrong as well, but the truth is that you are the regulator, you are the back-stop, and people's lives depend on you getting it right.

***Dame Jo Williams:*** I appreciate where you are coming from and absolutely understand the points that you are making. One of the challenges for the CQC, but maybe also for the way in which the whole system is working, is the expectation that there is some mechanism, a silver bullet, a magic, that will ensure that in every situation everything is going to be all right. The real issue for us, as a regulator, is making sure that we understand and work with, in an interdependent way, people who provide services, people who commission services and the public. The challenge for us is to get that right, to use that information judiciously, to use it in a way that will enable us to take appropriate, timely action, as quickly as we can. That is a hugely challenging proposition.

We are saying to you this morning that we recognise what you are saying about public expectation—we are a back-stop—and we are determined that, through analysing what has gone before and looking across the world at what is happening, we can play our part and improve in our role as the regulator. The health and social care system is extraordinarily complex and nowhere that I know of has got that absolutely right. If they had, we would take that off the shelf and take it away.

It is a very important challenge that you make and we do not underestimate what you are saying. The public, as you say, are entitled to feel that the regulator can make everything right and the truth is that we need to, as a robust, high-performing organisation, play our part. That is what we are determined to do as we move forward.

**Chair:** Chris Skidmore wants to ask a quick question and then I want to move on to the specifics of Kay Sheldon.

**Q34 Chris Skidmore:** I want to ask about David Behan's point as to the differentiation between registration and inspection. Going back to Morecambe Bay, the trust was registered in April 2010 and then you had an unannounced inspection in June 2010. Obviously, inspections are unannounced, but is the process of registration itself unannounced?

***David Behan:*** No, but—

**Q35 Chris Skidmore:** Do you not think that, rather than create the kite-mark of a standard through registration, and then have unannounced inspections later on, the very process of the registration erodes confidence in the CQC if the CQC registers an organisation which then turns out to not live up to the standards of care that should be expected? Shouldn't the process of registration follow similarly the process of inspection in that there should be some form of unannounced process by which, when you turn up to register a trust and talk to providers, they cannot sweep anything under the carpet?

***David Behan:*** It is an interesting proposition, Chair, as to what degree of, in a sense, spontaneity there is about the registration process. Clearly, the system is set up at the present time such that it is a licence for people to begin to be a provider.

**Q36 Chris Skidmore:** There is that bond of trust by handing over the registration process.

***David Behan:*** Absolutely. These issues about trust are hugely important. I see my job with the board as driving forward the CQC so that the public can have trust in what we do and the judgments that we make. I feel that as a personal mission. I think that is how I

should be judged in doing this job and that is what I am determined to do.

What we are doing in our documents—our forward strategy—is asking questions about what the best way is to do it. It is not only that we are learning from the past, Chair, but that we are trying to find a way forward, and this comes to the points made by you and other members of the Committee about whether we have the right direction, and whether we are being clear about our purpose. What we will do between now and December is ask people whether we are asking the right questions and answering these in the right way. What we must do in December is bring this not only to a conclusion—this is not a seminar—but to a decision and that should inform what we do. That is key to building this bond of trust that Members have said is so important.

I have one last point on the trust, if I may. We got 1.7 million visits to our website last year. We got 685 completed "share your experience about care services" forms coming in. So a mixture of whistleblowing, hits on our website and sharing experiences gives us some of the intelligence that we are using to drive forward. It is not everything, but they are some of the things that we are doing differently that allow us to position—

**Q37 Chris Skidmore:** You would look at changing the registration process to possibly reflect an unannounced inspection. It is part of the—

***David Behan:*** What I would like to do is take that away, if I may, Chris, and have a look at it: is it possible to get spontaneity into, effectively, a licensing process?

**Chair:** Could we spend some time on the important, serious allegations being made against the CQC by Kay Sheldon? Rosie, you want to lead on that.

**Q38 Rosie Cooper:** I would like to start by asking about when you first became aware of Kay Sheldon's concerns, what they were and how they were addressed. I have a number of questions to follow, but perhaps you could walk us through from the original concerns right through to today, as that may answer some of these other questions as well, please.

***Dame Jo Williams:*** Perhaps I can begin by giving a little bit of context, if I may. Last year, the CQC was well aware that there were matters of concern. The board was, quite rightly, sighted on those concerns. You have mentioned some of them this morning. We were a very small board. In fact, one of the commissioners indicated in September that he would be leaving because his work location had changed. So we were a board of five, myself and four commissioners. On the issues that were being raised, which we understood and needed to be addressed, every member of the board had a different perception, a different view. We were, together, taking our responsibilities very seriously, looking to work effectively as a corporate board tackling those problems and looking to solutions. When Kay Sheldon, for instance, began to raise her concerns, what we felt as a board was that, yes, these were reasonable but there is a difference between raising a question, raising a concern, and expecting that, having raised it, there is immediately going to be a solution. That was the difference between Kay Sheldon and the rest of the board. To be specific, she had concerns about the regulatory model and about the culture of the organisation.

**Q39 Rosie Cooper:** How would you handle the procedures for assessing the performance and abilities of board members? Do you think that worked well in this case? I will come back, if you like, to your or the executive team's control in determining what board members may or may not do. Let us go to procedures. How do you establish how your board members are doing?

***Dame Jo Williams:*** How do I establish—

**Rosie Cooper:**—the performance and abilities of your board members?

***Dame Jo Williams:*** I beg your pardon?

**Rosie Cooper:** What are your procedures for establishing the performance and abilities of your board members?

***Dame Jo Williams:*** There is a process that was driven by the Appointments Commission but now is driven by the Department of Health. It is a formal process of analysis on an annual basis, looking at how individuals have contributed and the way in which they have carried out their functions as board members. For instance, at the very basic level, are they apprising themselves of what is going on in the organisation, what are their specific skills and how have they been able fundamentally to add value to the organisation?

**Q40 Rosie Cooper:** How did that work in relation to Kay Sheldon, both before and after her wish to appear at Mid Staffordshire?

***Dame Jo Williams:*** I need to explain some of the issues that had happened during the autumn of last year. We were going through an exercise in late September, building and developing the board, quite rightly, and we will continue to do that this year. It was at that meeting that Kay told us that she was embarrassed and ashamed to be a member of the CQC board, which was very concerning to all of us. Following that, she left the meeting and was subsequently found to be in considerable distress. It is true to say that throughout the autumn I spoke with Kay and expressed my feeling that I believed I had not only a duty to ensure the board worked effectively but a duty of care to her as a board member.

Subsequently, as you well know, it was her decision to go to Mid Staffordshire. Following that—again it is in the public domain—my colleagues and I felt that there was a breakdown of trust in what had been a small group of people working together with common purpose doing what we believed was everything possible to bring about change and address the issues relating to the CQC. You would not be surprised to hear that, following that—and it is quite clear that that action led to a significant change in the relationships—it has not been possible to reach agreement with Kay Sheldon about when she and I would sit down and have that appraisal.

**Q41 Rosie Cooper:** You said your colleagues had agreed there was a breakdown of trust. Who constitutes "my colleagues"?
***Dame Jo Williams:*** The other commissioners.

**Q42 Rosie Cooper:** So you had a meeting. Was Kay there?
***Dame Jo Williams:*** No.

**Q43 Rosie Cooper:** Was this the purpose of the meeting, to discuss Kay's actions?
***Dame Jo Williams:*** What I should say to you is that when Kay made her decision to go to Mid Staffordshire, the response from us was huge shock. We had been working together as a group of people wishing to address the issues. So there was huge shock. Therefore, the question in our mind was, "Were we able to work together, could we work together?" She made some very strong statements about individuals, both executives and myself as chair, and other commissioners felt that, reflecting on what her statement had been, their view was—and I wasn't party to this conversation—they wanted to issue a statement of support for my leadership. But quite clearly, in my conversations with them, we were shocked and we did believe that trust had broken down.

**Q44 Rosie Cooper:** Dame Jo, I am not sure from your responses there whether this just happened or there was a meeting where you, without Kay Sheldon—a group of you—decided there was a breakdown of trust and therefore actions should follow. What you are actually saying there is if there is real dissent that goes to the core of it, you are going to be cut adrift by the board. Is that true?
***Dame Jo Williams:*** Your proposition is that if there is real dissent—

**Q45 Rosie Cooper:** I have chaired organisations. I have dissented more than enough and I probably would have found myself out in the Irish Sea or perhaps up in Antarctica by now. Dissent is absolutely to the core of everything. You sort it out. You don't suddenly say, "Just because you disagree with me, we are going to cut you off." I don't understand how you can go into a room and make that decision.
***Dame Jo Williams:*** It is not my intention in any way, Rosie, to mislead you. It absolutely was not like this. This was a period of time over several weeks and months when my belief was—and other commissioners believed this—that we were addressing the issues and the concerns. That was our purpose. As to dissenting voices, you are absolutely right that you cannot expect a group of people who are doing a job like this always to agree. If we were all agreeing, we would be in terrible trouble, so that was not the point. The point was that, without discussing with us her determination to go further, she went to talk to the National Audit Office and then to the inquiry. There are processes and procedures that we have within the CQC that she did not choose to use. She could have gone to the Secretary of State, a Minister, to express her concerns. We were not in any sense underestimating anyone's concerns within that board. The point I am making is that what she did—it was not that she should not and is not entitled to raise matters that concern her so deeply but that she was working as part of a group—was to choose not to let us know that that was her course of action, nor did she follow procedure.

**Q46 Rosie Cooper:** Can I ask you a question then? Was Kay Sheldon told by the deputy chief executive that she could go to Mid Staffordshire as an observer? Is it your knowledge that she was told she could go as an observer but not to give evidence?
***Dame Jo Williams:*** I would have to come back to you on that. I do not know of an occasion when that question was asked. Is the proposition you are making in terms of our original evidence? I do not know the answer to that. I will come back to you.

**Q47 Chair:** Can I clarify that, Rosie? Kay Sheldon says very specifically that she told Jill Finney she wanted to give evidence at Mid Staffordshire and was told by Jill Finney that there would be an official giving evidence. We were further told by Kay Sheldon that the official had not at that stage agreed to give evidence and was told to give evidence by Jill Finney following her interview with Kay Sheldon. Is that true or not?
***Dame Jo Williams:*** I do not know, Chairman. I received the information that you received late yesterday afternoon and I will need to come back to you on those specific points. I do not know. That is the situation.

**Q48 Rosie Cooper:** Could you come back?
***Dame Jo Williams:*** Of course.

**Q49 Rosie Cooper:** Could I also ask how many compromise agreements have been signed in the time that the CQC has been operating and how many of those contain gagging clauses?
***Dame Jo Williams:*** While David looks for the detail of that, can I also say that even though we did include compromise agreements—and I know they are now called gagging clauses—it was quite clear in every case that that would not preclude public interest disclosure.
**Rosie Cooper:** I am going to end my comments by thanking you for the information you have given us. We will look to get some more information, but I think that, David, as you take this organisation forward, a board member does not need the permission of other board members to do their duty.

**Q50 Andrew George:** In terms of the organisation itself, being the Care Quality Commission, obviously you want to be setting the highest possible—
***Dame Jo Williams:*** Absolutely.

**Q51 Andrew George:**—quality standards, including in the area of medical ethics. That will of course include patient confidentiality and patient consent. In those circumstances, why was it that without Kay Sheldon's knowledge you were seeking an independent medical assessment of her?

***Dame Jo Williams:*** The situation was this. She wrote to me asking for an assessment. She said that—I do not have the exact words in front of me—because she was a disabled person with a mental health issue she was seeking an assessment. When I received that request, I was genuinely pleased that that was an opportunity to move forward. My initial response to that was to believe that the occupational health department—we had a contract with an organisation—would be the appropriate place to seek that advice. I notified Kay Sheldon that arrangements were being made for her to have an appointment.

**Q52 Andrew George:** That was done collaboratively because she was saying in her evidence that—
***Dame Jo Williams:*** I wrote to her to tell her that was the case.

**Q53 Andrew George:** You told her.
***Dame Jo Williams:*** What I did not do—and I am disappointed in myself that I did not do this and this was wrong—was send her a copy of the referral that I made. But I did let her know that that appointment was being made.

**Q54 Andrew George:** She says in her evidence that she had requested this.
***Dame Jo Williams:*** Indeed.

**Q55 Andrew George:** Therefore, I think it is reasonable to expect—as she had made the request—that that should be done with both sides consenting. In other words, there should be a collaborative approach rather than you unilaterally going to Medigold and simply commissioning something, and not only commissioning something but commissioning it in a manner which did not fully consult her or she was not fully aware of.
***Dame Jo Williams:*** I take the point you are making. As I say, at the time I felt this was an opportunity to make progress. It seemed to me that our occupational health contractors were the right people to approach. What I did not do was to talk through with Kay the making of the referral I made and send to her a copy of it. I agree that that was not the right way to move forward. Subsequently, when it was made clear to me that, in Kay's view, she was asking for something different, we then did collaborate and look at what would be the most appropriate means of getting that assessment.

**Q56 Andrew George:** You are content that the person who was commissioned to undertake this work was qualified to undertake a mental health assessment. Are you satisfied that when you received a report—I understand it was a three-page letter—that, as you say, should be shared in a collaborative way? When that report came in, did you make any effort to show it to Kay Sheldon and to consult her about that report?
***Dame Jo Williams:*** No. First of all, it was a record of a telephone conversation. It was not an assessment in any sense. My understanding is that the purpose of that conversation was to determine who would be the most appropriate practitioner to undertake an assessment. That was the whole purpose of the discussion on the telephone. Subsequent to that, the doctor who had had the conversation wrote the letter describing that conversation.

**Q57 Andrew George:** This communication included a number of comments about Kay Sheldon herself from someone who is not qualified to make assessments, saying that she is likely to have one of the conditions that involve paranoia. There were a number of other comments including that it was really important that she be "assessed or else removed from her position" and comments of that nature. Those comments were not shared with her at that point.
***Dame Jo Williams:*** That is true.

**Q58 Andrew George:** Kay Sheldon, in order to find out what had happened, could only obtain that information through Freedom of Information requests—through a Data Protection Act request for that information. That is a very unsatisfactory situation, isn't it?
***Dame Jo Williams:*** It is unsatisfactory. I want to say two further things. In my duty of care and concern for Kay Sheldon, there were two issues that I want to draw to the attention of this Committee. First of all, at the end of September, when we had the meeting when she told us that she felt ashamed and embarrassed to be a commissioner, she disappeared from the room for a considerable period of time and it took us possibly well over an hour, an hour and a half to locate her. I was not there myself, but two senior members of the executive found her. She was very distressed. She wasn't recognising her own name. She was in a toilet, there was water everywhere and she was completely wet through. There was genuine concern on my part for her wellbeing. Subsequently, later in the autumn, she told me that her reality was that when she walks down the street she believes that everyone is talking about her. So I had concerns about her wellbeing. That doesn't in any way answer the question that you raise and you are quite right that—
**Andrew George:** Not only does it not answer the question, it reinforces the assessment she has made herself. Here we have a letter which was kept from her which—

**Q59 Chair:** The question, if I may say so, Andrew, was, is it appropriate for this assessment or preliminary opinion about Kay Sheldon's condition to have been passed to you and not been shared with Kay Sheldon? Can we confine ourselves to that question?
***Dame Jo Williams:*** Indeed, okay. Thank you, Chairman.

**Q60 Valerie Vaz:** I am sorry, but I have to say that you are making comments about someone who does not have a chance to speak against them. They are very personal comments and I feel incredibly uncomfortable that you should sit here in a public forum and say those things, which is just your word. No one has a chance to answer back. Please withdraw those comments now.

***Dame Jo Williams:*** I will do. Chairman, I understood that in this arena I was at liberty to answer the questions put to me.

**Q61 Valerie Vaz:** You should not be making personal comments about someone who does not have an opportunity to put the case herself.
***Dame Jo Williams:*** I withdraw.
**Andrew George:** The question I was asking was based on the evidence that was supplied through the—

**Q62 Chair:** The question you asked was a very narrow one, which is whether it was appropriate to share that letter.
***Dame Jo Williams:*** Yes. It was not. I should have shared it with her.

**Q63 Andrew George:** It was not appropriate.
***Dame Jo Williams:*** I beg your pardon. It would have been appropriate for me to share that with her.

**Q64 Andrew George:** It would have been appropriate.
***Dame Jo Williams:*** Indeed.

**Q65 Andrew George:** You announced, two working days ago, your resignation. Was this episode anything to do with the basis on which you have decided to resign?
***Dame Jo Williams:*** It is quite right that over the last 12 months or so it has been extraordinarily complex and difficult to make sure that the CQC board is working effectively. What I said when I told the Secretary of State that I was stepping down was that I was pleased that David had moved into the job, that I was confident that, with our new document and the strategy moving forward, there was an opportunity for us to move from strength to strength and a chance for me, having done four years with the CQC, to step down and step back. Of course, it has been a tough job, of which some of the things we are talking about this morning are a dimension. But it has been a tough job for a whole range of other reasons as well.
**Chair:** Can we move the discussion on, therefore, from Kay Sheldon's case to the broader issue of whistleblowing and how that is dealt with by the CQC?

**Q66 Dr Wollaston:** Dame Jo, to make that link, can I quote from your letter to Kay Sheldon, in which you say, "your decision to place information into the public domain are not formal 'whistleblowing' but a self created opportunity to criticise decisions with which you do not personally agree." Isn't that the excuse, if you like, that is made by all organisations to silence whistleblowers? Would you agree that that is true?
***Dame Jo Williams:*** First of all, at that stage the concept of Kay being a whistleblower was not the point I was making there. As I have said earlier this morning, we were functioning, working together, trying to resolve difficulties and issues. The lifeblood of the CQC is receiving information, matters of concern, from people who may be working in an organisation. In no way would I wish the CQC to be seen as an organisation that didn't support people and want them to speak out.

**Q67 Dr Wollaston:** Can I make the point perhaps that a care home, or indeed a hospital board, could make the same argument? They could say, "Look, we recognise we have troubles in our organisation and we are working together as a corporate body to address that. Therefore, what you are doing is undermining our brand or the corporate body and the board." It is a way in which whistleblowers are always sidelined, by accusing them of not acting with other board members to deal with the problem, even where that is in the public interest.
***Dame Jo Williams:*** Yes, that is true, but I think it is also true to say what I have said before. There are processes for raising concerns and those processes weren't followed. There is a duty when you, as a person who is called a whistleblower, raise a matter of concern to balance that against the potential impact on the organisation, thinking through what that impact will be.

**Q68 Dr Wollaston:** Surely if you took any private provider, for example, you could argue the same for them. Of course, it is going to have an impact on any care home or provider if somebody blows the whistle, isn't it?
***Dame Jo Williams:*** I can only say to you that, at the time that this occurred, I was trying to balance the CQC and our role in offering a very important service to the public.

**Q69 Dr Wollaston:** Would you do the same again?
***Dame Jo Williams:*** I have learned a great deal over the last few months. If I had the opportunity again, of course I would want to do things in a slightly different way. I have already talked about the matter of engagement. But my fundamental concern was that the CQC should move forward with a board that could be effective. I did not believe at that time, because there had been a breach of trust and a relationship breakdown, that we could effectively work as a board and move forward.

**Q70 Dr Wollaston:** Even though, ultimately, her allegations turned out to be correct?
***Dame Jo Williams:*** Her allegations?

**Q71 Dr Wollaston:** I mean her concerns about the CQC and the points she raised.
***Dame Jo Williams:*** Some of the concerns did, but some of them remain unsubstantiated.

**Q72 Dr Wollaston:** Right. So, moving on to the wider point perhaps, the issue for whistleblowers is how do we support whistleblowers in organisations like care homes who want to make allegations? We know that professional bodies often support members who make allegations, but if you are a care worker in a care home without that professional body of support, how can you feel confident that your allegations will be taken seriously and you will be supported?
***Dame Jo Williams:*** It is a very fair challenge and I am not sure that there is a simple answer to that. We

are the regulator. When people pass information to us, if they choose anonymity, we can make sure that that is respected. But we know that, at the end of the day, it is our role to try to bring about that change, not directly supporting the whistleblower but bringing about the change so that the service improves. Good organisations now have very clear whistleblowing policies. That is one thing that we can look at as a regulator: what are the policies and support mechanisms that are in place? You are quite right that in some very small provider organisations they are less than robust, yes.

***David Behan:*** May I supplement what Dame Jo has said? One thing that I have seen since I joined the CQC is the development of a policy with NHS Employers on whistleblowing to create this climate that Jo has been talking about. There has already been published a set of joint principles with, among others, the BMA, RCN, GMC and the Nursing and Midwifery Council in relation to these issues. The volume of whistleblowing referrals through to the CQC has gone from 50 after Winterbourne View up to about 500 a month and a dedicated team is now established at our call centre in Newcastle, which is dealing with these referrals as they come through. As I have already indicated in an earlier answer, Chair, there is an audit process of that work going on to make sure that we know where those whistleblowing referrals are going.

If you depersonalise "What have we learned since that?" and make it "What has the organisation learned?", then I offer that as evidence of some of the changes that have been made to try and raise the CQC's performance in relation to whistleblowing. There is still much to do, but I think that is some sense of a signal about how we want to take whistleblowing seriously and respond.

**Q73 Dr Wollaston:** You started with a team initially of six people to handle the whistleblowing call centre. How many people now are manning that team?

***David Behan:*** The number is still about six. They are managing to do that well. They are the team that receive them. They then pass them on to our inspectors and that is the process that goes through. I don't particularly like this word, Sarah, but they are the "field force" that would then go out and make those investigations that take place. The team of six are acting to receive these and respond to them. I referred earlier to the fact that we publish the times, meaning the length of time it takes for us to respond to those claims coming through. The issue is not the time it takes us to respond to them—that is important—but what the outcome is.

That is why I mentioned earlier that the audits, and what we know of those audits that go through to safeguarding teams, are those which trigger responsive inspections. I am not saying that is a definitive answer, but I offer it as some evidence of changes which are taking place as a consequence of the challenges relating to whistleblowing that have been made which sit underneath the answer that Jo has shared with you.

**Q74 Dr Wollaston:** Those whistleblowers would receive feedback as to what had happened to their complaint?

***David Behan:*** Can I come back to you on precisely what that is? This is one of the difficulties, isn't it? I say yes and then you have a case of somebody that did not get feedback. Our principles and standards are that people do know what happens to those referrals that come through. I would like to think that all of our practice meets those standards. Rosie Cooper is busy nodding as I am saying this.

**Q75 Rosie Cooper:** I was there.

***David Behan:*** I know you observed this, Rosie.

**Q76 Rosie Cooper:** Absolutely. If the calls are not anonymous, then they do go back to them. That was exactly what I saw.

***David Behan:*** Yes.

**Q77 Chair:** Does the CQC regard the report of a whistleblower from a particular provider as evidence that the culture within the provider is wrong? Surely the proper course of action in a healthy healthcare organisation is for the concern to be raised and dealt with through the local channel and the professional regulator. Almost by definition, if somebody feels the need to report as a whistleblower to the CQC, it is evidence of something going wrong within the provider, isn't it?

***Dame Jo Williams:*** That is a very fair point, Chairman. I do not dispute that. That should be a trigger in itself, but I think we are also recognising that some of the calls we are getting are very high-risk situations, so it may be, for instance, there is an issue of safeguarding an individual. But you are quite right that if an organisation is not dealing appropriately with people that are raising concerns, it is an indicator.

**Q78 Chair:** By extension, if an inspector goes to a provider, do they ask for the evidence of concerns that have been raised locally and what has been done about them? Also, how would they react in the case of a provider where the answer was, "We had no concerns raised"?

***Dame Jo Williams:*** I am not sure that I am able to answer that question, Chairman.

***David Behan:*** One way we have—and again apologies for using jargon or technical language—is a quality risk profile, which is, in a sense, an in-tray in which information about a particular service is received, whether that comes from a member of the public, a member of staff or another organisation. It is that which inspectors are using to inform their judgments about where to prioritise inspections and what are the kinds of issues to be raised. I am currently signing all the letters of response that you and your colleagues here in this building send to us. One thing that we are trying to do is make sure that we give both you as MPs and individual members of the public feedback, if it is not an issue that we can help with, about where to get that help and how that might be resolved. The reason for this is so that we can both collect the information and ensure that people get some feedback.

What we are trying to do, Chair—and I am deeply committed to this—is have it so that we should view complaints information about us and whistleblowing information about services as free intelligence. We should be open to use it in a way that allows us to ask questions when we visit such as, "Is this true? What does this mean? How do we move forward?" The creation of that approach is one that I remain committed to. The organisation is committed to it. Jo has been indicating that in her answers as well. Yes, there have been challenges about the way we have responded to allegations generally about whistleblowing, but we, I hope, are setting out through the strategy what we intend to do about that and how we intend to move forward.

**Q79 Chair:** The reason I raise the question in the way that I do is that it seems to me that the ability of a healthcare provider or care provider to respond to concerns raised locally is a very good proxy for the culture within the organisation. My answer to my own question, "Is it plausible for any but the tiniest provider to have no concerns raised between inspections?" is that it isn't plausible and that if the answer from a provider is, "We have had no concerns raised," it is prima facie evidence of the culture being wrong.
***David Behan:*** Yes.

**Q80 Chair:** To be honest, that is the answer I was hoping you would give me.
***David Behan:*** Thank goodness this is not the interview, but I think you are right. There has always been this debate, hasn't there, about whether a number of complaints are evidence that a system is working effectively, because it is encouraging people to feed back and the organisation to learn from that, and that an absence of complaints is not a signal that this is a good service but indeed a signal that this is a service that might be not encouraging that kind of feedback and moving it forward? I apologise for misunderstanding the question, Chair, and can I say I agree to your answer to your own question?

**Q81 Rosie Cooper:** Do those answers reflect your view of the CQC as well? In terms of Kay Sheldon and people who were having a view, or complaints, why did you not see that as almost a mirror on the culture of your own organisation?
***Dame Jo Williams:*** I do take the point that you make, of course. What I tried to do this morning, particularly in relation to the evidence that you have been given, was explain the context within which I was working, and I can say no more.

**Q82 Andrew George:** I have a brief question, but preface it with congratulations to the CQC for a recent case that I referred and the very appropriate manner in which the CQC spoke to and referred to whistleblowers in that particular case. That was a recent case, so I want to say that, obviously, the procedures were satisfactory.
Following on from Stephen's question, I want to ask about whether and to what extent you see a pattern of the most serious cases which have been raised by whistleblowing being by those whistleblowers who have failed to use internal processes within organisations, or the extent to which internal and organisational processes for concerns being raised have been fully utilised and yet still the whistleblower remains frustrated and disappointed by that response. Is there a pattern? Can you draw anything from that?
***David Behan:*** That is a good question.
***Dame Jo Williams:*** It is a very good question. My response is that I do not think we have differentiated in that way. As David has indicated, there will very soon be an audit looking at whistleblowing calls. We should consider that and think about whether or not there is some learning to be had from the very point that you make. Thank you.
***David Behan:*** We will build it into the audit, Chair.

**Q83 Barbara Keeley:** In many cases, the families of people using health and social care services have an intimate understanding of the services and would be the first to see if people are left soiled, undernourished and that sort of thing. Are their concerns about a particular service or an organisation going to be treated in a similar way to those of whistleblowers? Can they be? Is there one process for staff whistleblowing and a different process if it is a family complaint? Do you see them as different things? You said, David Behan, that you see them as free information that can be used, but I think it is very important to people how what they say about a service and what they have found of it is treated.
***David Behan:*** In a strict legal sense—and far be it from me in this building of all buildings to comment on this, but you would know that—personal interests disclosure legislation does set whistleblowers apart from others, but—

**Q84 Barbara Keeley:** But the way you handle it is the important thing.
***David Behan:*** But, in a sense, you talked about procedures. I want to make that distinction so I am not avoiding the question, Barbara, and you have done as much as anybody to champion issues around carers and how their voice should be listened to. It is our determination that we should treat people with compassion and see services that treat people with compassion as well. So yes, we do need to listen to what people are telling us about services and begin to incorporate those comments. Andrew George's point about detecting any patterns in what people are telling us is one way that I think we need to develop in the work we do over this next period of time.
What are the trends? Valerie Vaz began the question about the evaluation—and this is exactly the point—and what do we know and what is important about what we do. For proper reasons, Chair, Members have raised issues of concern about us. I am grateful to Andrew George for raising issues about where we have got things right, and you have been able to see those things have been got right and that improvements have taken place. We need to listen to these bad cases and also learn from our experiences of what goes well. It is important that our learning goes right across the spectrum and does not only go on the cases where we have not been as successful.

If you look at the volume of activity that the CQC goes through on a daily basis—let alone weekly, monthly or yearly—we come into contact with considerable numbers of members of the public and it is important that we listen to them. But we are in a legal process, so when we take action we need to ensure that we have the evidence that would stand up to challenge when it is placed in those formal processes. Also, quite properly, people have a right of appeal. In answer to Virendra Sharma's question about delay, collecting the evidence which can resist any challenge in a legal process will take time. Our job is to ensure that we do that as speedily and quickly as possible for those urgent cases and we are committed to doing that and improving. We will listen to both complainants and whistleblowers on what they tell us about our effectiveness and build that in.

I do a newsletter. We got a tweet back saying, "Your whistleblowing number is not prominent enough on your website." One of the things we will do is make sure the whistleblowing number is prominent on the website so that people do not have to go looking for it. It is a small bit of feedback which has led to a decision and an action which will make the number more prominent.

**Q85 Barbara Keeley:** Can we go back to the care-home sector? I made the comment earlier from the written evidence from the Relatives and Residents Association that it thinks you do not have sufficient expertise. There is also the question of the volume of inspections. Given that 62% of adult social care locations were inspected last year, and in fact the inspection regime almost ground to a halt the year before that, can you tell the Committee how many adult social care locations have not been inspected? You had a year when it ground to a halt. Last year it was 62%. How many have not been inspected?

***David Behan:*** I did not anticipate that question, Chair. Where are we up to in terms of our inspection programme? I will get the exact figures. We have 35% of all NHS inspections carried out.

**Q86 Barbara Keeley:** You do not have a breakdown for social care.

***David Behan:*** Can I come to it, Chair? We plan to hit that target, so it is green rated at the minute on our risk register. For adult social care, we have 27% of all adult social care inspections which are completed. That is, more interestingly, behind our plan. That is amber rated. I am now receiving weekly reports so that we can make up the ground to deliver on our plan. We are aiming to complete that plan and working hard to do that. In relation to independent healthcare, dentists and ambulances, we are behind our plan. They are red rated and, again, there is action in place to make progress.

**Q87 Barbara Keeley:** Let us stick with social care for the moment. It clearly has been demonstrated that large case loads for inspectors adversely affect the overall quality of inspections. I don't think anybody would be surprised about that. You have talked about numbers earlier and recruitment. Have you had success in reducing case loads and is that continuing to be an objective? Also, have you acted on the Committee's recommendation to track staffing ratios, because there is a concern about the ability of staff to highlight risk? That is the key thing that they are doing now.

***David Behan:*** Yes. These are all very good questions, Chair. In terms of the case loads that our inspectors carry, the average is 41 and the range is from 30 to 70. There will be some outliers on that and outliers at the top end where there are vacancies. We are going through the recruitment process and that was the answer to Valerie's question earlier. So they are figures as of this morning. We are running these figures on a weekly basis. This Committee's challenge last year was in relation to whether we have a work load planning tool. A considerable amount of work has been done on that. I was briefed on this last week, not because of this but because I was new to the job. There has been some excellent work in relation to that, if I may say so to my colleagues who have done that work. It is not yet complete. We need to do some further work.

Interestingly, some of the things we need to tease out—and again, Chair, apologies if this sounds too technical—are how do you benchmark with a home-based work force, who else has a home-based work force, how do you get a benchmark for key issues and how do you work that through in a way that is consistent? I was pleased to see in the trades union evidence to the Committee that they acknowledge that those conversations are going on. This is a conversation we are having with staff representatives as well as staff to try and get this right. I am encouraged by that work rather than thinking it is completed. We need to run that on an annual basis, Barbara, in relation to how that informs our annual business plan to make sure that, of the tasks we have, we have the resources there.

As Jo said earlier, we have moved from a period of the CQC being set up, where you have to go through this registration process and these huge numbers of services being registered for the first time, and are now into what we have called the forward strategy, "The next phase". It is clear that having registered those services we are now in this inspection period where, in a sense, we are going to go through, refine and develop our inspection methodology. We need a work load which reflects the next phase of our development, which is much more about inspection than it is about registration. Good progress is being made and we will continue to be open in the way that we discuss and take these issues forward.

**Q88 Barbara Keeley:** Would you say there is a lack of consistency across regions because providers are concerned that there is inconsistency between regions?

***David Behan:*** Yes.

**Q89 Barbara Keeley:** You mentioned finding difficulty recruiting in London and the south-east. Could you touch on how inspectors understand which standards apply in different cases and is there central co-ordination? Clearly, we do not want a situation where there are different standards applied or where

you are so short of inspectors in London and the south-east that you cannot maintain the same standards there that you do in other parts of the country.

***David Behan:*** That is absolutely right.

***Dame Jo Williams:*** We have established our own internal quality assurance team to address the point that you make, making sure that there is, as far as possible, consistency in the application of those standards.

**Q90 Barbara Keeley:** Do we accept that at the moment there is inconsistency and a regional problem?

***Dame Jo Williams:*** Yes.

***David Behan:*** I am not saying that I think that is linked to the amount of resource, Barbara. I think it is important to agree with you about the issue of consistency. From being appointed to taking up post, probably the most often-quoted issue to me saying "Please sort this out, David" was consistency, particularly from the larger providers that provide in more than one area.

Again, as Jo has said, at both a national and a regional level there are arrangements put in place to assure the consistency of our decisions, so it is something, again, that the organisation is trying to respond to. It is a desperately difficult issue to deal with, as I think members of the Committee will know. How you can get consistency on a multiplicity of interventions going on nationally is very difficult. What we need to ensure is that the organisation is performing to meet the standards it has set for how it should perform. Where we want inspectors to make judgments based on their professional background—and I think that was in the evidence you have received—then you are going to get difference. I am looking at Dr Wollaston. Not all GPs determine things in the same way, as not all inspectors will determine things in the same way. I am not making a frivolous point here. You have audit as a way of ensuring consistency with standards and I think that is exactly what the organisation has done. It has introduced some systems to try to assure consistency in our approach. It is an absolutely legitimate and appropriate challenge.

**Q91 Barbara Keeley:** Have you measured the impact removing the central investigations team had on the quality of investigations and the level of expertise you were left with to deploy into the more complex and challenging situations?

***David Behan:*** Personally—and this is week four—no, I have not.

**Q92 Barbara Keeley:** Will that be done? It sounds like it should be.

***Dame Jo Williams:*** Part of our strategic document is very much looking at the whole issue of differential regulation. I think David talked about that earlier. We have also recognised, by having the register of associates—professionals—that that strengthens the inspectors and they are available to them to use if they believe that they are in a situation where they need additional expertise. What we have done to date is recognise that that is a way of strengthening an inspection, but we hope, through the consultation process, that we will hear back from those who are directly involved in our work, and we will need to consider those reflections. If necessary, we will, over time, change the way in which we regulate. As David has said, we want to use evidence, want to look at what is happening around the world to inform the best way to carry out inspection in England.

**Q93 Andrew George:** Do you believe that you have all the powers you need in order to fully interrogate and to complete inspections?

***David Behan:*** That is an interesting question, if I may say so, Chair.

**Q94 Andrew George:** I can give you an example if you want. The example is, in the case I was referring to earlier, that the CQC indicated to me that it did not have the powers to forensically interrogate some crucial information in a call-handling system, to find out whether there had been any manipulation of the data. It didn't have the forensic powers to go that step further to interrogate and to satisfy itself that the information it was being given was robust and accurate. If that is the case, to what extent are you undertaking an inspection but you can only go so far and you get to a point where you do not have the powers to interrogate or cross-question the information you are given?

***Dame Jo Williams:*** There is a review of the regulations going on, so we need to take that point away and also talk to the inspectors on the ground about it because that is a very important question that you raise there. It is taking us into new territory, I think. The question in my mind is that we do sometimes refer to the police and I think it is about what would be our appropriate role vis-à-vis another organisation. But we must take that away and consider it.

**Q95 Chair:** Could you write to us when you have had a chance to reflect on it?

***Dame Jo Williams:*** Yes.

***David Behan:*** The point I would want to emphasise, Chair, is exactly this latter one about the issue being not only about our powers but about how our powers sit with other organisations. You have previously encouraged us to work with others. Part of it is that, but, as Jo has said, there is an important conversation going on with the Department at the present time about the adequacy of the regulatory framework. I think Grahame Morris's question about fit and proper persons is why I smiled when you raised the question about adequacy. It seems to me that the legal framework and the regulations always lag behind what we know about practice. Therefore, the issue is how that can catch up. It is important that we have this mature dialogue with the Department about where we need its help in terms of the framework that we operate in to actually move forward.

**Q96 David Tredinnick:** It seems to me, assessing what you have said this morning, that there is quite a range of areas where you are still thinking about what you should be doing and what resources you should

be deploying, yet when you came before this Committee in June 2011, Dame Jo, you told us that you needed an additional £15 million. You also qualified that by saying that the CQC could fulfil its existing obligations without additional resource.
Going back to what I have just said, there seem to be areas where you are not very sure about what you are asking for or for what you want the money. Let us focus on the £15 million for a moment. Could you illustrate how the allocation of an additional £15 million to your budget will enhance your work, please?
***Dame Jo Williams:*** We received an additional £10 million and our priority was to recruit additional inspectors. David, as he says, has only been with us a very short time and one question he is already raising is the extent to which we have an appropriate distribution of resources across the CQC. That will be work in progress, I think, over the coming months. It will be influenced by the response to the consultation document but, quite clearly, we have a number of people who are involved in analysis and data analysis. Do we have people with the right competencies, possibly in terms of management information? These are key questions that are appropriate for a new chief executive to bring in. But the fundamental issue for us was getting people on the ground carrying out the inspections.

**Q97 David Tredinnick:** The resource model point of information I have—you have agreed with the Department—includes 200 more full-time equivalent inspectors and 20 more full-time compliance managers than you had at what was then the present. However, last year you managed to meet your core inspection targets. What will you be doing in 2012–13 that you weren't doing last year?
***David Behan:*** More inspections, Chair.
***Dame Jo Williams:*** It will be more inspections, but—
***David Behan:*** We have more people on the ground, more inspections will be done and we will be publishing thematic inspection reports. We have completed the report on Winterbourne View and we have reports on "Dignity and nutrition" with over 250 inspections that we will report on.

**Q98 David Tredinnick:** You also told the Department that 580 other inspections had been forgone as a result of launching inspections into the termination of pregnancy services at the request of the Department of Health. Could you explain that a little bit? What does that mean exactly?
***Dame Jo Williams:*** Perhaps I could help there, David. The point was that those inspections were completed but in a different timeframe. They were completed after the follow-up to the abortion clinics, the termination of pregnancy work. Having said that, what was absolutely clear was that if people were moving from one piece of work to another and following up on the termination of pregnancy work, we were not failing in our duty to follow up inspections where there was information suggesting there was high risk. Those 580 inspections were delayed somewhat.

**Q99 David Tredinnick:** Which is another way of saying, "We were unable to carry out inspections which we had intended to carry out because of the additional burden that the Department had put on us", and in a sense it was firing a shot at the Department, wasn't it?
***Dame Jo Williams:*** It was at a later time that they were carried out, yes.

**Q100 David Tredinnick:** So they were delayed.
***Dame Jo Williams:*** Yes.

**Q101 David Tredinnick:** Were there any consequences that you are aware of? Did these delays result in unfortunate circumstances?
***Dame Jo Williams:*** Not that I am aware of.

**Q102 David Tredinnick:** Do you think there are any inspections that should have been conducted that have not been conducted as a result of that situation?
***David Behan:*** If I may, Chair, this goes back to Barbara Keeley's question about where we are on the inspection programme. If I have the sequencing of this right, the issue that you are referring to was in the earlier part of this year, in March. Barbara's challenge to us is where we are on the inspection programme. I can only do it on our progress against the trajectory to complete all of our inspections and, as I said, we are currently rating that as amber. We are at about 27% and we should be at about 35%. What I have asked for is work to ensure that we can complete our programmes by the end of the year. So in reply to your question—your proper question—about whether we have displaced any of our mainstream activity in order to do that, we should absorb that as we go through the year.
The additional inspectors are coming on through the year. As I said, in April of this year, we had 197 vacancies across the organisation—that is more than just inspectors—but now we have 49. As I hope I indicated, there are 75 interview slots which are set to take place. Providing people are of the right quality, I am optimistic that we have made considerable progress on bringing in the right calibre of people to be able to undertake the jobs which are supported by that additional £10 million from the Department which has allowed us to bring in potentially up to 250 additional inspectors. So I think, David, we are making up the ground.

**Q103 David Tredinnick:** So you say you are making some progress?
***David Behan:*** Yes.

**Q104 David Tredinnick:** That is reassuring. This is my last question. We were talking in the briefing about your earlier request being for £15 million, but the discussion has focused on £10 million. What happened to the £5 million?
***Dame Jo Williams:*** We asked and that is what we got.

**Q105 Chair:** I will remind you that the Committee did not back the £15 million request because we did not think it was substantiated last year.
***Dame Jo Williams:*** We got £10 million.

***David Behan:*** Hence the work load management system, Chair, and the planning tool which allows us to get to an absolute figure based on work loads.

**Q106 Grahame M. Morris:** I want a bit of clarification on a question from one of my colleagues a little earlier. You asked a rhetorical question, "How do you benchmark performance?" and you particularly mentioned the complexity of organisations, the home-care work force and so on. It is difficult, but what was your rationale—apart from criticism from the Health Select Committee and the Public Accounts Committee about lack of focus—for deciding to scrap the social care excellence awards? Wasn't that a means of benchmarking or demonstrating performance?

***Dame Jo Williams:*** It pre-dates David, so I must pick up that question, if I may, Grahame. The rationale was that we were working to different legislation. The new legislation was very much about the essential standards and focusing on outcomes for people. It was about "Is this service compliant or is it not?" Our predecessor organisation had created the star ratings and we recognised that, for many people, they were proving to be valuable, but we weren't regulating against the same regulations, so that was the rationale for it. Perhaps David will pick up where we are now because, within the social care White Paper, I think there are some proposals for moving that forward.

***David Behan:*** There are. In a sense, the Department, in its White Paper, made some propositions relating to rating systems. Interestingly, some of the large corporate providers—I am not sure, but I think in your evidence pack there is information from Peter Calverley about ratings and I do not know whether his organisation is involved, but this was covered in *The Guardian* yesterday about the providers themselves taking an initiative to ask Ipsos MORI to do surveys of their own residents to demonstrate it.

Going back to earlier questions about what is our role and what is the providers' role as to driving quality, I have to say I commend those providers for taking that initiative and publishing that in a public way because that is providers taking responsibility themselves for driving quality in their services. There are some interesting conversations for us to have around "How does that fit with the regulatory framework that we have?" But this fits with a bigger theme, which is, how does the information we collect go on to our website in a way that is accessible for people, to give them information about the quality of services?

I do believe some progress has been made. One of the interesting things is that there is a piece of development work going on, test work, as to whether we can link between our website and a provider's own website so that people can go on to—forgive the name—"Happy Valley Nursing Home" and immediately click straight to the last inspection report to see what it said. That will give an immediacy of feedback. One criticism that comes through is people's difficulty in finding the inspection reports, so how can we make that easier?

There are some developments we are going to make to the website, going back to your commissioning point, Chair, as to sorting providers by local authority areas, so then commissioners can see that. Interestingly for this place, we will be doing them by constituencies as well and then Members of the House may find it easier to find out what are the services in their areas.

**Q107 Grahame M. Morris:** It would be quite difficult as well, with a large public sector organisation such as an NHS trust that provides a range of services in a range of different locations, to rate it using a star rating or a traffic-light system overall for performance, as most of it may be excellent but there might be failings in a particular part of it. But in terms of the profiling—and we are waiting for the detail from the Government's proposals—do you think there should be an element of, and you touched on it before, a complaints system like Trip Advisor? This is much more serious in terms of choosing, say, a care home for an elderly relative, but do you think, in assessing the criteria for the provider profile, there should be some element of feedback from complaints in there? I am only asking for your opinion.

***David Behan:*** Yes, I do, and alongside—if I may go back to the job I have recently left—the White Paper there was an announcement on the day of the White Paper by some of the major providers, and I think Peter Calverley's organisation was one of them, that they would agree to publish information, the score card, if you wish, of their organisations and that would include the number of complaints received. So the sector is beginning to change in responding to this and so is the leadership by those large national organisations. One of our challenges is how we can reinforce those initiatives so it does not simply trickle down but other organisations begin to respond in that way.

**Q108 Chris Skidmore:** Going back to the figures regarding inspections, I understand you have performed 18,000 inspections in total in the previous year, and that was with 750 inspectors, rising to about 900 now, say, so you have 50 vacancies still to fill. In our brief we have been told that the plan is for 31,000 inspections in 2012–13. I couldn't see that in your document, but I wonder if you could confirm that that is the anticipated trajectory of rising inspections. Do you have any concerns about whether you will need an increased number of inspectors in the future? Obviously, it is a significant rise on the 18,000 the previous year, but can the 950 cope with doing 31,000 inspections when 750 to 900 did 18,000 before?

***David Behan:*** That is an absolutely legitimate question, Chair, and it goes right to the heart of the line the Committee has been pursuing about whether we have a work force planning tool that allows us to do this. I said we would monitor and evaluate this, that we would do this on an annual basis. At the minute, I am being reassured by the teams that are responsible for this that they have a plan to bring us back to that trajectory. Can I come back to the Committee, Chair, on whether the absolute target number is 31,000? I would not want to commit to that without being reassured of it. We have plans in place based on the numbers, but I would want to come back on the precision of your question.

**Chris Skidmore:** Sure. Secondly—
***David Behan:*** I am sorry—I do apologise—but we need to be more productive as well. I do not think this is only about absolute numbers. We need to be productive within that. There is an issue about our efficiency and effectiveness and how we move forward.

**Q109 Chris Skidmore:** In terms of the timescale of inspection, would that be a three-day or a week's process? How long would an individual inspector be expected to take, from beginning to end, to put together a report? Going on the 31,000 inspections with 950 inspectors, that is roughly 31 to 32 inspections a year per inspector, but that is probably rising from maybe the 18 or 20 they are doing at the moment.
***Dame Jo Williams:*** It seems to me that there is not a very simple answer to the question that you raise. The work force model will be working on averages but, quite clearly, if an inspector goes into a large institution, that is quite different from a small place and, of course, it also is influenced by what they find. Those are the kinds of variables which will affect the time scale.
***David Behan:*** As to the benchmark information, on average an inspector is doing an end-to-end process and it is about one every five days. The point is, can we bring some of that down to one every four days in relation to some of the simpler issues that Jo has raised? There will be more complicated issues—a multi-site hospital is not going to be done in the same timescale as a dental practice or a three-bedded care home. The figure we are going for is 31,915 at the end of the year.

**Q110 Chris Skidmore:** Another figure—I hope you do not mind me bringing it up—is that of the departmental underspend in the past two years. There is roughly, I see from the letter from Richard Douglas, about £13 million as a result of staff vacancies. Once you have then fully filled the vacancies, that underspend will disappear.
***Dame Jo Williams:*** Indeed.

**Q111 Chris Skidmore:** If you have a £13 million underspend and you have vacancies, just off the top of my head, that means there will be at least a £2 million—
***David Behan:*** Projecting the variance for the year end of this financial year, Chair, it is about £7 million. It is down from the £13 million last year. We do not have all the inspectors in, in the full year. That was my answer to Valerie earlier. Currently, as of my conversation with the director of finance yesterday afternoon, we are projecting a variance of £7 million at the year end—interestingly, in that there is over-recovery of income as well.

**Q112 Chris Skidmore:** In terms of registration fees, they are paid annually into the CQC?
***Dame Jo Williams:*** If I could be clear, registration is a one-off process.

**Q113 Chris Skidmore:** Does that not create a structural problem for the CQC as well, given that the large amount of your money, £92 million to £93 million, is in registration fees?
***Dame Jo Williams:*** I am not intending to mislead you. Registration is a one-off process but there is an annual fee.

**Q114 Chris Skidmore:** Yes. To reverse that, you are getting an annual registration fee. As you increase the number of people being registered, could you then be weaned off funding by the Department?
***Dame Jo Williams:*** That is the idea.

**Q115 Chris Skidmore:** It has gone from £50 million to £60 million, but, obviously, hopefully, you could be self-sufficient.
***Dame Jo Williams:*** That is right.
***David Behan:*** We are on a trajectory, for our regulatory activity, of full cost recovery.

**Q116 Chris Skidmore:** When would that take place?
***David Behan:*** We are about to publish a document for consultation on our fee structure which picks up on exactly the point you and Jo have been teasing out about what the annual fee is and how we determine the fee for services new to regulation, dental practices, GP practices and how you do it, by practice size, geography or by locations. How do you calculate an appropriate fee? There is a consultation document being developed, which we are about to publish, which will open up this conversation in exactly the way that you are referring to and allow us to explain the approach we are taking to full cost recovery and what fees will be contributing to in relation to—

**Q117 Chris Skidmore:** To refresh my memory, the scale of the fees at the moment still varies, doesn't it, between various locations and practices?
***David Behan:*** It does. It varies between locations and sizes. What we are trying to do is be absolutely clear and consistent in the way we are structuring that fee.

**Q118 Chris Skidmore:** In terms of registration, when do you anticipate full registration of services? I know that is obviously dependent on new services being opened—dentistry and everything together.
***David Behan:*** The dentists are registered. We are currently on general practitioners. We have asked people to notify us. I think out of 8,000 there is something like about 7,500 that had notified us by last week. That is about 95%, we think. We are working with all the associations that support general practice in relation to that and, as of Friday evening, we had 60 people that had registered. It was interesting that Tuesday last week came and went and we begin registering GPs on the Tuesday of next week.

**Q119 Chris Skidmore:** And the current fee for GP registration at the moment is—
***David Behan:*** Blimey. I will have to come back to you on that.

**Q120 Chris Skidmore:** There is the potential to cover costs and reduce reliance on the Department of

Health, but you have yet to have an end point on which you will say, "We will have full recovery of our costs."

***David Behan:*** Yes. We are on a trajectory, Chair, to full cost recovery, rather than being at it.

**Q121 Chris Skidmore:** When would you anticipate full cost recovery? That could then influence the level of the fee increase on GPs, couldn't it?

***David Behan:*** Yes, it does. That is the issue we are trying to tease out about what the combination is between the fee level and granting aid from the Department.

**Q122 Chris Skidmore:** Do you think you would be there by the end of the CSR, in terms of when the next settlement comes around?

***David Behan:*** Why don't we send you the consultation document, Chair, and I will be very happy, if you wanted a separate meeting on the fee structure and what that would mean on the trajectory, to come and see you and go through that with you?

**Chris Skidmore:** Okay.

**Q123 Dr Wollaston:** Can I follow up on the point about GP registration and how you are going to avoid duplication and unnecessary bureaucracy? Of course, the GP practices are already accredited by the Royal College and they are going to be registered by the NHS Commissioning Board. Do you think it is going to be necessary for the NHS Commissioning Board to register them in addition or could there be a process whereby you can streamline that?

***Dame Jo Williams:*** If I could begin the answer to that—David may want to follow on—the point you raised about accreditation systems is very important and it doesn't only apply to primary care. It is an issue that we say in our consultation document we do want to consider, how we can utilise accreditation schemes to inform and safeguard the public by recognising that certain schemes are very sound. So we are keen, as a regulator, not to duplicate. We want to go in where we believe there is a high risk. You are absolutely right. We are going to be talking. We have been talking with the sector about our respective roles and responsibilities. The difficulty for us at this stage with primary care is, of course, that we have never done it before. We will next year want to explore, through our inspections, what we are identifying as the risk issues and talking to, as you suggest, other organisations about how, together, we make sure that there is quality service.

**Q124 Dr Wollaston:** You touched on this point before, that one of the themes about well-functioning organisations is that they carry out their own accreditation and internal audits—

***Dame Jo Williams:*** Yes, absolutely.

**Q125 Dr Wollaston:**—and how you can create that bow-wave of encouraging good practice rather than only creating another whole raft of bureaucracy. So you are confident you are going to do that rather than—

***Dame Jo Williams:*** What I am saying is that we are considering this. It is certainly one issue that we have identified in our consultation document and we will be interested in what people say in response to that, but it feels appropriate to me that, in terms of using our resources properly and targeting them on organisations where there may be difficulties, that is the right way to proceed. We should acknowledge those organisations that are getting to grips, as you say, quite rightly, with quality assuring.

***David Behan:*** Briefly, if I may—and I know you want to move on—this is an important point. There was an advisory group that comprised the BMA, the Royal College, the Family Doctor Association and the NHS Alliance. They have overseen the work we have been doing on this. There has also been a provider reference group. That has involved, I think, GPs and practice managers to make sure that exactly the points you are raising about how this fits together are actually taken forward. Of course, we are going to learn from the way this goes. These are organised in tranches. It will be interesting to speak to these early adopters, these 60 that have already done it, got on with it and got their application forms in.

We are making contact with those practices that have not yet notified us. There are still about 5%, 6% or 7% of GPs that have not yet notified us. This is on a digital platform. We have tried to strip it out to make it easy and less burdensome. We have calculated that the application form takes no more than 90 minutes to complete, having taken to heart some of the challenges about what we have learned from our previous methodologies. I have to say, coming in and seeing this, I have been very impressed by the simplicity of the approach that has been taken.

The additional year that resulted from the discussion with the Department of Health about deferring registrations I think has been put to good effect by allowing exactly those conversations with the professional associations to make sure that the approach that is being taken is something that people are familiar with and aware of and we will spend time over the next period—and I will personally spend some time—going round meeting doctors' leaders to discuss the effectiveness of the system.

**Chair:** We are going well over the estimated two hours. Valerie has a quick question.

**Q126 Valerie Vaz:** I have a quick one on that. As to out-of-hours providers, you register them separately, do you, and they are all registered now?

***Dame Jo Williams:*** Yes.

**Q127 Valerie Vaz:** Have you inspected any out-of-hours providers?

***Dame Jo Williams:*** We have indeed, and your colleague Andrew George, I think, was referring to an inspection that we carried out in Cornwall in relation to an organisation that—we heard from a number of sources—was not delivering appropriate care.

**Q128 Valerie Vaz:** That was after a complaint as opposed to one of your inspections.

***Dame Jo Williams:*** It was, yes, that is absolutely right.

**Q129 Valerie Vaz:** Can I change the subject slightly? It is really to do with the HFEA and HTA. Whose idea was it to include them in the CQC? Was it the Secretary of State? Was it a political decision or was it something that came from you?
***Dame Jo Williams:*** It certainly came as a consequence of a Department of Health review of all arm's length bodies. The Government determined that the number of arm's length bodies should be reduced and that there was potential for those two organisations moving into the CQC.

**Q130 Valerie Vaz:** Do you have the experience and the capabilities to oversee them and why?
***Dame Jo Williams:*** There is a consultation document out at the moment. We will be discussing this at the board next week. It is proposed that the change would not be until 2015, but, as things stand at the moment—and we have talked over the last couple of years, and certainly this morning, about our determination to deal with what we are dealing with, and deal with it well—we will make it clear that, for now, we would not wish to take on HFEA and HTA. We have said that already to the Government but we recognise that if, at the end of the day, that is a Government decision, of course we will get on with it. But we would need to make sure that the expertise came in to the CQC. We have done a lot with them in terms of sharing back-office costs and we are also very clear that where there is overlap we should avoid duplication and share data and information. That is taking place.

**Q131 Valerie Vaz:** Do you see any issue in relation to their remit over other devolved administrations compared to yours being only in England and Wales?
***Dame Jo Williams:*** I think that indeed is an issue, yes. We are England and they extend beyond England.

**Q132 Valerie Vaz:** So nothing is going to happen until 2015 and obviously it depends on the consultation. If the consultation comes back and says, "No, we don't think it is a good idea," you will not go ahead with it, or you will put the case for it not being incorporated.
***Dame Jo Williams:*** We will be making the case that we want to focus on our current work load but acknowledge that if Government are so minded to make that decision we would get on with it.
**Valerie Vaz:** Thank you very much.

**Q133 Chair:** To be very clear, you are contributing to the Government's consultation on this.
***Dame Jo Williams:*** Indeed, we are.

**Q134 Chair:** You are arguing that HFEA and HTA should not become part of the CQC.
***Dame Jo Williams:*** We are not saying it should not, quite like that. We are saying that we appreciated that no change is likely until 2015. That gives us time to strengthen our organisation and, as I say, if, at the end of the day, a decision is made, we would have to get on with it.

**Q135 Chair:** I will re-phrase it. Your preference would be that they will not.
***Dame Jo Williams:*** Exactly, Chairman.

**Q136 Chair:** Thank you very much. Could I ask a very specific question also about HealthWatch? Part of the CQC which perhaps comes up slightly less than instinct suggests it might in a hearing of this nature is HealthWatch. Could you tell us whether you are confident that that will have an independent voice and a sufficiently authoritative voice and perhaps that we have finally emerged from however many years it is of endless change of what started with the CHCs and has been through so many chapters that most of us have forgotten the ones in the middle?
***Dame Jo Williams:*** Okay. I will begin by saying that, as you know, the chair of HealthWatch has been appointed. She is currently recruiting members of her committee. It will indeed be a sub-committee of the CQC, but already, through preliminary conversations and also through the way in which HealthWatch has been set up and public expectation, it will most definitely have independence of voice. There is no doubt about that. The CQC regards the development of HealthWatch as a real opportunity. We hope that, through its connections with local HealthWatch organisations, it will be an increasing rich source of information for us as we carry out our work. But we are absolutely committed to the chair of HealthWatch and her committee speaking out unfettered by the CQC. It is entirely appropriate that that is the case.
**Chair:** Thank you.

**Q137 Dr Wollaston:** I have one final question on the issue of your role in monitoring the operation of the Mental Health Act.
***Dame Jo Williams:*** Yes.
**Dr Wollaston:** Do you feel that that is the appropriate place for that responsibility to sit?
***Dame Jo Williams:*** It is a very good question and I think we have had some discussion about this before. We are, within our forward thinking, absolutely determined that we need to highlight the special issues relating to mental health. It is a service that we provide and one thing that is happening is that those people who are carrying out their commissioner responsibilities as Mental Health Act commissioners are increasingly working with our inspectors. I do not think we have capitalised sufficiently at the moment on that crossover of information, but, for the future, I think that helps us to do even more in monitoring what is going on in hospitals and keeping people safe.
**Dr Wollaston:** Thank you.

**Q138 Chair:** I also want to have a final shot, I am afraid, going right back to the beginning, to this business of what is the core function of the CQC and the balance between the assurance of essential services and the participation in the ambition we all share for improving quality. Do you think that the Government's stance on the National Patient Safety Agency and the whole issue surrounding the guarantees of patient safety should be feeding back into that debate within the CQC? Doesn't that reinforce the argument that, actually, from the

patient's perspective, from the service user's perspective, the thing they really look to the CQC for is that the system observes the old rule "First, do no harm"?

***Dame Jo Williams:*** You are well aware that the functions of the National Patient Safety Agency have been transferred largely to the NHS Commissioning Board. At the very heart of what the CQC is about are the people who use services. There is no doubt about that. That is what the work force, the board and the executive are committed to. In taking forward our purpose we have identified a number of priorities, not least making sure that we do work with others but also continue to keep our focus on people who use services.

Are we sufficiently geared up and focused on that patient perspective? We certainly receive a lot of information from patient surveys and we use that in analysing what is put into our risk profiles. We are where we are, Chairman, and I think that we have to be constantly mindful of the need for us to, as I said earlier, work in an interdependent way with those others that have responsibilities as well as ourselves.

**Q139 Chair:** On the basis that we are where we are but the new chief executive is taking us somewhere else, hopefully.

***Dame Jo Williams:*** Hopefully, in terms of taking the service forward, indeed, but that was not quite what I meant.

***David Behan:*** Rather boringly, I will repeat. This has been right at the centre of the debate about why the CQC exists. The 2008 Act is unambiguous in that our role is to protect and promote—"promote" is a big word, I think, Chair—the health, safety and welfare of people who use health and social care services. It goes on to say that we will do that for the general purpose of encouraging three things: improvement, ensuring that services focus on the people who use them and then, thirdly—and I think this plays to Grahame Morris's earlier question—that resources are used effectively and efficiently. That is unambiguously clear.

Our unique contribution to what is arguably a crowded landscape around quality is that we measure whether services meet the national standards of quality and safety, the essential standards of quality and safety. Nobody else does that. The Committee has challenged us on whether people can trust our judgments and that is exactly our role, but I think we do that for the purpose of improvement. We are not an improvement agency, but one of the big things that we have got back, not just from yourselves but also from people whom we regulate, is "Why don't you acknowledge what 'good' looks like and describe what 'good' looks like?" There is a legitimate challenge, I think, about how we do that without becoming an improvement agency. What we are doing in the document is signalling that we have a role to identify when we see "good" work, that we talk about that good work.

One thing that the CQC needs to consider—the board, myself and the executive team—is, when does the bar in relation to quality get raised? At what time does that happen and how do we have that conversation? When do today's "quality standards" become tomorrow's "essential standards"? Otherwise, we are saying that this is a zero-sum game and we stay where we are. I anticipate that you would, as a Committee, have something to say if that is what we set out. So very clearly in this document we are setting out that we are not going to drop standards as we move through this next phase of our development and there is an important conversation that I hope we can join in together about how we do that. But I would ask that we do not see measuring against essential standards and improvement in a binary way. These are not either/ors. They are "ands". We undertake this for the purpose of improvement, otherwise services will simply stay where they are and won't improve. That is not the job I think I have been hired to do, nor is it the job I think you would want me to do.

**Q140 Chair:** On that note, thank you very much.

***Dame Jo Williams:*** Chairman, before you close, may I express my apology for straying into sharing information in a way that I acknowledge and regret?

**Chair:** Thank you. I probably should have stopped you and I apologise for not doing so. Thank you very much.

# Written evidence

**Written evidence from the Department of Health (CQC 01)**

1. This memorandum has been prepared for the Health Committee by the Department of Health in response to the Health Committee's invitation to provide evidence to assist it in its second annual review meeting with the Care Quality Commission (CQC). The Department is grateful for the opportunity to contribute to this process. This submission is based on CQC's current legislative role and describes:

(a) Background

— Health and Social Care Act 2012 provisions affecting CQC

— Healthwatch England

(b) Current Issues—Department of Health

— Performance and Capability Review

— Review of CQC registration regulations

(c) Current Issues—CQC

— Development of CQC strategy

— Inspection regime

— Market Reports

— GP registration

— Whistleblowing

(d) Inquiries and Review

— Mid Staffordshire NHS Foundation Trust Public Inquiry

— Winterbourne View

## A. Background

*Introduction*

2. The CQC is the independent regulator of health and adult social care in England and has a key responsibility in the overall assurance of essential levels of safety and quality of health and adult social care services. Under the Health and Social Care Act 2008 (the 2008 Act) all providers of regulated activities, including NHS and independent providers, have to register with CQC and meet a set of essential requirements of safety and quality.

3. CQC forms part of the wider quality framework, having responsibility for:

— providing independent assurance and publishing information on the safety and quality of services;

— registering providers of regulated activities (including NHS, adult social care and independent sector healthcare providers);

— monitoring compliance with a set of registration requirements;

— using enforcement powers (where necessary) to ensure service providers meet requirements;

— undertaking special reviews and investigations of particular services, looking across providers and commissioners of health and adult social care;

— monitoring the use of the Mental Health Act; and

— helping manage the impact of regulation on service providers and commissioners.

4. The CQC has faced a very challenging 18 months, in which it has been subject to wide ranging Parliamentary and public scrutiny, questioning performance at every level of the organisation, particularly in the context of the events at Winterbourne View. The Department's Performance and Capability Review of the CQC (completed in February 2012), found evidence that the CQC is addressing the challenges and issues it faces. The Department believes it is important to build on this progress and allow the CQC time to address the challenges, build capacity and consolidate its role as a regulator. Importantly, there has been a strong message from stakeholders on providing stability and supporting CQC, rather than creating a new regulator or dismantling the system.

5. This memorandum will now describe key issues for the Department and CQC.

*Health and Social Care Act 2012—provisions affecting CQC*

6. The Health and Social Care Act 2012 received Royal assent on 27 March. The Act made a number of changes to bring CQC legislation in line with other arms length bodies. The most significant changes to CQC's functions are:

- Healthwatch England will be established from 1 October 2012 as a statutory committee of CQC to act as the national champion for health and social care consumers;
- CQC will gain responsibility from the National information Governance Board for the monitoring of, and seeking to drive improvements in, information governance practice by registered care providers in England from 1 April 2013;
- CQC will be placed under a duty to operate a joint licensing system with Monitor from 1 April 2014; and
- CQC will also be required to gain Secretary of State approval before undertaking a special review, investigation, or review of data, studies or research (except where it believes there is a risk to those receiving care).

*Healthwatch England*

7. Healthwatch England will be established as a committee of CQC. Basing Healthwatch England in CQC will place the views of patients and service users at the heart of the health and adult social care regulator and will provide a clear route for the concerns service users to be considered by CQC.

8. It is envisaged that the functions of Healthwatch England will:

- provide leadership, guidance and support to local Healthwatch organisations;
- escalate concerns about health and social care services raised by local Healthwatch and others to CQC. CQC is required to respond to advice from its Healthwatch England committee; and
- provide advice to the Secretary of State, NHS Commissioning Board, Monitor and the English local authorities, and they are required to respond to that advice. The Secretary of State for Health is required to consult Healthwatch England on the mandate for the NHS Commissioning Board.

## B. Current Issues—Department of Health

*Performance and Capability Review*

9. The Department undertook a Performance and Capability Review of CQC between October 2011 and February 2012. It was led by a panel of senior departmental officials and external reviewers, chaired by the Permanent Secretary. The Review aimed to assess whether the CQC was achieving its objectives and has the capability to meet goals going forward. The Review worked closely with CQC throughout to ensure the findings have resonance. The timing of the Review was scheduled to allow recommendations to inform CQC business planning and was published on 23 February.

10. The focus of the Review was on future capability. The Review took on board the 2011 reports of the Health Committee *(Annual accountability hearing with Care Quality Commission, Ninth Report of Session 2010–12 HC 1430)* and the National Audit Office *(The Care Quality Commission: Regulating the quality and safety of health and adult social care, Session 2010–12 HC 1665)*. It also incorporated evidence from CQC itself, from Panel discussions with staff and a wide range of stakeholders, including organisations representing patients and service users.

11. The Review sets out recommendations for CQC and the Department, based on six key lines of enquiry developed during the Review, ie Strategy, Resources and Prioritisation, Accountability, Engagement and Communications, Regulatory Model Development and Regulatory Model Delivery. The main recommendations were:

- *CQC Board*: The Review recommended strengthening the CQC Board, through new membership and reviewing corporate governance. The Review proposed that the Department consider the development of a unitary board ie including executives and non-executives.
- *Strategy*: One of the key findings of the Review was limitations in the strategy and strategic capability of CQC. Limitations in strategic direction can make CQC too responsive to external events and lead to uncertainty in their role, but can also mean a gap between what is expected of CQC and what can realistically be delivered.
- *Regulatory Model*: The Review makes recommendations about front line inspectors, including access to expertise, improving consistency and meeting future demand.

12. Overall, the approach has been to balance the achievements of CQC with areas for improvement, with the aim of challenging and supporting the CQC to succeed. The Review found evidence of change over the six to nine months before the Review and the Department believes it would be productive to build on this progress.

13. Based on the Review, CQC set out alongside its Business Plan for 2012/13 an agreed action plan providing detail of how these recommendations will be taken forward. The action plan sets out how CQC is responding to the Performance and Capability Review, with clear arrangements for monitoring and reporting. A key element is the development of a new strategy for CQC. The new strategy, scheduled for publication later this year, will set out clearer purpose and direction for what the CQC will do and how it will do it. The CQC has already undertaken extensive engagement on the draft strategy ahead of publication.

14. The Review also recognises that the Department has more to do to support the CQC and ensure that it is held to account for its role in regulating health and social care. The Department is taking steps to strengthen the Board to ensure improvements can be sustained. Formal accountability arrangements have already been strengthened through the Department's sponsorship functions.

*Review of CQC Registration Regulations*

15. As a key part of the new health and adult social care system architecture, it is important that CQC's functions are set out clearly in legislation, enabling it to exercise them effectively and efficiently. The Department has a commitment to keep the registration regulations under review to ensure they are up to date, proportionate and do not place unnecessary burdens on providers or CQC. The Department plays an important part in ensuring this is achieved, and has already carried out an initial review, which looked mainly at issues that became apparent on implementation and tied up some loose ends that were not resolved before laying the regulations. The amending regulations were debated and agreed in the House of Lords on 22 May 2012 and in the House of Commons on Thursday 24 May 2012. Most of the provisions of The Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2012 (SI 2012 No. 1513) came into force in June 2012.

16. A second review of the CQC regulations is currently underway and will take a more comprehensive strategic look at the whole set of regulations. This will ensure the framework they set out is consistent, proportionate to the risk to people who use services, and the extent to which CQC regulation can mitigate that risk.

17. The Department is aiming to develop a set of proposals for consultation early next year, which will allow any recommendations from the Francis Review, the Winterbourne Review and CQC's strategic review to be taken into account. The Department is aiming to lay amending regulations before Parliament in time to be implemented by April 2014.

18. This review of regulations will look at:

- the scope of registration (to ensure that the requirement to register is based on the risk of harm to people using services and where there is scope for CQC registration to mitigate that risk);
- the safety and quality registration requirements (do they adequately reflect the risks to people using services, and will CQC oversight of those requirements provide appropriate assurance);
- the other requirements underpinning the regulatory framework (such as requirements around provision of information, fitness to practice); and
- the regulations around enforcement to ensure they allow CQC to take appropriate enforcement action.

19. The review is not intended to make changes to CQC's operational approach to implementation of the regulations, but there may be amendments to the regulations which enable CQC to improve its operational approach.

20. As the review is focused on the regulations it will not be considering the wider strategic issues around the role of CQC or the extent to which CQC has met its objectives unless this has a direct bearing on the regulations. These wider issues have already been considered as part of the Capability Review and in the Health Select Committee, Public Accounts Committee and National Audit Office reports.

*The Human Fertilisation and Embryology Authority (HFEA) and Human Tissue Authority (HTA)*

21. The Department's Report *Liberating the NHS: report of the arm's-length bodies review* recommended that the functions of the HFEA and HTA should transfer to the CQC and the new research regulator (the Health Research Authority), with a limited number of functions potentially transferred elsewhere. The intention was that, subject to the passage of legislation, functions would transfer before the end of the current Parliament. The Department has recently published a consultation, seeking views on a number of options relating to the transfer of functions of the HFEA and HTA. This consultation closes on 28th September 2012.

## C. Current Issues—CQC

*Development of CQC Strategy*

22. The National Audit Office report highlighted the need for CQC to have a clearer strategy, concluding that CQC "has not made it clear what success in delivering its priorities would look like." Similar concerns were also noted by the Public Accounts Committee and in the recommendations of the Department's Performance & Capability Review of CQC.

23. The Capability Review found that, although CQC's core purpose is recognised externally, its strategic prioritisation of essential standards is not understood at all levels within the Commission. The review recommended that a clearer strategy would give CQC greater confidence on how it carries out its functions and enables push back on external pressures.

24. Following the Performance and Capability Review, CQC recognised that it needs to reflect on a number of themes and take action, including:

- publishing, early next year, a new strategy, which will set out more clearly CQC's role, its aims and the measures of success. The strategy will be tested extensively with the public and stakeholders, as part of a full consultation later this year;
- developing how it measures, describes and reports on its success, impact, and effectiveness; and
- implementing information system improvements that will allow CQC, at individual inspector level, to capture and analyse decisions that led to inspection activity and resulting judgements about compliance.

*Inspection Regime*

25. CQC has implemented a new regulatory model from 1 April 2012, following a public consultation. It has made changes to both its judgement framework and enforcement policy to bring them in line with the new regulatory model.

26. CQC is simplifying and strengthening its regulatory model to reflect its core business of monitoring and inspecting. The changes will result in most services being inspected more often and inspections becoming more targeted. Under this model, CQC will inspect most social care services, independent healthcare services and NHS hospitals at least once every year. Dental services will be inspected at least once every two years.

27. The changes are not designed to toughen the approach or to raise the bar for compliance. Rather they are designed to make it clearer about whether a provider is meeting the standards and if so what regulatory action will follow.

28. One of the key changes is that CQC will no longer use "improvement actions". These were previously used in two cases. First, where a provider was compliant with registration requirements, but CQC had limited confidence that they would remain compliant. Second, where providers were non-compliant, but CQC was confident that the provider was taking adequate steps to achieve compliance.

29. In future, this "confidence factor" will be removed from the judgement. If a provider is compliant, no action will be taken. If they are non-compliant, CQC will take appropriate enforcement action to bring about improvements. The CQC believes that this is a more straightforward and transparent process.

*Market Reports*

30. The CQC publishes its annual "state of care" report each autumn. The report provides an overview of compliance and enforcement action across all sectors. In addition, CQC intends to publish quarterly "market reports" on the provision of health and adult social care in England. The first market report was published in June 2012.

31. The Market Reports are designed by the CQC to:

- provide an update on compliance in each of the sectors that CQC regulates on a quarterly basis;
- identify themes and trends in each sector's performance;
- flag issues of non-compliance to providers and other bodies who have responsibility for the health and adult social care system; and
- demonstrate the volume and effectiveness of CQC's inspection and enforcement action.

32. The first report presents the results of inspections of some 14,000 services, between June 2011 and 31 March 2012, across all the sectors that CQC currently regulates. This, and future reports, will provide a snapshot of the compliance of providers against the essential safety and quality requirements. The Department intends to review the findings and any trends in these reports and will decide how best to respond to areas of concern.

*GP Registration*

33. In response to concerns raised last year, the registration of most providers of primary medical care services has been deferred by 12 months until April 2013. The postponement will allow CQC sufficient time to improve its registration system to make the process as straightforward as possible. The registration of out-of-hours providers took place, as originally planned, in April 2012.

34. The CQC has developed an online account for GPs to use when applying for registration. Feedback from providers who have tested the form has been extremely positive. The website contains full information on the registration process and provides updates on the progress of an application and how long it is anticipated it will take for key decisions to be made. The CQC will also put in place a central team to handle applications,

reducing the risk of the registration of NHS primary medical service providers impacting on the CQC's ability to monitor competence for other registered providers.

35. The CQC has put in place an electronic system for CRB checks for the registration of providers of primary medical services and will be accepting GMC numbers instead of requiring CRB numbers for registration. This will be effective and simpler and should avoid the delays experienced in the registration of dentists.

36. The CQC has also worked closely with GP bodies, including the BMA's General Practice Committee, to ensure that the registration process is not too burdensome on practices, while still assessing the quality and safety of services. CQC carried out an extensive communication campaign to inform GPs about registration and has staged 10 events across the country which were attended by over 2,000 GPs and practice managers.

*Whistleblowing*

37. Following the events at Winterbourne View, the CQC has strengthened its arrangements for dealing with whistleblowing. A dedicated team of call handlers are trained to deal with whistleblowing calls and are responsible for ensuring they are passed to the appropriate local inspectors for assessment and consideration and tracking contacts through to a satisfactory conclusion. Whistleblowing concerns can be raised with CQC through its public contact phone line. Where whistleblowing concerns are received by the regions, they are required to send the information to the central team for logging and tracking. This new process will ensure that all whistleblowing concerns are tracked from receipt through to conclusion.

38. In addition, the Department has raised awareness of whistleblowing through the re-published NHS Constitution to include an expectation that staff would raise concerns early, a pledge that employers would support them in doing so and clarity around the existing legal protection available. The Department has also considering whether there is a need for even further developments; both to protect whistleblowers and ensure action is taken, where necessary, in response to concerns raised. Together with the national regulators, we are looking at how whistleblowing concerns are currently handled and where appropriate, implementing improvements to systems for ensuring concerns are not overlooked.

## D. Inquiries and Reviews

*Mid Staffordshire NHS Foundation Trust Public Inquiry*

39. The public Inquiry has focused on the role of the commissioning, supervisory and regulatory bodies in the monitoring of Mid Staffordshire NHS Foundation Trust from 2005 to 2009. Chaired by Robert Francis QC, it builds on the work of his previous independent Inquiry, which considered individual cases of patient care, and reported in February 2010.

40. The Inquiry is the most detailed examination of the workings of the NHS and its supervisory framework since its inception. The Inquiry heard from 164 witnesses in person, and in addition 87 witness statements and 39 provisional statements were "read" into the Inquiry's record. This included hearing evidence from both the Chair and Chief Executive of CQC, the former Chair Baroness Young and members of CQC's executive team. Evidence was also taken from senior officials of the Department and the former Chair of Monitor, the independent regulator of NHS foundation trusts.

41. The Inquiry also held a series of seven forward look seminars to inform the Inquiry's work on applying the lessons of Mid Staffordshire to the wider NHS. These seminars covered putting patients at the heart of healthcare, organisational culture, trust leadership and management, nursing, information, commissioning and regulation. Between December 2011 and February 2012, the Inquiry carried out a series of seven visits to healthcare organisations. These gave Robert Francis the opportunity to see examples of good practice and to help put the evidence heard into context.

42. Robert Francis QC intends to deliver his final report to the Secretary of State on Monday 15 October 2012. The Department will work with the other organisations in the health and social care system to ensure the recommendations are taken forward.

*Review of CQC operations following the incidents reported at Winterbourne View*

43. A serious case review into the events at Winterbourne View is ongoing. Both the CQC and the Department will consider the findings of this review and make changes where they are required.

44. The Department's interim report sets out the national actions that we are taking now to address the serious issues we have already identified. The national actions will set the strategic direction, create the policy and legal frameworks and look at what longer term changes are needed in terms of monitoring and inspecting services.

45. The interim report will feed into the wider Departmental review of Winterbourne View, due later in the year. Once criminal proceedings are concluded, Ministers will report its findings to Parliament and determine what further action is necessary.

46. CQC undertook a focussed inspection programme of 150 services for people with learning disabilities, assessing whether service users experience effective, safe and appropriate care. CQC published its national overview report of learning disabilities inspections alongside the Department's interim learning disabilities review report. Whilst this has found that failings on the scale of those seen at Winterbourne View are not widespread, it has found that 48% of the inspected providers were not providing care that met all the essential levels of safety and quality.

47. To ensure the social care system of the future is fit for purpose, the forthcoming social care white paper will explore the place of regulation alongside other mechanisms in driving quality improvement in social care. As was the case with the NHS white paper, this will include a discussion of the opportunities presented to refine and strengthen CQC's role as a quality inspectorate in this new system.

*July 2012*

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**Written evidence from Dr Pete Calveley, Four Seasons Health Care (CQC 05)**

1. Summary of Key Points

1.1 Four Seasons Health Care believes that consideration should be given by the CQC to re-introducing a simple and transparent form of rating system that gives an overview indication of how a home is performing in a way that may be easily understood by the public.

1.2 Four Seasons Health Care believes that the value of the CQC inspection process would be enhanced by: (1) a reduced interval between an inspection and the subsequent publication of the report (2) a reduced interval to follow-up re-inspection of homes when they have implemented required improvements.

2. About Four Seasons Health Care

2.1 Four Seasons Health Care is the largest independent provider in the health and social care sector in the UK. It operates 445 care homes, with 22,364 registered beds in the UK, Isle of Man and Jersey. Its specialised services division, The Huntercombe Group, operates 61 hospitals and care centres, with 1,601 registered beds and is a leading provider in the areas of adult and child and adolescent mental health, acquired brain injury, neurodisability, eating disorder and addictions and children with special needs. Four Seasons employs more than 30,000 staff caring for more than 20,000 residents. I have been Chief Executive Officer of Four Seasons since 2007. I am a former GP and Primary Care Trust Executive Chairman. I am a member of the Department of Health Forward Thinking Group.

3. A Simple and Transparent Overview Guide to Quality

3.1 The star rating system that was discontinued in 2010 provided a simple and transparent overview of how a home was performing that could easily be understood by residents and their relatives. It was a helpful reference point for members of the public considering placement in a care home and drawing up a short-list of various homes to visit.

3.2 We recognise that the system was perhaps two dimensional (Excellent/Good vs. Adequate/Poor) and suggest that a five star or tier system may provide more helpful guidance. For instance:

- 5 stars—excellent.
- 4 stars—very good.
- 3 stars—good.
- 2 stars—satisfactory.
- 1 star—unsatisfactory, improvements required.
- 0 stars—poor, major improvements required.

3.3 We believe such a simple and transparent system, that is also well recognised in other sectors, would appropriately reflect the different standards of quality achieved overall within a home. This would not replace the detailed report but would simply serve to better inform the individual using a common and easily understood measure.

3.4 Arguably it is difficult for a lay person to get a clear picture of the overall performance of a home without spending a lot of time studying and comparing the scores and comments against each of the core assessment criteria and, for instance, there may be difficulty in weighing up the difference between a moderate concern and major concern. A simple view- at-a-glance rating of overall performance would contribute to transparency and would provide context and proportionality to the scores and detailed comments against each of the core assessment criteria.

4. Timing of Inspection Reporting and Other Follow-up Process

4.1 Four Seasons Health Care believes that the purpose of CQC inspection and reporting would be served better if the time that lapses between the inspection and the publication of the report could be reduced.

4.2 We are very aware of and sympathetic to the pressures of resource versus demand under which the CQC operates. However, we believe that reducing the timeframe from inspection to report is important to help protect service users and potential service users.

4.3 A long timeframe between inspection and report means that commissioners and service users or potential service users to not have appropriate timely information on which to base decisions. This applies irrespective of whether the report overall is favourable or critical.

4.4 We continue to see instances where inspections highlight aspects of service performance requiring improvement and the improvement plan has been put in place by management and fully implemented before the final inspection report is published. This means that the information contained in the report is not an accurate reflection of the current situation in the home or specialist unit. The publication of such critical reports is almost invariably the subject of a press release by the CQC. In many, if not most, cases there is little or no appetite from inspectors to reflect improvements in the final report causing unnecessary concern and worry for residents and or their relatives.

4.5 In many cases the inspectors may not be aware that the required improvements have been implemented if they have not re-inspected. In other instances, there has been a re-inspection that confirms the improvements have been implemented and the home is compliant, but its findings are not necessarily incorporated as an update to the original inspection report. We believe consideration should be given to incorporating such update information at least as a side note if not within the main body of the report. For example, in one recent instance within Four Seasons Health Care there was an inspection report released in July of a home inspection conducted in April, in which a number of areas for improvement were identified. By the time the report of the April inspection was released, the home in question had already implemented an improvement plan and had been re-inspected and found to be fully compliant. However, this updated information was not included in the July report.

4.6 In instances where inspections have identified areas for improvement, we believe the interests of service users would benefit if providers could invite inspectors to re-inspect when they are confident that they have successfully implemented the improvement plan. Some flexibility within the CQC inspection calendar would be needed for this, but it would serve the interests of service users, their relatives and commissioners by ensuring the information available to them is as current as it can be.

*July 2012*

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**Written evidence from The Relatives & Residents Association (CQC 06)**

ABOUT R&RA

I. The Relatives & Residents Association (R&RA) speaks up and speaks out on behalf of older people in care homes. It is the only national charity for older people providing a daily helpline which concentrates entirely on residential care for this age group.

II. R&RA was founded to campaign for a better quality of life for older people living in care homes. By using the unique perspectives of relatives and residents, we work in harness with others to help improve service and standards. We also try to influence policy and practice by reflecting the experience of our members and callers who use our daily Helpline and thus can make evidence based comments on the case we make, the research and training we carry out and the policies we advocate.

III. We provide support and information through our Helpline and helps older people and their relatives make better informed decisions about looking for a home, their rights under guidance and regulations, and the benefits and standards they should expect.

IV. We also act as a listening ear to help support families and individuals at what is often a time of crisis and trauma for them, when it becomes apparent that a partner, parent or friend can no longer live at home. We also help them when there are difficulties and complaints about the standard of care and often act as brokers between the relative/concerned individual and the care home.

V. Our comments are based on our Helpline service and our activities, including training, research and feedback about the reality of life in care homes for older people.

SUMMARY

Our comments follow the recommendations made by Department of Health in their Performance and Capability review and say:

- CQC are not acting as an agent for improvement as required in their governing legislation;
- CQC does not have sufficient expertise in the care home sector;
- CQC's strategy should build in the capability to inspect care homes least twice a year;
- performance measures for care homes should focus on improvement in the health, safety and welfare of residents;

— there should be two inspections of care homes per year;
— a focus on selected standards only is negligent;
— specialists with expertise in care homes should be recruited to inspect care homes;
— CQC appear to be taking steps taking steps to being a learning organisation, but they have a long way to go;
— CQC could reduce the burdens on care homes for older people by becoming a reliable and trusted organisation;
— CQC should carry out an evaluation of its priorities and inspection methodology;
— CQCs regulatory regime should be specifically tailored to meet the needs of each sector;
— The DH should improve its capability and expertise on the regulation of safety and quality; and
— The CQC website should not allow care homes to expunge their (often poor) records by changing the name under which the provider is registered.

## Comments on the Performance of CQC

*Quality improvement (Recommendation 1)*[1]

1. R&RA remain concerned that the CQC are not complying with provisions in s3 of the Health and Social Care Act 2008, in particular the provision in s3(2), "to perform its functions for the general purpose of improving health and social care services", and in a way that "focuses on the needs and experiences of people using those services". The evidence from callers to our helpline would suggest that the experience of the residents of poor quality care is not exceptional and neither is the lack of immediate action by CQC when complaints are made.

2. The R&RA commend CQC for carrying out its thematic inspections and publishing the findings, and look forward to further such inspections in care homes. We would also like to see an evaluation to establish whether those providers who were compliant, remain compliant, and whether providers who need to make improvements have done so in a sustainable way. R&RA would also want to see how far the findings have informed and empowered the users of services to seek and uphold improved services.

*Impact of regulatory action in specific sectors (Recommendation 2)*

3. R&RA is deeply concerned that CQC as an organisation is viewed as lacking in expertise and capability and is not viewed as an authoritative body on what represents good quality care in care homes. Our strong view is that CQC's revision of strategy should include recruiting staff at all levels that have real knowledge and expertise in the care home sector with a view to becoming an organisation respected by providers, rather than one which is viewed with disdain.

*Improve strategic planning and analytical capacity (Recommendation 3)*

4. R&RA agrees with recommendation 3 that CQC should improve their strategic planning and analytical capacity. Our view is that any strategy must however be able to respond to operational drivers and CQC should build into its strategy the capability to inspect care homes at least twice a year.

*Clearer measures of success and simple strategic performance metrics should be developed (Recommendation 4)*

5. Care homes are where our most vulnerable and frail citizens live, and are places that older people in particular will end their days. While we must be able to judge whether CQC is succeeding in its task, it is far more important in our view that performance measures are developed for care homes which genuinely protect the health, safety and welfare of care home residents.

*Focus on selected frequency of inspections standards (Recommendation 5)*

6. R&RA are campaigning for increased inspections in care homes. We are strongly of the view that two inspections per year should be the minimum. Unlike general hospitals, dentists or GP surgeries, care homes are places where people live and where they depend on the home to meet the majority, if not all, of their needs. The delivery of good quality care depends on experienced, knowledgeable and caring staff with appropriate training and qualifications as well as strong leadership in the management team. Standards of care can drop considerably with a change in management, or from takeovers by other companies or with vacancies occurring in senior positions.

7. We are also of the view that because a care home is a person's home, their welfare and safety cannot be effectively safeguarded through an annual inspection. Older people living in care homes are now at a greater age (80s, 90s and 100s) than in previous decades and consequently more vulnerable. Their spouses are also at a great age and the evidence from our helpline shows that many relatives are reluctant to complain for fear of

[1] Performance and Capability Review—Care Quality Commission Department of Health 23 February 2012.

retribution on their loved ones. We are also concerned about the 20% of older people in care homes who have no kith or kin or are not visited either because their relatives are unable to visit because they themselves are infirm, too far away or have other family responsibilities or where there has been a family breakdown. For many of those unvisited residents and many self-funders the CQC are their only advocate, and an annual inspection could mean they are living a miserable and painful existence unchallenged for 12 months during which time many will die without having their circumstances questioned by anyone.

8. What R&RA do not want to see is a focus only on very few outcomes and standards. We are of the view that inspections of care homes, where they are not thematic should encompass all the regulations and standards set by Government. We consider that residents' lives and well-being are put at risk by selecting a small sample of the standards and find the practice unacceptable. This approach brings the concept of regulations and standards into disrepute if legal requirements can be ignored at will. In what other situations where people lives depend on delivery of a safe service is it acceptable for regulators to pick and choose what they inspect?

9. What also needs to be borne in mind is that the vast majority of staff in care homes for older people are not registered professionals. The only regulatory body who can determine compliance, issue warning notices and ultimately cancel a care home's registration is the CQC. Therefore, inspecting against a few standards ultimately undermines their ability to perform their statutory function and also their authority to protect older people living in care homes.

*More wider and sector-specific expertise (Recommendation 10)*

10. R&RA welcome the appointment of David Behan as Chief Executive of CQC and believe that further social care and care home expertise is required throughout the organisation at a senior and at inspector level.

11. We do not agree with the concept of "generic" inspectors and are campaigning for specialist inspectors to inspect care homes who can properly distinguish between poor and excellent care and good, bad or mediocre care homes. The problem is not only that some inspectors do not see poor care because they cannot recognise it, but neither do they acknowledge when good care is being provided which only serves to undermine their credibility as well as keeping residents at risk.

12. We believe that only with specialists will CQC be able to fulfil its requirement to act as an agent for improvement of care in care homes in general, and in each care home where they find that the regulations and standards are not being met. We do not believe it is good enough for inspectors to find a care home "non-compliant" (sic), and then not to be able to advise the care home how to improve their practice, if that is viable

*Proactive and systematic in understanding the expectations of stakeholders and demonstrate it is a learning organisation. (Recommendation 12)*

13. The R&RA and CQC are currently engaged in a pilot project to inform CQC about the experiences of living in a care home. CQC has acknowledged that information received from R&RA is of clear value and have triggered inspections leading to warning notices being issued. However, the overall numbers of callers to our helpline who have given us permission to pass their information on to CQC is disappointing. This is because many of our callers have previously approached CQC about concerns about poor care and found either no response or that their response has been unsatisfactory. While CQC appear to be taking steps to becoming a learning organisation, they have a long way to go before they can enjoy the confidence and trust of relatives of care home residents.

14. R&RA is calling for a regulator that listens and responds to serious complaints. CQC's stated position that they do not deal with formal complaints is bewildering to the general public. CQC's *raison-d'etre* is to establish the fitness of the provider. Therefore, any complaint which speaks to the fitness of the manager is CQCs business because it is an intrinsic part of their role to ensure that the staff, management and environment are fit for purpose and meet the registration requirements and the regulations. We recognise that ultimately the responsibility for care lies with the care home, but if complaints to the care home are unheard, then there is a fitness issue which is the clear responsibility of CQC. The evidence to our helpline suggests to us that CQC is not a responsive regulator and fails to recognise their key role in ensuring that the service meets the residents' needs.

15. In addition, it would be helpful if CQC did not regularly change its terminology. It has variably called its inspections by different titles, ranging from "visit", "assessment" and even "inspection". The use of "compliance" instead of the previous CSCI clear terminology of "met", "not met" and "partially met" in regard to the requirement s and standards is muddling and imprecise. As is their use of regulations and standards interchangeably, when they have a different status in law.

16. Here are some examples from our helpline which illustrates why R&RA are calling for a more responsive regulator:

— Caller reported home for not taking her father with septicaemia to hospital—she had to take him and he died shortly after. No investigation has been done following caller's complaints to CQC. May 2012.

— Caller found poor quality care, including feeding practices, general living standards in the home, alerted CQC, police and local authority. Despite expressing her major concerns.

— Her mother lost a great deal of weight. No registered manager in post from June 2010 to January 2012. Home still deemed OK by CQC April 2012.

— No registered manager in home from date of registration in October 2010. CQC knew, asked home to comply. It didn't, CQC asked it to comply again, gave until April 2012. No further action to enforce compliance. April 2012.

— Caller complained to CQC of mishandling of her mother's medication. CQC told the home, home gave poor response. Caller told by R&RA to go to CQC because she had already gone through internal complaint process. Caller reluctant because CQC had been unhelpful before.

— Caller noticed cuts/bruises on mum, however, he has no faith in CQC to act on any information he may send them. May 2012.

— Caller saw that home was not administering medication correctly, so she gave them to her mother herself. Was then arrested for "poisoning" her, then charges were dropped. Still wants to administer them to her mother herself because home will not listen to her complaints, has not recorded her formal complaint. R&RA suggested she alert the CQC but caller was not confident in CQC's ability to safeguard residents. April 2012.

— Caller wanted RRA's help in addressing suspected abuse issues in her father's home because CQC's response gave her no confidence that they would pursue it properly. March 2012.

— Caller's mother had died while in a care home about which she had serious concerns. Asked CQC to investigate, was told that CQC doesn't investigate individual complaints. November 2011.

17. With reference to information for stakeholders, we are particularly concerned about a current practice which allows care homes to expunge their (often poor) records from the CQC website by changing the name under which the provider is registered. Homes that have changed their names are difficult to trace, and relatives will often not be able to find a previous inspection showing CQCs concerns. This is certainly not fair to the potential resident or commissioner in seeking to establish a home's previous track record. It is neither transparent nor Open Government to allow such practices to continue.

*Work more closely with other regulators within the health and care sector to increase joint effectiveness and reduce burden on providers. (Recommendation 13)*

18. Some local authorities and other commissioners undertake their own "inspections" because they have no confidence in CQC's rigour. They also have a duty of care for those people they place in residential care homes as well as to ensure that they get value for money. CQC could reduce the burdens on care homes and councils by becoming a reliable and trusted organisation that carries out inspections using trained specialists who inspect care homes at least twice a year.

*Set out clear plans for on-going evaluation of the regulatory model and the effectiveness of individual interventions (Recommendation 16)*

19. R&RA believes it is absolutely necessary for the future credibility of the regulatory regime that CQC carries out an evaluation of its inspection methodology. Without evidence it cannot demonstrate it is an effective organisation that is responsive to those who use services, or demonstrate that it is carrying out the functions laid down in the Health and Social Care Act 2008. We would like to see evidence of how CQCs inspections are improving the lives of those older people living in care homes. The statistics they currently produce showing a year on year "improvement" cannot be trusted because not all the regulations and requirements are necessarily inspected, as previously stated.

*The compliance regime should be tailored to reflect the different risks and needs of different sectors and locations. (Recommendation 18)*

20. R&RA's strong view is that the so-called "compliance" regime should be tailored to meet the needs of the care home sector. We feel that it is not credible to have a generic system where the sectors are so vastly different from each other, varying in the type of care, nature of the provider and models of ownership. We consider the regime needs to reflect the differences in those that use the services and respond accordingly. Of course there are some universal principles that must be adhered to across the sectors, such as dignity and privacy, but how those principles are applied must be far more specific and relevant to the nature of the service being provided and the ability of people to be able to speak up for themselves if they are not treated or cared for properly. This is particularly germane for those people who are frail, vulnerable and at the end of their lives.

*The Department should develop its capability and capacity on the regulation of safety and quality (Recommendation 19)*

21. R&RA is in full agreement with this recommendation and look forward to hearing the response from the Department of Health. We believe that greater capability and expertise is needed as well as a recognition that a "one size fits all" approach creates more problems than it was designed to solve. For example, the Care

Homes Regulations 2001 contained a provision at s28 which required the owner of the home to visit once a month to make sure the home is being run in accordance with standards and regulations. This regulation was dropped, presumably because the majority of health providers are in the public sector and do not have "owners", which is in complete contrast to the care home sector where private and independent providers own the vast majority of care homes. The lack of this provision means that owners can (and often do) divorce themselves from the day to day complexities of care homes and fail to see how corporate policies, eg, to cut costs effects the lives of staff and residents. R&RA want to see the expertise and capability at the DH improved vastly before the regulations are reviewed so that there is proper appreciation of what it is required to manage a care home and for people to live in them with appropriate emphasis on quality and well-being

*July 2012*

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**Written evidence from the Foundation Trust Network (CQC 07)**

1. Introduction

1.1. The Foundation Trust Network (FTN) is the trade association and collective voice for NHS foundation trusts and those working to achieve foundation trust status. We have 215 member organisations providing care across the acute, mental health, ambulance and community services. The FTN welcomes the opportunity to inform the annual review of the Care Quality Commission (CQC) being carried out by the Committee.

1.2. The FTN supports CQC's vital role in creating a baseline for quality and safety in the NHS to provide assurances to patients and the public, and safeguard minimum standards.

1.3. We welcome CQC's initiatives in recent months to ensure a proportionate approach to regulation, and their openness in reviewing and seeking to improve their own consistency and transparency of approach.

2. Key Messages

However, we argue in this submission that CQC needs to continue to improve its culture and approach to regulation:

— Embed in CQC's organisational culture a risk-based and proportionate approach to regulating quality and safety which is consistently applied. FTN members want to see this approach across inspector training on the new Judgement Framework; quality assurance processes; the approach to requesting data from Trusts; and media and communications strategy. We remain concerned the quality of CQC inspectors is highly variable and that Trusts are heavily penalised for minor breaches of the regulations: CQC should focus on systematic failures which affect patient outcomes.

— Clarify the regulatory responsibilities of CQC and Monitor to avoid the potential for "double jeopardy." Trusts can face enforcement action from both Monitor and CQC for the same incident, as CQC judgements inform Monitor's Compliance Framework risk ratings. This effect can be compounded as commissioners and lenders use the risk ratings to influence negotiations with providers. FTN members wish to see greater co-ordination between the regulators and a reduction of the existing potential for double jeopardy.

— Clarify CQC's role in driving systemic quality improvement in the health sector, including how this complements commissioners' oversight, and the central role of provider boards in leading and owning the quality agenda at level and beyond. We see a role for CQC as a thought leader in the health system, analysing the data it holds to unpack the drivers behind standards and inform best practice.

— Align regulatory and policy approaches, examining how care pathways can be regulated effectively, and flexing CQC's approach to different care settings. The health service is developing care pathways which suit the needs of patients, spanning locations and providers, but we see little recognition of this in regulation. We recommend that the Department of Health considers how regulation will keep pace with policy development, particularly in relation to integrated care.

— Use more timely and robust data to inform regulatory judgements. Members have reported judgements made on the basis of data many months old, and we remain concerned that some CQC inspectors request significant supplementary data from Trusts. FTN members would welcome a clear rationale for new data collections.

— Sustain the focus on organisational change at CQC to build the credibility of the regulator. Government, the NHS, other regulators and the public all rely on the credibility of CQC judgements. This submission sets out a number of concerns with CQC's approach which have been raised by our members over the past three years. We are supportive of the trajectory of improvement which our members perceive at CQC, but it is important to recognise that CQC's ability to build trust rests on implementing a cultural change which addresses these well rehearsed problems.

3. Comment

*Embed in CQC's organisational culture a risk-based and proportionate approach to regulating quality and safety which is consistently applied*

3.1. The FTN welcomes CQC's recently introduced Judgement Framework, and the spirit of "Better Regulation" within which this was undertaken. There is much to support in the Framework at the level of principle, however its success will rest on how it is interpreted and applied. We accept that a more targeted focus on identifying non-compliance should focus regulatory activity more effectively, and potentially reduce the burden of unnecessary inspection. However, we consider that adopting a risk-based approach will require a significant change in behaviours and organisational culture at CQC, and we would welcome further clarity around plans to support this change.

3.2. We are concerned that rather than improving proportionality, a targeted focus on identifying "non compliance", could create a " fault finding" culture which increases reports of non-compliance unnecessarily, and creates an imbalanced view of the overall quality of FT services for patients, public, staff and other stakeholders. We remain to be persuaded that the regulatory burden will be reduced as providers will need to gather data to refute certain judgements on grounds of proportionality or general accuracy. As one member comments:

> "CQC seem to want to have absolute rather than reasonable assurance. They give as an example in the (Judgement Framework) consultation document that you can be achieving the standard of medicines management on 12 out of 13 wards but classed as non-compliant. I would suggest that is not proportionate and will cause the hospital reputational damage when the overwhelming majority of patients are meeting the standard. In fact I would go further and suggest if this approach is enacted there is no Trust that will be compliant".

3.3. There is a perception among our members that CQC is achieving greater proportionality in its inspection activities. However, it is worth noting that over the last three years our members have reported concerns that CQC interventions can be disproportionate and inappropriate, with undue escalation of matters which do not impact patient safety. We are particularly concerned that many FTs have experienced disproportionate judgements which then become unfairly amplified because Monitor ratings are affected by CQC judgements and commissioners and lenders use the ratings to influence negotiations with providers.

3.4. Further recurring concerns include:

- The classifications of minor, moderate and major concerns and the lack of proportionality in categorising breaches of compliance. We have many examples of relatively trivial breaches categorised as major when they are not systemic and do not impact on patient care;
- An inconsistency around guidance on registration with some, but not all, organisations having to register many sites—undermining attempts to establish a "level playing field";
- Variability in inspectors' approach to the evidence required to make a judgement;
- A lack of dialogue with providers around reports; and
- A sensationalist media approach that has unnecessarily damaged the reputation of organisations, often for relatively trivial breaches.

3.5. The application of the new Judgement Framework provides a timely and welcome opportunity for CQC to redress the balance in these recurring issues and to demonstrate a maturity of judgement which shows greater system leadership.

3.6. Under the new Judgement Framework, a more transparent scale of enforcement action will determine what regulatory response to take (the enforcement escalator). We welcome this change in emphasis and consider that the new framework should identify whether concerns are systemic and influence safe patient care. It is worth re-emphasising the FTN view that a fundamental element of CQC's role is to register providers who meet acceptable safety criteria permitting them entry to the health and social care market. Strengthening this important "gateway" can only protect quality and patient safety.

3.7. Ensuring consistent application of the new framework will be essential in building provider and patient confidence that CQC assurances are of a given standard. Variability in the quality and consistency of reports and judgements points to potential training issues among inspectors and the teams that support them, which we are keen to see addressed.

3.8. The FTN has also previously raised concerns with the CQC about how judgements are usefully put in the public domain. As an illustration, one foundation trust commented:

> "The sensational, name and shame, nature of their reports and their adversarial use of the media has over inflamed the situation and should have been a last resort when other actions had failed".

Appropriate and proportionate communications remain a significant concern to our members and we are cautious about the reputational damage which could be created by a sole focus on "non-compliance".

3.9. It will be essential for CQC to ensure the communication of judgements of non-compliance are specific, balanced and clear for patients, the public, staff and stakeholders. Communications must clearly identify the

quality issues which need to be addressed while acknowledging the "full picture" of services provided by the Trust which will only be inspected against a handful of "essential standards" suspected to be below standard.

*Clarify the regulatory responsibilities of CQC and Monitor to avoid the potential for double jeopardy*

3.10. The FTN continues to support an appropriate and risk based approach to the regulation of quality and financial indicators, with a strong emphasis on the interaction of both indicator sets in predicting and averting failure. We would welcome an open debate about how best to reflect the interrelated nature of quality and finance in regulatory practice. Looking ahead, one of our most significant priorities is to ensure there is role clarity between the functions of the regulators and regulated; and better interaction between CQC and Monitor.

3.11. CQC's judgements on quality and safety are fundamental to the functioning of the system and underpin public confidence in the NHS. Our members report that gradually CQC appears to be getting better at proportionality, but it is still a consequence of the system, that the effects of CQC judgements are compounded because they inform Monitor's Compliance Framework risk ratings, causing potential double jeopardy. This effect can be further compounded because commissioners and lenders use the risk ratings to influence their negotiations with providers.

3.12. We strongly encourage CQC to work closely with Monitor, and other regulators, to improve co-ordination and clarify respective roles. On quality issues, regulators need to share information, but should be wary of blurring the boundaries of their responsibilities or creating an over-bureaucratic system that stifles innovation. This point is only further endorsed by the recent Monitor report into lessons learned from Peterborough and Stamford NHS Foundation Trust where issues were exacerbated by confusion and a lack of full communication between the two regulators.

*Clarify the role CQC plays in driving systemic quality improvement in the health sector, including how this complements commissioners' oversight; and the central role of provider boards in owning and leading the quality agenda at provider level and beyond*

3.13. The FTN is clear that the quality improvement agenda is most effectively owned and led at the local level by provider boards which are closest to patients, and able to monitor and action improvements on a continuous basis. However, as the new health system continues to takes shape, we would welcome an open dialogue on how CQC's role in monitoring minimum quality standards relates to, and aligns with, other regulators and wider stakeholders with an interest in the quality space.

3.14. We welcome the development of a thought leadership role for CQC to share insights from its valuable evidence base across the health and social care sector, including analysis, Quality Risk profiles and good practice case studies. However, we are unequivocal that inspection should be carried out as a clearly defined task, distinct from thought leadership.

3.15. CQC's recent "Market Report," is an important first step in building this leadership role, however much deeper analysis will be required to enable providers to act on information and recommendations—for instance to unpack the drivers behind standards of maternity services, such as demographic variability, local innovation, and leadership, rather than focussing at a superficial level on comparing staffing ratios and patient numbers. FTN members would also welcome insights which inform best practice on the integration agenda, and improving quality.

*Align regulatory and policy approaches, examining how care pathways can be regulated effectively, and flexing CQC's approach to different care settings*

3.16. FTN's members observe that the approaches taken by CQC have been dominated by an acute care mind-set which is an inappropriate means of gauging the standards of mental health and community services. All healthcare services should be judged with equal rigour but the judgement should be made with due regard for the setting in which the care is provided.

3.17. As part of the debate on being fit for future purpose, it will be important that organisational resources both at CQC and provider level align with the emerging policy landscape. For instance, there is increasing focus on developing patient-centred care pathways as a means of improving patient experience, quality outcomes and productivity. However, to date, CQC has been a regulator of organisations rather than pathways. As integrated health and social care pathways become more widespread it will be important for the Department of Health to ensure the regulatory regime reflects this in its working.

3.18. A further illustration is the rearrangement of local CQC area teams by postcode rather than aligned with natural patient catchment areas, or other health system borders, leading some foundation trusts to deal with multiple inspectorate teams—a frustrating experience which does not lend itself to building strong working relationships and risks wasting provider time which would be better spent on patient care.

*Use more timely and robust data to inform regulatory judgements*

3.19. CQC has confirmed that it will publish information regarding its quality assurance systems which is welcome. However, FTN members remain concerned that the new Judgement Framework retains a risk of subjectivity, based on small sample sizes, which may perpetuate inconsistency between inspectors' judgements.

3.20. We are concerned that CQC's systems are not currently sufficiently responsive in compiling and analysing real time data. There is still a significant lag in the use and publication of data which impacts on overall regulatory ratings. To give one example, CQC inspectors have told members explicitly that they do not have the time to enrich the national data in the Quality and Risk Profile with "local" data. This should be addressed with some urgency to ensure the accuracy required to protect patient safety, make robust judgements and sustain public confidence in the system.

3.21. There should also be a clear rationale behind data requests and wider public understanding of the resource implications of collecting data. Information is a powerful and welcome driver to underpin improvement and accountability but within finite resources new data requests will impact on the funds available to invest in patient care.

*Sustain the focus on organisational change at CQC to build the credibility of the regulator*

3.22. The credibility of CQC's judgements underpins public confidence in the system, and can determine action by other regulators, notably Monitor. We are supportive of the trajectory of improvement which FTN members perceive in their relationships with CQC, however, it is important to recognise the scale of cultural and behavioural change required to ensure a regulatory approach which is targeted, proportionate and consistent. The CQC's ability to build trust with the sector, government, other regulators, the public and other stakeholders, rests on addressing the outstanding issues outlined in this submission.

*July 2012*

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**Written evidence from the NHS Confederation (CQC 10)**

1. Introduction

1.1. The NHS Confederation is the only body to bring together the full range of organisations that make up the modern NHS to help improve the health of patients and the public.

1.2. We welcome this opportunity to provide evidence to the Health Select Committee's annual accountability hearing with the CQC. Our evidence is based on feedback we have received from members' experiences of the regulator and our involvement in informal consultations the CQC recently organised to review and develop its regulatory model.

1.3. This submission starts by setting out our view on the proper role of quality regulation. Given the context of the Department of Health's capability review of the CQC, the CQC's own strategic review, and the broader remit of the Mid Staffordshire NHS Foundation Trust Inquiry, this is a useful juncture at which to reflect on the role quality regulation should play in the health service.

1.4. We also reflect on the changes that have happened to the CQC during the previous twelve months and the progress we believe it is beginning to make following criticisms of the regulator. We do not go into detail about the CQC's registration processes and the use of Quality Risk Profiles as these were reviewed in detail by the Committee last year.[2]

2. Executive Summary

*How quality regulation should work*

2.1. The NHS Confederation supports strong, effective regulation. Effective regulation should:

- secure public trust in the individuals and organisations providing care;
- ensure patients receive high-quality and safe care provided by well-run organisations;
- offer value for money, given any waste ultimately takes money away from patient care; and
- ensure alignment between the different regulators to avoid overlap and duplication.

2.2. The Mid Staffordshire NHS Foundation Trust Inquiry is about to report and this is going to require a robust response from the NHS and national leaders to address any concerns raised. However, there are some pitfalls for the inquiry to avoid. We are concerned that it could lead to further pressure for yet more regulation at a cost beyond the public benefit. There have been similar calls following recent high-profile failures of care, focusing particularly on increasing the number of inspections (including unannounced inspections). Inspections are important for reinforcing public confidence. However, a balance needs to be struck: frontline clinicians and their organisations are ultimately responsible for improving quality, and inspections only demonstrate an

[2] Our submission to last year's inquiry can be found online here: http://www.nhsconfed.org/Documents/HSC%20regulation.%20FINAL%20June%202011%20with%20logo.pdf

organisation is meeting standards at a particular time and place. The CQC also needs to look at making use of other mechanisms for maintaining essential standards. This could include highlighting what good practice looks like, and advising and supporting poor performing healthcare organisations to improve.

2.3. We caution against yet another major structural reform of regulation. With the NHS facing unprecedented financial changes and undergoing major changes to its structures it will be more challenging than ever to maintain quality and safety standards. It is essential to avoid a reorganisation which would disrupt CQC's focus on monitoring whether essential standards are being maintained. Instead there should be a closer working relationship between the CQC, Monitor, and the professional regulators.

*The CQC's future work*

2.4. Since the last health select committee report we believe the CQC has shown a willingness to recognise concerns about its operation and performance. Some improvements are beginning to be made and we welcome the appointment of David Behan as the new Chief Executive.

2.5. However, it is too early to fully assess the impact of these changes and our survey of members (see 4.2) shows they continue to have major concerns about the regulator. We look forward to seeing proposed changes to the CQC's model making a positive impact on the ground, and we hope the regulator will win back the confidence of the public and the organisations it regulates.

2.6. We believe the Department of Health's capability review sets out realistic steps that must be taken to improve the regulator, and avoid the need for a major upheaval in the regulatory system. We also encourage the Committee to scrutinise the consultation on the CQC's strategic review which we expect to be published before the Committee's session.

2.7. The CQC needs to be clear about its role and avoid future mission creep, particularly given Monitor's new role as the sector regulator:

- The Government should amend the CQC's statutory duties to reflect that its primary role is to assure essential standards, and that it has a limited role to play in driving improvements in the quality of care.
- It is important for both the regulator and government to better communicate to the public what quality regulation can and should achieve.

2.8. It is essential for the CQC to be a clearly independent body if it is to be an objective advocate of quality and safety. Clarity is needed on the regulator's relationship with government. The CQC needs a strong independent leadership which is prepared to raise concerns when it is asked to divert resources away from other priorities or if it believes that national policy is having a detrimental impact on front-line services.

2.9. We would like to see the CQC provide clearer information to the public about whether services are meeting essential standards. At the moment, compliance is only checked at a location against a few essential standards, rather than by individual service. This can be meaningless to patients and the public if this is a large organisation covering many varied services.

2.10. Inspections, and the results of inspections, should be better co-ordinated with other regulators and oversight bodies to avoid duplication. For example, the costs and disruption arising from duplication could be reduced if the different regulators combined inspections and shared information more regularly.

2.11. The regulator needs to be transparent about the likely impact of taking on additional responsibilities from the Human Fertilisation and Embryology Authority and the National Information Governance Board for Health and Social Care.

2.12. 80% of our members are not confident that Healthwatch England is ready to effectively discharge its responsibilities in 2013. The body needs to urgently appoint its Chair and Board, and set out how it intends to work with patients, the public, the NHS, the Government, and other regulators.

## 3. The Proper Role of Quality Regulation

3.1. We believe it is essential for all regulators to have clear objectives and a clear understanding of their role and how this relates to other regulators. We have previously identified five key elements as the proper focus of regulation:

- Protecting people from harm, especially the most vulnerable in society;
- Protecting and promoting the patient interest;
- Assuring the quality of services and delivery of good outcomes for patients;
- Ensuring access to essential services; and
- Changing behaviours and internalising good practice to achieve the desired objectives.

3.2. In the past, there has been insufficient clarity about whether the CQC's role should be about improving quality or assuring essential standards. This could be confusing for the public and healthcare providers. Without

clarity about its role, it is difficult to define the regulator's purpose and focus and its performance gets judged accordingly.

3.3. We are pleased to note that the CQC has indicated that it sees itself as an essential standards regulator and that its role in driving up quality is through effective registration and regulation against its essential standards.

3.4. We agree with this position. The CQC has a limited role to play in improving the performance and quality of providers which is the primary responsibility of front-line clinicians providing direct care and their organisation's leadership. This is supported and reinforced by a range of other organisations and levers such as NICE quality standards and complaints monitoring.

3.5. To improve clarity and to avoid future mission creep, the Government should amend the CQC's statutory duties to reflect this. Whilst the essential standards that the CQC assesses against may rise over time, operating these essential requirements for entry to the market effectively must be CQC's core role, particularly given proposals to encourage new providers of NHS services. The regulator should encourage providers to develop more robust systems for monitoring and delivering quality, and to reinforce that with an effective enforcement regime.

3.6. It is important that the CQC's role—and the role of regulators more broadly—is clearly and honestly communicated with the public by all national leaders, including government and the regulator, to manage expectations about what regulation can and should achieve.

*We need stability in our regulatory system*

3.7. Whilst we recognise the CQC is not perfect, we caution against yet another major structural reform of regulation. Recent evidence sessions at the Mid Staffordshire public inquiry have highlighted the benefits of a single economic and quality regulator for health and social care.

3.8. It is essential to avoid a reorganisation which would disrupt CQC's focus on monitoring whether essential standards are being maintained. With the NHS facing unprecedented financial changes and undergoing major changes to its structures it will be more challenging than ever to maintain quality and safety standards. Our recent survey of members indicated that 47% were worried about the outlook for quality of care over the next 12 months.[3]

3.9. Furthermore, while the rest of the NHS is already engaged in structural change, the CQC's eye must be on the ball. There have already been three reorganisations of health and social care regulation in six years and this is not a moment for hiatus and distraction. The CQC needs stability to give the regulator a fair chance of success.

3.10. Rather than merging regulators, we need closer working between the CQC, Monitor, and the professional regulators to ensure that they work with common purpose to common goals, sharing information readily.

3.11. Recent experiences with financial services regulation have also illustrated some of the pitfalls of creating a supra regulator for an industry, particularly for the quality of oversight of day to day operations and public protection. Hence the current proposals for reform.[4]

3.12. A more systematic approach is needed, and we hope the public inquiry into Mid Staffordshire NHS Foundation Trust will result in a sensible and considered approach to the respective roles and functions of the different parts of the regulatory and oversight structures, rather than calls for even more regulation. Such an approach is particularly important given Monitor's new role as the sector regulator for the NHS.

*The role of inspections*

3.13. Inspections of frontline services are a crucial element in the armoury of the regulator which must fit alongside analysis of data and feedback from patients. They are also important for maintaining public confidence in the health system. They can act as a useful tool for regulators where there are good reasons for believing that an organisation, or part of an organisation, is failing to meet essential standards.

3.14. Following recent high-profile failures of care there have been calls to increase the number of inspections that the CQC carries out each year. There have been times when the NHS has fallen short of the standards the public rightly expect. But we need to have a debate about what the right level of inspection is. Too much regulation and inspection can be costly and end up adding little to guarantee quality, safety and access for patients, and disrupt an organisation's activity.

3.15. A balance needs to be struck as inspections risk providing false assurances based on a snapshot view. The CQC's inspections normally only assess a few standards in a particular part of an organisation (such as a few hospital wards), using other tools (eg self-assessment) to assess compliance with other standards. Any

[3] The NHS Confederation asked the Picker Institute Europe to survey the chairs and chief executives of all its member organisations. The survey was conducted between 26 April 2012 and 16 May 2012. It was sent to 625 chairs and chief executives in 362 organisations. There were 252 completed surveys—a response rate of 40%—from 200 organisations.

[4] http://www.hm-treasury.gov.uk/fin_stability_regreform_structure.htm

inspection can therefore only examine what is happening at a particular time in a particular part of an organisation.

3.16. Where inspections do take place, the regulator needs to do more to disaggregate the information in its reports to provide assurance to patients about whether certain services are meeting essential standards. At present the CQC only provides a single assessment for compliance based on the location of an organisation (eg a hospital site) rather than by available services. For example, Imperial College NHS Trust operates Charing Cross hospital, Hammersmith hospital, Queen Charlotte's and Chelsea hospital, St Mary's hospital, and Western Eye hospital—all of which have individual compliance assessments. However, we do not know how much variability there is in the quality of the approximately seventy services operating across those locations. Quality and safety can never be uniform across such a large organisation, and it is almost meaningless to patients to provide an overall rating for a large hospital that operates a large number of varied services. Although it may be cumbersome and costly to evaluate every service, the regulator could choose to inspect a few key areas as part of a planned visit.

3.17. Inspections, and the findings of inspections, need to be co-ordinated with other regulators and oversight bodies. Disruption to an organisation could be minimised without reducing assurances to the public if regulators accepted each others' inspection reports or carried out joint visits. Lessons from the joint assessments of children's services led by Ofsted but including the CQC are worth considering.

3.18. The CQC could make better use of other tools at its disposal to assure itself that providers are compliant with essential standards. For example, existing data sources such as the Quality and Outcomes Framework and practice accreditation could help to determine whether primary medical providers are compliant. The CQC could also look at highlighting what good practice looks like, advising and supporting poor performing healthcare organisations, and maximise its use of special studies and reviews to report on care pathways to assess patients' overall experience of care rather than individual organisations.

*How NHS organisations can improve quality*

3.19. Regulation can help to identify problems and act as a "back-stop", but ultimately it is up to the leaders of an organisation to take responsibility for improving patient care.

3.20. To genuinely improve quality we need to proactively improve the way commissioners and providers design and deliver care to patients. Primary responsibility for delivering high quality care lies with the board of an organisation who take strategic responsibility for:

- Developing a positive culture that pursues high quality care throughout the organisation;
- Putting in place appropriate governance systems and processes to deliver high quality care and ensuring their implementation;
- Setting quality objectives;
- Tracking performance;
- Collecting key information, including acting on patient complaints; and
- And benchmarking against peers.

3.21. As part of our commitment to driving up quality in the NHS, last year the NHS Confederation launched the Commission on improving dignity in care for older people with Age UK and the Local Government Association. The Commission's report *Delivering Dignity* made 37 recommendations for health and social care organisations to improve the way we care for older people. We will be working closely with NHS organisations over the coming months to share good practice and to encourage implementation of our findings to lead to effective change in how we care for older people.

## 4. Our Members' Views of the CQC and the Regulator's Progress over the Last 12 Months

4.1. Last year's report from the Health Select Committee and the recent Public Accounts Committee report on the performance of the CQC closely reflect many of the concerns our members have raised about the CQC's operation. We were pleased that the Committee noted our members' concerns that "the CQC's approach is too acute and social care focused" and has a "one-size fits all" registration model with "guidance that does not make sense" in specific services such as "mental health, ambulance and community services".

4.2. In our recent survey of members,[5] 69% said they were not confident about whether the CQC would be ready to effectively discharge its responsibilities in 2013, compared to 31% who were confident. The only organisation that fared worse was Healthwatch, which will be hosted by the CQC. 80% of respondents said they were not confident about Healthwatch compared to 11% who were confident. For comparison, our members were most confident about the readiness of Monitor in its new role as an economic regulator. Sixty eight% said they were confident compared to 31% who were not confident. Other organisations with positive ratings were the NHS Commissioning Board and the NHS Trust Development Authority.

[5] The NHS Confederation asked the Picker Institute Europe to survey the chairs and chief executives of all its member organisations. The survey was conducted between 26 April 2012 and 16 May 2012. It was sent to 625 chairs and chief executives in 362 organisations. There were 252 completed surveys—a response rate of 40 per cent—from 200 organisations.

4.3. Our members also continue to be concerned that the CQC is being expected to do more but with limited resources and when the efficacy of its current approach is being fundamentally questioned. For example, it is proposed that the CQC takes on responsibilities from specialist regulators the Human Fertilisation and Embryology Authority and, by April 2013, the National Information Governance Board for Health and Social Care. We encourage the Committee to scrutinise what plans the CQC has to assimilate these functions, the likely impact on its existing activities, and how it will retain and integrate the specialist expertise of these bodies.

4.4. Earlier this year, we welcomed the Department of Health's capability review of the CQC which set out a number of realistic steps that need to be taken to improve the regulator. The Department's recommendations also avoid an unnecessary overhaul of the regulator which would cause further upheaval at a time when the NHS needs to focus on the transition to the new system and tackling its financial challenges.

4.5. It is still too early to conclude whether the initial changes made to the CQC in response to the Department's capability review and other criticisms have made a positive impact. However, there are signs that the CQC is taking on board criticisms and beginning to make some improvements which we set out below.

4.6. The CQC is working on a revised strategy which we understand is due to be published for consultation soon. This is expected to help clarify the CQC's role and its expected outcomes from regulation and measures of success. We encourage members of the Committee to take the opportunity to thoroughly scrutinise the proposals in the CQC's consultation. We are pleased that the CQC is closely involving the NHS and other stakeholders in revising its strategy. As part of early discussions they are focusing more clearly on how they can best measure their own effectiveness, and they are proposing to consider allocating their resources according to the level of risk of different services and settings.

*Registration*

4.7. Our members have previously expressed concern that the registration processes are too generic, cumbersome, bureaucratic, poorly administered, and subject to significant delays. As the Health Select Committee already dealt with the issue of registration last year, Committee members should refer to our previous submission on the CQC for further detail about our members' criticisms of the registration process.[6]

4.8. We are encouraged that the recent registration process for dental providers went more smoothly after the CQC listened to their feedback. We also broadly support the recent changes to the regulations for CQC registration, particularly those that have sought to simplify and reduce the burden of regulation on providers. For example, the regulations alter the level at which mental health providers must notify the CQC of unauthorised absences for people who are liable to be detained under the Mental Health Act 1983. This change removes the duplication of reporting to both the CQC and the mental health minimum data set.

4.9. However, we encourage the Committee to probe how the forthcoming registration of primary care medical practices will work. There is a real risk of duplication and burdening GPs with unnecessary bureaucracy if the CQC fails to take sufficient account of existing arrangements that are already well-developed in primary care, including practice accreditation. The CQC should also draw on any lessons from the registration of primary care dental practices to ensure that registration adds value.

4.10. The CQC will need to give patients the confidence that all GP providers have been properly assessed. CQC registration will be important for consistency but we must not overstate what it will achieve. We need to look closely at how the NHS Commissioning Board manages contracts for primary care and make sure the GMC regulates GPs as effectively as possible and that all these elements are aligned. As more care is moved into community settings, the responsibilities and activities of GPs will increase. For example, a number of GP surgeries carry out minor surgery and a broader range of diagnostic tests than just blood tests. It is important that the registration and inspection process for GP practices also reflect this.

*Independence*

4.11. The CQC continues to lack sufficient statutory independence from government. This has led, for example, to restrictions from Whitehall on its recruitment of staff, harming its inspection process. Insufficient independence makes it difficult for the regulator to be an objective advocate of quality and safety, particularly at a time of significant public expenditure constraints.

4.12. The regulator has also lacked a strong independent voice from its leadership. It is legitimate for the Secretary of State to suggest the regulator changes its work programme where strong concerns about the quality or safety of a service are not being addressed. However, the CQC's leadership must be prepared to question that decision where it is asked to divert resources away from other priorities, or where it needs further resources to complete tasks. It must be prepared to highlight where national policy is having a detrimental impact on the quality of front-line care.

4.13. We are pleased to note that the CQC's strategy is expected to address when and how they act on the Department of Health's behalf, and to set out how the CQC will be more transparent in what they are working

[6] Our submission to last year's inquiry can be found online here: http://www.nhsconfed.org/Documents/HSC%20regulation.%20FINAL%20June%202011%20with%20logo.pdf

on, where they are focusing resource, and what they have found in their inspections. Alongside stronger leadership from the CQC, the Government's actions will be key to maintaining an appropriate level of independence. We understand the National Quality Board is looking at the roles of national bodies in the reformed health and social care system, and we look forward to further clarity from the Department about its future relationship with the CQC.

*Bureaucracy and the costs of regulation*

4.14. The costs of operating the CQC and associated administration in providers to monitor and demonstrate compliance are significant. Preparing for registration and on-going compliance are immensely bureaucratic processes demanding significant resources. Our members continue to question whether this provides value for money, particularly its impact on quality and safety standards.

4.15. All providers, including the NHS, pay annual fees to cover CQC's costs of operating registration. Despite initial promises that registration would be cost-neutral to the NHS, NHS organisations continue to pay significant fees. In some cases these are six figure payments. These can be difficult to fund in the current financial climate and in some cases they divert funding from frontline services. At this stage we also do not know whether Monitor in its new role as sector regulator will be charging license fees which could add further costs.

4.16. The NHS Confederation believes the CQC should be more transparent in setting its fees, particularly explaining how these relate to the costs of regulating different sectors, and the CQC fee structure should include incentives for providers to improve their quality.

*The CQC's market report*

4.17. We welcome the decision by the CQC to publish market reports which will set out the results of their inspection work on a quarterly basis. The NHS Confederation was pleased to be involved in the design of these and they should provide reassurance to the public. As the reports are published over the coming years they will help the health service to identify and act on emerging trends in compliance and quality. The NHS Confederation has urged NHS and independent sector organisations to look closely at these reports to identify what they should be doing to improve standards and ensure compliance.

4.18. At the end of June 2012, the CQC published its first market report. It is disappointing that a large number of organisations did not meet one or more of the CQC's essential standards. It was reported in some media outlets that one in four hospital providers were operating below essential standards. However, it is important to note that this was based on inspections of a low percentage of providers over a two-year period. As the decisions to inspect organisations were partly risk based the report may not have been reflective of the percentage of *all* healthcare organisations meeting essential standards. Though the number of organisations deemed to be falling short so seriously that the most drastic action was required was small, the NHS must not be complacent. The NHS is striving to comply with these standards and the CQC's report provides useful pointers as to where organisations commonly fall short.

4.19. In future reports, further value would be added if the CQC distinguishes the performance in different sectors. For example, it is misleading to directly compare a foundation trust hospital which treats a large number of patients through A&E with an independent sector prov*ider* that has no A&E service. The regulator should instead disclose whether some sectors are generally performing worse or better than others and provide more intra-sector analysis. The CQC should also take care to communicate clearly the extent to which the sample of organisations on which the market report is based is representative of health care as a whole, and the extent to which improvements may have been made since inspections were carried out.

## 5. Healthwatch England

5.1. Our members are very concerned about the readiness of Healthwatch England. At the time of writing neither the Chair nor the Board of Healthwatch England have been appointed even though the organisation formally starts its new role in October.

5.2. Throughout the Parliamentary passage of the Health and Social Care Act 2012 we argued that Healthwatch England needs to be independent and autonomous from its host body the CQC. It is vital that this independence is both perceived and real so that it can act as an effective champion for the public and users of health and social care services. It needs to be able to:

- set its own agenda;
- speak out publicly (including against the CQC);
- have a clear mechanism for making a complaint against the CQC;
- have a dedicated and sufficient budget; and
- and have a dedicated support team to work in the interests of the organisation.

5.3. Whilst we were pleased that the Act requires the CQC to respond to advice from Healthwatch England and the Secretary of State to consult Healthwatch on the NHS Commissioning Board's mandate, we remain

concerned that Healthwatch will not be sufficiently independent. We were therefore disappointed that recent regulations[7] require the Healthwatch England Chair to consult the Chair of the CQC on the appointment of the first members of Healthwatch England.

5.4. We encourage Committee members to scrutinise how the CQC will work with Healthwatch England ahead of the latter's establishment in October and to establish how Healthwatch England can secure an independent voice within the CQC. It would also be helpful if the Committee scrutinised how the new mechanisms for engaging with patients and the public will work in the new system as Healthwatch England's success depends to a large extent on the system around it. Given the importance of the role for patients, we encourage the Liaison Committee to include the Chair of Healthwatch England in its recommended list of pre-appointment hearings by Select Committees. In the meantime, the Health Select Committee should consider scrutinising the Chair of Healthwatch England at the earliest opportunity to satisfy itself that she or he will act independently of the CQC and be a powerful voice for patients. The Chair has yet to be appointed at the time of writing.

*July 2012*

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**Written evidence from the Care Quality Commission (CQC 12)**

1. This memorandum has been prepared for the Health Select Committee in advance of the Annual Accountability Hearing for the Care Quality Commission. This submission covers the following points:

Strategic Review:

— The environment in which CQC works.
— How we have developed our new strategy.
— Our purpose.
— Some of the issues that CQC's strategy will address.
— Doing more with less.

Response to External Scrutiny

— Develop a new strategy.
— Strengthen and improve the effectiveness and consistency of our regulatory model.
— Strengthen the governance of CQC.
— Develop CQC into a high performing and learning organisation.

Strategic Review

2. This section describes the work in progress to update CQC's strategy for the next five years.

3. *The environment in which CQC works*

3.1 It is three and a half years since CQC came into existence as England's first regulator of health care and adult social care. As we enter the next phase of our development, we do so amid much external change.

3.2 We see four major changes that present challenges and opportunities:

— Reduced economic growth and reduced public spending, which will put health and adult social care commissioners and providers under ever-increasing pressure to provide high quality services to increasing numbers of people within constrained resources.
— A changed and wider health and social care system, with a newly devolved and autonomous NHS and changing adult social care landscape.
— Increasing numbers of older people with increasingly complex needs and rising expectations of service standards.
— Technology that offers innovations and opportunities in the ways that care is provided.

3.3 These changes mean that we have had to look at what we do, what others do and how we operate, and make some hard choices. One result of this ongoing process is that we are preparing to launch a consultation on a new strategy in September that will clarify our purpose, role and priorities for the coming five years.

4. *How we have developed our new strategy*

4.1 We have listened to and learned from what has been said by the Health Select Committee, the National Audit Office, the Public Accounts Committee and the Department of Health's Capability Review, and in the Francis Inquiry.

[7] The Care Quality Commission (Healthwatch England Committee) Regulations 2012

4.2 We have also listened to our stakeholders, staff, representatives of organisations who provide care and other supervisory and regulatory bodies, we carried out an extensive engagement programme and a rigorous process of internal analysis, discussion and decision-making.

4.3 In preparing our strategy we have held 41 events with more than 700 people, including events focused on our role in mental health, as well as more general events and meetings with 40 senior leaders in the field of health, social care and regulation.

4.4 In parallel with our external engagement, we carried out a comprehensive analysis of the wider political, economic and social environment, looking at trends and future changes in health and adult social care and the provider market. We also looked at our own capabilities to identify our strengths and our areas that need improvement, and took time to look at external best practice in regulation.

4.5 Building on this engagement, analysis and feedback, we have clarified our purpose, role and priorities for the coming five years.

5. *Our Purpose*

5.1 Our purpose is to drive improvements in the quality of care[8] We will do this by:

- Regulating and monitoring services.
- Drawing on our intelligence and unique insight to provide an authoritative voice on the state of care.
- Working with strategic partners across the system.

6. *Some of the issues CQC's strategy will address*

6.1 We are in the process of finalising the consultation paper of our new strategy. At this stage we can share with the committee some of the high level major strategic shifts that the final consultation document is likely to address.

6.2 We will drive improvement through:

- Using intelligence and evidence to achieve the greatest impact.
- Strengthening how we work with strategic partners.
- Building better relationships with the public and maximising the power of Healthwatch.
- Building our relationships with organisations that provide care.
- Delivering our unique responsibilities on mental health and mental capacity.
- Continuing our drive to become a high performing organisation.

Using intelligence and evidence to achieve the greatest impact

6.3 We will use evidence to drive improvement in the quality of health and social care services. We will continue to regulate all health and adult social care services that provide regulated activities. In addition, we will move towards a model of differentiated, evidence-based regulation based on in-depth and wide-ranging evaluation of our regulatory activities.

6.4 To achieve this, we will analyse intelligence and evidence to deploy resource where the risk to safety and quality of services is the greatest.

6.5 Any move away from a standard schedule of inspections would be based on a body of evidence from the continued evaluation of our activity that considers the impact on quality of services.

6.6 In addition, we will highlight what works well to motivate providers to improve quality of care and we aim to develop methods to assess cultures and behaviours in organisations.

Strengthening how we work with strategic partners

6.7 CQC will remain independent in its ability to decide when and how we regulate and in the regulatory judgements we make.

6.8 However, in the context of a changing system, we will work to develop interdependent relationships with strategic partners, including Monitor, the NHS Commissioning Board, the NHS Trust Development Authority, professional regulators, health and wellbeing boards, and Healthwatch England and local Healthwatch to:

- Achieve the common purpose of safety and quality of services in the interests of the public.
- Challenge each other's performance and collectively leverage each other's powers to improve the safety and quality of services.
- Ensure intelligence is pooled and shared consistently, to identify emerging issues.
- Be clear about our respective roles.

[8] Our definition of quality of care is based on the definition used by Lord Darzi in High Quality Care for All and the social care white paper which includes safety, effectiveness and experience.

— Coordinate our activities.

Building stronger relationships with the public

6.9 We will build stronger relationships with the public. We will:

— Make the most of the opportunity of Healthwatch England and local Healthwatch offer, and support their development to make sure people's views, experiences and concerns about local health and social care services are heard.

— Do more to raise awareness and understanding among the public of our work, so that people know where to find us when they most need us through focused channels of communications.

— Ensure that people are informed about the standards of care they should expect, encouraging them to feel empowered to demand better standards of care and who to tell when standards aren't being met.

— Ensure public views, experiences and concerns more systematically inform who, when and what we inspect. We will improve feedback to the public so that they will understand how their concerns have been taken into account.

— Increasingly involve the public in CQC's work, to make sure their experiences are at the centre of the inspection of providers, including extending the use of Experts by Experience.

— Continue to protect the human and equality rights of the public throughout our regulatory work.

Building our relationships with organisations that provide care

6.10 We will further build respect and credibility with providers, and will be "good to do business with" through:

— Being consistent in our application of the regulations.

— Building confidence in the expertise of our inspectors.

— Constantly tackling unnecessary regulatory burden and supporting innovations that improve the quality of provider services.

— Providing insight on what works well across the sector.

— Continuing to deliver a professional registration service that swiftly and effectively controls access to the sector when providers meet the required standards of care.

Delivering our unique responsibilities on mental health and mental capacity

6.11 CQC has a variety of responsibilities which relate to the protection and promotion of the rights of people who are detained under the Mental Health Act, or subject to the Mental Capacity Act Deprivation of Liberty Safeguards (DOLs). These are to:

— protect the rights of people in health and social care;

— provide leadership across the sector to deter abuses of the powers given by the state, and to support responsible and ethical use of those powers; and

— identify and highlight good practice to support the improvement of services.

6.12 Both functions are vital for the protection of the human rights of people in the health and social care system and the CQC wishes to focus on how this can be done as effectively as possible. We intend to comprehensively review the way in which we provide these functions. We will do this in partnership with key stakeholders, not least those who use services and those who speak on their behalf.

Continuing our drive to become a high performing organisation

6.13 We will build on the foundation laid in the last three years and become a higher performing and learning organisation. We will do this by:

— Developing and supporting our staff.

— Becoming more responsive and adaptable.

— Being collegiate.

— Measuring our own success and learning lessons.

— Encouraging feedback, to help us improve.

7. *Doing more with less*

7.1 The environment in which we will operate over the next few years will be challenging. We do not expect the extra demands placed on CQC by the economic situation, policy, and social changes to be met through significant extra resources. We have tough choices to make on what we will do and what we will not do. We will have to work in smarter and more intelligent ways, making the most of how we work with our new partners in the system, and we will need to drive improvements in our own levels of efficiency, effectiveness and economy.

8. We believe that these draft proposals provide CQC with a strong future direction to drive the next stage of its development, to become a body that people increasingly look towards to drive improvement in the health and adult social care sectors.

9. *Response to external scrutiny*

9.1 We published an action plan[9] in April 2012 to address key findings from the reviews, audits and inquiries, and have targeted four key areas for action. These are to:

- Develop a new strategy for CQC.
- Strengthen and improve effectiveness and consistency of the regulatory model.
- Strengthen the governance of CQC.
- Develop CQC into a high performing and learning organisation.

Develop a new strategy

9.2 As set out in section 4, we have developed a new strategy for CQC; the consultation will be launched in September.

Strengthen and improve the effectiveness and consistency of the regulatory model

9.3 In 2011–12, we met our agreed targets for carrying out inspections. As part of these inspections we carried out 16,910 visits to services. Of the inspections, 2,589 were in response to risk. We have used the findings of these inspections to inform the publication of our quarterly market reports, the first of which was published earlier this year. In April this year we launched a simplified regulatory model. To improve effectiveness and consistency of the model we have done the following:

- *Expert advisers*: We use a pool of around 100 expert advisors to ensure our inspection staff have access to up-to-date specialist knowledge as and when they need it. We will continue to review the expertise available as demands change. In addition to providing advice to inspectors on an ad-hoc basis, our expert advisors continue to accompany inspectors on our themed inspections.
- *Experts by Experience*: We have extended our use of our 300 Experts by Experience—these are people who use services and carers who are trained to take part in inspections. We have used them extensively in our themed inspections, most notably in our recent inspections of learning disability services.
- *Continuous improvement*: We launched an ongoing evaluation programme, working with an external expert advisory group, to evaluate our regulatory model and measure its impact and effectiveness. This programme will embed a culture of review and evaluation to ensure continuous improvement of the model. It includes the appointment of an academic group to carry out an external evaluation of CQC and its overall effectiveness in the wider context, and to help us to define further measures of our effectiveness. This work is due to complete in December 2012.
- *Whistleblowing*: We have strengthened how we respond to whistleblowers. We set up a dedicated whistleblowing team of six in June 2011. They have handled more than 5,000 contacts since then, following them through to resolution. We carry out regular audits of whistleblowing calls and use information from the audits to adjust and reinforce our work. We have recently agreed a set of joint principles on whistleblowing with the BMA, RCN, NMC and GMC.
- *Performance*: We have listened to and acted on feedback from providers and other stakeholders, which has resulted in new performance indicators being developed and published on our website, with regular updates on how we are doing. New indicators include the length of time taken between an inspection and the publication of a report, and the amount of time taken to issue a warning notice after an inspection.
- *Providers*: In March this year we carried out a survey of providers on their experience, understanding and confidence in CQC's compliance process. 86% reported a good understanding of our model; 72% believed the approach to be beneficial to the quality of care received by people; and 85% believed that the inspector's understanding of their care type was good or very good. This survey will be repeated every six months, with the next survey taking place in September 2012.

Strengthen the relationship with the Department of Health

9.4 We have a renewed working arrangement with the Department of Health to encourage a more strategic relationship. Our framework agreement is being developed to reinforce CQC's independence and underpin greater transparency with DH.

Strengthen CQC's internal governance

9.5 A new unitary board structure will be effective from this autumn. We have recruited additional non-executive directors to vacant posts on the Board. Our revised operating model has also been developed to

[9] http://www.cqc.org.uk/public/about-us/corporate-strategy-reports/performance-and-capability-review-action-we-are-taking

include clear demarcation of the roles of the Chair, and the Chair of Healthwatch England, emphasis on the collective responsibilities of the board, and clarity on the roles of the non-executive and executive members. We have strengthened our internal governance to support the new strategic direction outlined in section 4.

Online registration of primary medical services

9.6 Since opening the first stage of registration at the beginning of July, more than 6,000 (more than half of) primary medical services have completed the process. This will enable them to submit their completed application forms from September. In preparing to launch this process, we undertook user testing and consulted the sector on the best approach to take. Specifically we have:

- *Consultation*: Consulted an advisory group of sector specialists to help shape how regulation of primary medical services will take place in practice. This group includes representation from the BMA, RCGP and other groups representing GPs' interests. It has now been meeting for two years.
- *User testing*: Used a virtual reference group to comment on tools and guidance, take part in user testing of the registration form, and feedback more generally on the overall registration and compliance processes.
- *Engagement*: Talked to more than 1,600 GPs and practice managers about the registration process through a series of dedicated roadshows.
- *Test pilots*: Carried out pilots of both our registration and compliance monitoring methodology to ensure they are fit for the sector, with refinements to existing methodology made as appropriate.
- *Online system*: Created an easy-to-use online application system, which takes 90 minutes to complete and submit. It is intended that this online process will be used for all new applications for registration in future.

10. In conclusion, our purpose is now clear and described as to drive improvements in the quality of care. We will do this by:

- Regulating and monitoring services.
- Drawing on our intelligence and unique insight to provide an authoritative voice on the state of care.
- Working with strategic partners across the system.

*July 2012*

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**Supplementary written evidence from the Care Quality Commission (CQC 12A)**

This additional memorandum has been prepared for the Health Select Committee (HSC) Members and provides a short response to a number of the matters raised in the written evidence submitted by Ms Kay Sheldon. Many of the material items raised in Ms Sheldon's evidence are the subject of legal proceedings and will be addressed via that process and therefore, a detailed commentary on these matters is not included.

As Chair of CQC I have focussed on improving the experience of people who use services and driving improvements at CQC. The values and principles that have underpinned my work for the last 40 years have been the foundation of my work at CQC. The statements made by Ms Kay Sheldon call that into question.

This memorandum is intended to support the key issues that were discussed at the hearing and is a reflection on:

- CQC's early days;
- The Board's role in driving improvement and embracing the criticisms and challenges identified by internal and external scrutiny;
- The need for further improvements in the performance of CQC although much has been achieved in the last 12 months; and
- "The next phase our consultation on our strategy for 2013 to 2016" sets out the way forward and will lead to future change.

The CQC faced a huge task from its inception as the new unified regulator of health and social care merging the work of three predecessor commissions and developing a new regulatory system under new legislation, whilst maintaining performance under the previous legislation and all with a significantly reduced budget. The extent of this challenge was recognised by the National Audit Office report: *The Care Quality Commission: Regulating the quality and safety of health and adult social care*.

As explained to the Committee at the hearing, initial expectations (as to timescales and resources) were unrealistic, the necessary processes and systems were not fully in place and there was also significant resistance to change from the predecessor organisations all of which compounded the level and complexity of the challenges that CQC faced.

The Board and the Executive were fully aware of the scale of the task that CQC had to address and the time this would take to achieve. Nevertheless they were committed to facing these significant operational and strategic challenges. The Board was clear that there was a lot to do and priorities needed to be established. In

line with CQC's Corporate Governance Framework, the Board challenged the Executive to provide consistent high quality data, whilst acknowledging that the Executive needed stability and support to deliver the necessary changes. In conclusion the Board's approach was designed to be supportive, positive and solutions—orientated in the way in which it held the Executive to account.

During 2010 and 2011 the Board was very focussed on the need to improve CQC's performance. There were critical events, for instance Winterbourne View and the terrible abuse of people there, which impacted on the whole organisation. As the Chair, I publicly apologised and an internal review was undertaken. It was an open and honest appraisal of the failures and made recommendations for change and those recommendations have been acted upon.

Arising from the challenges that CQC faced I encouraged Commissioners to participate fully in Board discussions and provide their perspectives to ensure robust debate, which Ms Sheldon and other Board members did. Also, on many occasions throughout 2011/12 I wrote to Commissioners seeking their views on various strategic matters. Ms Sheldon, along with her colleagues provided in-put, which was then considered as part of the on-going collective discussions which were taking place.

It was undoubtedly frustrating for everyone that matters were taking time to resolve but that was hardly surprising given the nature and scale of the issues being addressed and was exacerbated by the fact that there were constraints on recruitment. The Board was rightly a place where such frustrations could be aired. However, at the same time it was recognised that there was a need for careful planning and the ability to build alliances that focused on solutions, in order to deliver the changes and development that was required.

The evidence submitted by Ms Sheldon sets out her understanding of events during 2011 and 2012. Her interpretation and views are notably different to that of all other members of the CQC Board. The turning point was the meeting in late September 2011, after which Ms Sheldon believed her voice was not being heard and that she was being excluded. This was not the case and Ms Sheldon continued to participate in CQC business including contributing at Board meetings.

During the last 12 months there has been significant change and progress in the way in which CQC discharges its responsibilities. The information provided to the Committee provides further details.

This included:

- The establishment of a dedicated team to deal with matters of concern raised by the public and employees of health and care services;
- Strengthening of the Governance and Risk Framework;
- 16,900 inspections carried out during 2011/12 and follow up where necessary to ensure improvement or take action against poor performance;
- A processing centre now functioning effectively eg; registering services within 8 weeks and, answering 95% of calls within 30 seconds;
- Effective training of inspectors; and
- Preparation for registration or primary care services on target.

The progress made under my stewardship outlined above has been significant but the most important question is has the regulator made a difference to the lives of people who use services. To date the evidence is anecdotal, for instance many Chair's have taken the time to tell me that the Dignity and Nutrition inspections ensured that they and their Board's paid additional attention to these matters. The evaluation processes now underway will provide information that will inform future regulatory activity and provide some analysis of the impact of CQC's work.

CQC and I are not complacent about the work that still has to be undertaken. *The next phase: Our consultation on our strategy for 2013 to 2016* sets out a clear direction and priorities for action. The results of the consultation will help shape the future. In addition, external reviews are being undertaken into CQC's actions relating to University Hospitals of Morecambe Bay NHS Foundation Trust and Barking, Havering and Redbridge University Hospitals NHS Trusts. These reviews will address specific matters relating to regulation of those Trusts but will also draw out more general lessons that will help guide and shape the way in which regulation is developed. This will be supplemented by work being undertaken by Professor Kieran Walshe.

The reviews will be published and the findings used to strengthen the work of CQC and importantly the impact we have on public safety and the quality of care across health and social care.

Finally, the results of the 2012 CQC staff survey highlight the need for further cultural change within CQC including the need to raise staff morale. The planned response includes improved communication, greater visibility of leaders and continued investment in staff training and development.

To conclude, this short note is submitted in order to bring balance to the, differences of perception and understandings which have been a significant distraction and are not in the public interest.

It is time for CQC to move on. The differences of opinion relate largely to events in the latter part of 2011. There is a real determination to make further progress and this includes facilitated mediation. The public are entitled to expect an effective fully functioning Board dedicated to ensuring their safety and a focus on the

quality of services. This is a common goal shared by the Board and the Executive and nothing further must deflect CQC from that task.

*Dame Jo Williams DBE*
Chair, Care Quality Commission

*October 2012*

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**Further written evidence from the Care Quality Commission (CQC 12B)**

This memorandum sets out additional evidence for the Health Select Committee following CQC's Annual Accountability Hearing on 11 September 2012.

## Evaluation

Professor Kieran Walshe, leading academic expert on regulation, has been commissioned to work with CQC to help develop our strategic framework for evaluation. Between September and December 2012, Professor Walshe will be using a variety of research methods to consider which methods of regulation are effective and to identify where more work is required to develop an evidence base.

This work will cost £50k.

We have also begun a joint piece of work with Professor Julian Forder at the London School of Economics which aims to analyse and interpret the data and information we collect, to ensure we are using it to best effect and that we are using all of the relevant data and information which us available to us. This work will also aid reviews of the content of our reports, both in terms of content and presentations as part of our quality assurance processes. This work is due to commence in October, and is being funded by the National Institute for Health Research.

In addition to this, we are already undertaking a number of internal projects to evaluate key aspects of our regulatory approach, and are developing a more balanced suite of economy, efficiency, quality and effectiveness measures. We hope to commission further evaluative work in the future to enable us to continue to make better use of evidence to target our regulatory approach.

## Recruitment of Inspectors

The Department of Health agreed to give us an additional £10m in our overall budget from the beginning of the 2012–13 financial year. £3 million of this is ring fenced funding for Healthwatch England; the remaining £7 million is for additional costs for inspectors. The calculated cost of the 229 inspectors is around £12 million, the additional £5 million will be covered through efficiency savings elsewhere in the budget.

We planned to phase the recruitment and induction of the additional inspectors throughout 2012 with the aim of offering all posts by the end of September 2012. The position at 14 September 2012 was:

- 784 inspectors in post against an establishment of 955 posts, leaving 171 vacancies.
- Of these vacancies, 112 applicants have been successful and are due to commence employment later this year.
- The remaining 60 posts will be recruited into later this year.

We reported that we had 49 inspector vacancies at the session on 11 September. At the same time as recruiting Compliance Inspectors we have been recruiting to vacant Compliance Manager posts. Ten of our inspectors have been successful in gaining promotion to these posts, leaving their Compliance Inspector posts vacant. An additional inspector has resigned from their post, leaving the current position of 60 vacancies.

Our recruitment process has been rigorous and focused on ensuring that we recruit the right calibre of candidate. Because of this, some regions have been slower in recruiting inspectors than originally anticipated, which has contributed to the current underspend.

We are currently forecasting an underspend of £4.8 million on staff expenditure for 2012–13. Of this £2.8 million relates to Compliance Inspectors, and their phased recruitment and induction. We anticipate that we will have recruited the additional compliance inspectors by the end of this calendar year.

## Clinical Advisors and Experts by Experience

A bank of specialist advisors (clinical and professional) was launched on 2 July 2012 to support our inspection staff. Between the beginning of July and the end of August we carried out 2,469 inspections. Of these, 36 of our general inspections and 286 of our dignity and nutrition themed inspections used professional or clinical advisors. We have also used them to inform other aspects of our work, including developing information guides and sector specific development meetings, which help to support our inspectors to develop their knowledge about those sectors.

We are encouraging our inspectors to use specialist advice when appropriate. This may not always mean that they will accompany inspectors on inspections. Inspectors will make a decision about whether they need someone to provide advice, which may be advice by email or phone, or to accompany the inspector on an inspection. We monitor this process, and we will evaluate this input as part of our overall evaluation programme.

We have a pool of around 300 experts by experience. Experts by experience are people who either receive care or are carers or family members of people who receive care. They are able to accompany our inspectors on inspections to give a patient or service user perspective. In the last financial year they accompanied inspectors on more than 600 inspections. They took part in 73 planned inspections during July and August, and have taken part in 527 themed inspections between June and August this year.

### Sector Specific Expertise—Senior Management

CQC's new Chief Executive, David Behan, took up his post at the end of July this year. He is responsible for delivering the actions needed to address the recommendations of the Department of Health's Capacity and Capability review. With regard to the specific recommendation of sector-specific expertise at Board and Executive Team level, it was decided that it would be beneficial to wait until a new Chief Executive was in place to be able to review the Board and Executive Team more generally, especially as a unitary Board structure is to be introduced. Vacant posts on the Board have been advertised recently. The Secretary of State is responsible for the appointment of our Board members. David Behan is now in the process of considering how best to structure the organisation in the future, and will take this issue into account in his considerations.

### GP Registration—Site Visits

We have set up an internal team to manage the registration process for GPs. This team will carry out the assessment of all completed and submitted registration forms, and make a decision whether a site visit will be needed as part of the registration process.

Our Registration Assessors, a group of Operations staff who focus on registration activity on a daily basis, will carry out any site visits which are deemed to be necessary as part of the GP registration process. Because of this, our Compliance Inspectors will not be required to carry out any inspections or site visits as part of the GP registration process, and will only begin to inspect GP practices from 1 April 2013 when the practices will move into their portfolios.

*Our powers to investigate*

Our powers are set out in the Health and Social Care Act 2008. Section 48 outlines that we can carry out investigations; section 64 allows us to ask for any information we require from providers of regulated activities, and under section 65 we can ask for an explanation of that information. Where we do not have the necessary skills internally to carry out a specialist analysis we can engage an external expert to work with us.

In the particular case referred to by Andrew George, Serco, CQC had inspected the provider in response to concerns raised by whistleblowers about staffing levels and about the accuracy of performance information. We identified that there were problems with staffing levels, and we also identified that there were issues with the data which the provider submitted to Cornwall PCT as part of its performance data. It was alleged that this data had been altered before it was submitted to the PCT. We analysed a sample of this data and found that it had been altered. As the data related to performance targets set out in Serco's contract, we passed the relevant information to the PCT as the commissioner of the service. The PCT has since commissioned Dr David Colin-Thomé to carry out a review of Serco's services, as well as asking Serco to carry out an audit on its data processes, which will then be subject to an external validation.

In all, we found that Serco was non-compliant with four outcomes including Outcome 16 which is about quality assurance systems, and gave them 14 days to provide an action plan to address the issues identified. We will follow up with them to ensure they have taken appropriate action in the timescales outlined in their action plan.

*Fees*

We are launching the consultation on our fees structure for 2013–14 on 28 September. This document will outline the level of fees we are proposing for all provider organisations for the year. This is an annual fee to retain registration with CQC, and the income is used to contribute to the costs of regulating providers.

In this consultation we will set out our plans to phase out grant-in-aid contribution, as much as possible, by 2015–2016. It sets out the current levels of cost recovery which are 76% overall, broken down into 88% cost recovery in the NHS, 75% in independent healthcare, 67% in primary dental care and independent ambulances, and 93% in adult social care. Like all public bodies with fee-setting powers, CQC is required by government to set fees that cover our costs. Income from fees can only be used to cover the cost of regulating providers—currently £123 million per year.

In 2013–2014, this document proposes generating £100 million from fees and reducing the grant-in-aid contribution from 24% to 19% of CQC's overall costs. Our proposals are to achieve this without increasing fees in this year for NHS trusts, adult social care, and the majority of independent healthcare providers. The additional income will come from introducing fees for primary medical care, which we propose to set prudently at 50% of expected costs (as we have done in the past for other sectors new to regulation). The savings will come from CQC's efficiency and cost-effectiveness efforts.

The key messages in the consultation document on CQC's strategic approach to fees are:

— Increased, on-going engagement with providers to involve them in developing fees and making the rationale for fees transparent.

— Designing fees to reinforce CQC's approach to regulation and how it drives improvement in services—in particular, grouping fees by regulatory methods rather than unrelated categories, moving towards higher fees for providers who require extra inspections and therefore cost more, and using lower fees to help incentivise quality of care.

— Maximising efficiency in how CQC works, to contain and reduce costs.

— Improving customer care, for example through online payment and payment by instalments.

### Kay Sheldon—Mid Staffs Seminars

As part of the process for the Mid Staffs Inquiry, a series of seminars was held about specific issues identified during the course of the Inquiry. The majority of these were held in October 2011, with a couple in November 2011.

Generally, participation in the seminars was by direct invitation from the Inquiry Team. Core Participants were also allowed to send along a representative to participate at each seminar, and observers were allowed to register with the Inquiry on a first come first served basis.

Jill Finney wrote to all members of the Board, including Kay Sheldon, on 12 October 2011 with the timetable for the seminars, and outlining which were open for Board members to attend as participants and those which they would be able to attend as observers, subject to agreement with the Inquiry Team. Those where staff would be participating, and Board members were offered the opportunity to observe, were on regulation methods, information and patient experience. It was felt that staff would be best placed to participate in these seminars as they would be responsible for implementing changes as a result of the Inquiry and these seminars were the most directly relevant to CQC. The others, where Board members were invited to attend as participants, were development and training for trust leaders, organisational culture, nursing and commissioning.

Kay Sheldon replied on 13 October that she would like to attend the patient experience seminar as a participant. Jill Finney replied later that day outlining that a member of staff would be attending that seminar, although she would be welcome to attend as an observer. CQC's Head of Involvement, Diversity and Human Rights participated in the seminar on behalf of CQC.

### Delivering the Programme and Risk

We set out in our Business Plan for 2012–13 that we will inspect all NHS trusts and independent health and adult social care services once a year and all dental services once every two years.

*September 2012*

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## Written evidence from Kay Sheldon (CQC 15)

### Introduction

This document is provided for the Health Select Committee (HSC) accountability hearing of the Care Quality Commission (CQC) on 11 September 2012. This follows concern expressed by some HSC members about an article published in the Independent on 15 August 2012 which described some of the treatment I have been subjected to as a board member of CQC since I started to raise serious concerns about the organisation internally and then more widely including with the National Audit Office (NAO), the Department of Health (DH) and at the Mid Staffs Public Inquiry (PI).

I have been a CQC board member since 1 December 2008 having been invited to apply particularly on the strength of my achievements with the Mental Health Act Commission (MHAC) and Mind. I was a publicly appointed Mental Health Act Commissioner for 10 years and a member of the MHAC board for five years. My character reference for the position with CQC states "*Kay is a person of very high moral integrity whom I trust" and "I have every confidence in her ability to serve others and to hold Public Office—which in fact she has already done very successfully*".

I was appointed to the CQC board specifically for my expertise of using health and social care services and in mental health as well as my extensive experience of high level boards and committees. I have specific roles on the CQC board in relation to the Mental Health Act, Equality and Human Rights and user involvement. I

have experienced severe depression in the past. However, whilst the situation of the past year has understandably been very stressful, at no point have I been suffering from any form of depressive illness or psychotic symptomatology. Indeed I would argue that I have demonstrated a degree of strength and determination over the 14 months few could emulate.

Prior to raising serious concerns from last summer, I had received overwhelmingly positive feedback on my performance and commitment (which I can demonstrate) to the extent I was made an OBE in January 2011. My last appraisal states:

> "Kay is a highly committed and thoughtful commissioner who adds a great deal especially with respect to the impact of our work on individuals who use services. Kay challenges appropriately at Board Meetings, always careful to be constructive and respectful of the position of those that she challenges. She commands a great deal of respect from all members of the board (Commissioners and Executive) because of her intellectual rigour and non-confrontational approach. Kay's reflective approach means that she focuses on the strategic issues.
>
> Kay is generous with her time and is trusted by the workforce and so learns a great deal about what is happening on the ground".

I can clearly demonstrate how attitudes and behaviour towards me changed dramatically after I raised concerns more assertively which increased further after my appearance at the Public Inquiry. From last summer I have been subjected to a whole range of inappropriate behaviours and attitudes—my competence, integrity and health have all been brought into question. Additionally the fact that I have used mental health services in the past (which I am very open about and I have campaigned with Mind and others about stigma and discrimination) has also been used to undermine my credibility which I find particularly abhorrent. Initially this was expressed as "concern", followed by questions about my robustness and then on to the "impact" on the organisation, staff and even patients and the public. Thus, over time I have become the focus, and even deemed the cause, of the very problems I felt compelled to speak up about.

My personal data has provided compelling evidence of the nature and degree of the victimisation and discrimination I have been subjected to. There are obvious gaps in the information and I have requested all deleted data from this time given the worrying nature of the information that has been supplied. This has been refused by CQC and inaccurate reasons (I consulted the Information Commissioner's Office) were given for this. I have pointed this out and repeated the request. I am waiting to hear back from CQC.

My only motivation in raising these issues is with a view to establishing CQC as the strong and credible regulator that everyone wants. There is nothing for me to gain personally in doing so. As a publicly appointed board member it is my duty to ensure that the organisation conducts itself with probity and in the public interest. I have raised the issues (demonstrably) many times through the appropriate channels. I have been repeatedly (and demonstrably) stonewalled. In this context the only option left open to me is the media—hence the article in the Independent.

My experiences over the last year have brought me into contact with many whistle blowers. I have been stunned at the similarity and themes in these people's stories. They are stories I would have found difficult to believe if I'd not had similar experiences myself. They are truly shocking.

Below is a timeline and overview of key events. I am able to evidence the points I make. I am concerned that producing this document may lead to another "sham" review but given the seriousness of the issues at stake, this is a risk that I have to continue to take.

## Key Events

[N.B. I received some of my personal data from CQC on 28 July 2012 so some of the issues detailed below were not (fully) known to me until this point]

### *June—November 2011*

As I was so concerned about the lack of strategic direction, numerous lapses in governance, continuing under-performance and the culture (particularly reports of bullying and oppressive behaviour) of the organisation, I was clear that I had to raise these concerns more assertively and that it was my duty to do so as a publicly appointed board member. I also made a number of constructive suggestions on ways forward. Unfortunately as the functioning of the board was problematic I was not able to secure an adequate or appropriate response from the chair or the rest of the board. I decided that I needed to put my concerns in writing to make sure that the issues I was raising were clearly communicated and that there was a record of this. Bizarrely this was subsequently presented as evidence of inappropriate behaviour!

### *September/October 2011*

The NAO undertook a VFM review of CQC. I twice emailed Jill Finney (CQC deputy CEO) on 18 and 20 September 2011 for an appointment to meet the review team. She did not reply to either request.

*29 September 2011*

I left a board strategy board meeting slightly early as I was feeling unwell and also stressed by the situation. I had a viral infection (with a fever) and felt very hot with a headache. Members of staff were worried about me and this increased my distress as I dislike people worrying about me. When they insisted on calling a taxi to take me home to Norwich I agreed to this. I wrote to Jo Williams on 5.10.11 explaining the problems about the board and the organisation, why I had to raise these issues and why this was stressful. After my infection cleared I felt fine again (within a matter of days) and I emailed the board on 10.10.11 advising them I was fully recovered. My personal data contains a report of the events on 29 September which is exaggerated and distorted. The report has been re-written a number of times for different purposes.

*Early October 2011*

Jo Williams rang me up twice saying she wanted me to see CQC's in-house occupational health officer. I didn't think it was necessary but agreed nevertheless predominantly to provide reassurance for the organisation.

*12 October 2011*

I met with the occupational health officer just prior to going into the board meeting. She did not raise any concerns about my ability to undertake the role of board member which is confirmed in the report from this meeting. However Jo Williams continued to question my mental health continually referring back to the incident on 29 September. The more I said I was OK, the more she insisted I was ill. During this time neither my husband nor my GP expressed any concerns about my mental health. I continued in other roles with no problems whatsoever. A district judge (who I work with sitting on Tribunals) has offered to write a reference to support this and the fact that I am an "excellent" Tribunal member. I chaired a large conference on 15.11.11. I did not miss any work engagements due to ill-health and the only arena that my mental health was questioned was at senior level in CQC.

*10 October 2011*

I emailed Amyas Morse outlining my concerns about CQC stating that I may wish to raise these issues through the NAO's whistle blowing remit and advising him that I'd asked to speak to the review team. I met with Mr. Morse on *7 November 2011* who was sympathetic and acknowledged the concerns but did not feel they came into the whistle blowing remit of the NAO.

*13 October 2011*

I asked to attend the Mid Staffs Public Inquiry seminar on Patient Experience. I was advised by Jill Finney that I could only attend as an observer as a member of staff was already going as a participant. My personal data shows no member of staff was planning to attend and after my request Jill Finney ordered a member of staff to go saying it was "not optional" ie I was deliberately prevented from attending as an active participant.

*12 November 2011*

I emailed Lord Kamlesh Patel (former chair of MHAC) describing the degree of problems I was facing—that serious issues were not being acknowledged or addressed, and the discriminatory attitudes and behaviour I was facing. I knew he was already concerned about the culture of CQC as he had been approached about this by numerous internal and external sources.

*14 November 2011*

As I was so concerned about the leadership, governance and culture of CQC and the impact on our core business of regulation, I decided to contact the Mid Staffs Public Inquiry (PI) as the issues I was concerned about seemed relevant. It was hugely stressful to effectively "blow the whistle" about colleagues and regarding an organisation I am fully committed to but I was clear that "doing nothing", which included resigning, was no longer an option. Consequently I contacted them through the online enquiry form outlining the various issues and was subsequently invited to meet with the PI solicitors.

*17 November 2011*

I met with PI's solicitors for 5 hours producing my statement and was subsequently called to give oral evidence (the hearings were re-opened for this) alongside a CQC inspector who coincidently had also contacted the PI with serious concerns from an operational perspective. I would have been subpoenaed to attend if needed. I was open with the PI about my past mental health difficulties and the fact that this was being used to undermine what I was saying. No concerns were expressed about my credibility or my motivations by the PI team.

*28 November 2011*

I gave oral evidence to the PI. The other three board members at the time, Deirdre Kelly, John Harwood and Martin Marshall, publicly refuted my evidence through a message on the CQC website (which is still in situ). Jo Williams wrote to the Secretary of State on this day asking for my removal, immediate suspension and that I was replaced as soon as possible.

*November 2011*

Messages were sent to CQC staff from Cynthia Bower and from Jo Williams undermining the evidence that whistle blowers gave at the PI.

*7 December 2011*

I met with the DH who advised me that a review would be undertaken by Gill Rider to quickly establish the facts around what had happened prior to me approaching the PI. I was told the review would report "in 10 working days". I was asked not to attend board meetings until the review completed. I declined but attended with someone accompanying me as I knew a hostile environment was likely.

*19 December 2011*

I met with Gill Rider for less than an hour and subsequently sent some follow up information on 29.12.11. The interview with Rider mostly centred on the issue of bullying which I described in some detail and Rider indicated to me that she was looking to make some concrete recommendations around this issue and for me to be involved in this. This did not happen and I never heard from Rider again. Conversely Rider maintained contact with the chair and other board members until the report's eventual publication over three months later. Therefore I did not hear anything again about the Rider review until I received the report and letter from the Secretary of State on 30.3.12 saying he was considering removing me from the board.

*20 and 22 December 2011, 13 January, 29 February 2012*

I wrote to the Department of Health expressing my concern that I had not had sufficient opportunity to describe and demonstrate my concerns (including to the Capability Review and Gill Rider review) and how I sought to raise them ahead of approaching the Public Inquiry. *At no point have I been afforded this opportunity.*

*24 January 2012*

Jo Williams wrote to me stating my evidence at the Inquiry was "not formal whistle blowing but a self-created opportunity to criticise decisions with which you do not personally agree". This is completely untrue and she has not been able to identify which decisions I have not agreed with. Indeed one of the issues I was concerned about was that the board did not in fact make decisions as befits its role.

*December 2011—present*

I have been prevented from properly discharging my duties as a board member and from undertaking agreed or new special roles. Conversely all other board members have continued with or taken on specific roles. I attended board meetings between December 2011—March 2012 which was extremely difficult as a policy was adopted whereby many of my contributions were met with "I do not recognise that...[situation]" which effectively prevented me from undertaking my job in any meaningful way.

As an example at the board meeting in *January 2012* I raised the fact that there were still major problems with the integration of our Mental Health Act functions (which was widely known). The relevant director, Philip King, simply said "I do not recognise that situation". At the *February 2012* board meeting I had to refrain from contributing to the discussion on the MH Act functions as it could have had a negative impact on decision-making simply because of the likely disagreement with whatever I said simply because it was me saying it. Subsequently, on *7 March 2012* I wrote to the chair explaining why I could not take part in the discussion and describing in detail my concerns at the behaviour and attitudes I was experiencing from the board and executive team. These were not taken seriously.

*November 2011 onwards*

My personal data shows that an extensive file was kept on me after I started to raise serious concerns. This file, which is "held" by the CQC director of governance and legal services, Louise Guss, provides profoundly shocking details of the degree of victimisation I have been subjected to. Every internal comment that I have made or has been made about me is detailed in this file. Additionally, the media/press team at CQC has been instructed to put my name under surveillance for "priority monitoring". I am described as a risk to the organisation. The data shows that the chair raised significant questions about my health and integrity with the SoS and DH officials on a number of occasions. There is compelling evidence that there were ongoing concerted attempts to discredit and undermine me with a view to obtaining my removal from the board.

*18 January 2012*

I asked the Director of Operations, Amanda Sherlock, at the board meeting whether CQC would have picked up the issues at University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBFT) earlier if we had been fully functional as it seemed that that the problems had been around for a considerable length of time. The response, which perturbed me greatly, was that we had been fully functional and that it had been a robust piece of work by CQC.

*19 January 2012*

Even though I was attending board meetings it was impossible to do the job properly as the behaviour and attitudes towards me were so problematic. Obviously it was a very stressful time. I felt I had to take steps to address the situation so that I could undertake my duties and to get some support. Although I was worried about possible adverse consequences (which have subsequently been proven as well-founded) I asked for an assessment under the Equality Act 2010. I specifically requested that the appointment of an appropriate person was undertaken collaboratively. It was my intention to identify with someone with knowledge of disability issues and the Equality Act eg from the voluntary sector. Unfortunately Jo Williams immediately referred me to Medigold, a private occupational health company, without my knowledge or consent.

*30 January 2012*

When I learned that an appointment had been made I spoke to the executive chair of Medigold, Dr. Mike Goldsmith, on the telephone for around 10 minutes saying there had been some crossed wires and that I didn't need to see a doctor. We did not discuss any details about my health but he referred to the time in September when I left the board meeting early which worried me as someone had obviously discussed me with him. Dr. Goldsmith was very forceful but I politely declined. I did not think any more about this rather inappropriate conversation until I received my personal data:

> Following this conversation, and on the same day, Dr. Goldsmith wrote a three page letter to Jo Williams. It includes the following statements:
>
> > "My clinical view, based on a 20 minute telephone call, is that this lady is suffering from a mental health problem, which is likely to be one of the conditions that involve paranoia. The most common of which is paranoid schizophrenia and certainly some of the things that were said to me in a completely normal voice and without any emotion would fit with paranoid thinking" and "She may well be in denial, but I suspect she is actually suffering from significant paranoia at present". He also suggests that my past history is obtained "in confidence" and that "if necessary, obtained a psychiatric opinion on her". He said he would be happy to speak to the Chief Medical Officer about me. He also states "I think it is really important that she is assessed or else removed from her position, because I think there are some serious issues here that need to be dealt with and not swept under the carpet". [I can provide the entire letter if required]. There is also a separate email from Mike Goldsmith in my personal data in which he states he will be involved in my case "behind the scenes" which I find disturbing.

*February—April 2012*

A suitable person was identified through the voluntary organisation, Disability Rights (formerly RADAR) and an assessment under Equality Act took place. The resultant report, which was co-produced with me, identified some practical and straightforward measures to assist with my re-integration into the board and provide me with support particularly during the prevalent difficult circumstances. The recommendations included a PA, training for the board and facilitated sessions with the chair. The report was delivered to Jo Williams on 17.4.12 but the recommendations have yet to be agreed or implemented

*23 February 2012*

The DH Capability Review of CQC was published. The report confirmed a number of the issues I had raised internally and at the Public Inquiry. Cynthia Bower resigned on this day.

*19 March 2012*

I wrote to the CQC CEO and Director of Operations (with supporting evidence) outlining my concerns and asking some questions about how CQC responded at Morecambe Bay Hospitals as I had done some research and found some very concerning omissions and discrepancies. I did not receive a reply.

*22 March 2012*

I forwarded the communication about Morecambe Bay Hospitals to Una O'Brien and Richard Douglas at the DH. Una replied that it was a CQC "operational" issue. I responded saying I believed there could be issues of probity at stake. I did not receive a reply.

*March 2012*

Unison survey: as CQC refused to undertake a staff survey in 2011 and in response to concerns from their members at CQC, Unison conducted a staff survey of its members. The results, which were sent to board members by Unison, pointed to a demoralised, fearful and over worked staff group with reports of bullying and low confidence in senior managers. I wrote to the board reiterating my concerns about the culture of the organisation and the wellbeing of our staff. My personal data shows how the director of human resources dissuaded the chair from taking concerted action, including setting up an independent investigation (which I had requested), to identify and/or address the bullying and related cultural issues both after my appearance at the Public Inquiry and the publication of the Unison report.

*30 March 2012*

Public Accounts Committee report published which supported the issues I had raised about CQC including the fact that CQC has been "badly led and governed". This was subsequently accepted as accurate by the official Treasury Minute.

*30 March 2012*

I received a copy of the Gill Rider report and letter from Secretary of State (SoS) saying he was considering removing me from the board based on the recommendation of Gill Rider's report. The Rider report was partial, subjective and, it transpired, illegal. My decision to give whistle blowing evidence to the PI was described as the *cause* of the board's dysfunction and ineffectiveness whereas these were the *reasons* I approached the PI ie the messenger was being shot. Furthermore my attempts to raise the issues internally, including in writing, was described as inappropriate behaviour. Put bluntly the report was a deliberate hatchet job.

At this point I sought legal representation. My lawyers made it very clear that the proposed action to remove me from the board was illegal, unlawful and in direct conflict with national policy on whistle blowing in the NHS. They also wrote to Robert Francis (RF) and Margaret Hodge (MH). RF pointed out that it was a criminal act to cause, or to seek to cause, detriment to a witness of a Public Inquiry. MH wrote to the SoS confirming that the concerns I'd raised had been viewed by the PAC as "substantially true" and expressing concern at my current situation.

*24 July 2012*

A Compromise Agreement (CA) was signed. I had made it clear that I did not want any money (although I agreed to the DH paying my legal fees as I'm in receipt of Tax Credits) and my lawyers—successfully—requested the removal of a gagging clause. In the CA the SoS agreed not to remove me from the board and I agreed not to pursue legal action against the SoS, DH officials and Gill Rider in respective of: an application for judicial review; a claim under the Human Rights Act 1998; a Claim under the Equality Act (sex, race, disability, religion or belief discrimination or victimisation) or a claim under sections 47B, 48(1A) of the Employment Rights Act 1996 (protected disclosure). I also requested some form of mediation process to facilitate my re-integration on the CQC board which was agreed.

*25 July 2012*

The SoS wrote to Jo Williams stating that "I expect Kay Sheldon to continue to operate as a fully engaged and active member of the board".

*April/May 2012*

Following the letter from the SoS and the Rider report on 30.3.12 I did not feel able to attend board meetings. However I did request of Jo Williams a discussion with her about the emergent organisational strategy given the lack of this had been one of my major concerns about the organisation. However she did not arrange anything and therefore I have been excluded from this important piece of work which is very distressing to me as I am very keen to play an active part in the future of CQC.

*26 June 2012 (then re-issued on 12 July 2012)*

Monitor published an internal audit report it had commissioned on its responses to University Hospitals Morecambe Bay NHS Trust (UHMBT). The report contains some very serious questions about the performance and conduct of CQC. It is of note that the CQC board was not told of this report—I alerted them to it.

*July 2012 onwards*

I have seen clear evidence that CQC *was fully aware of the nature and extent of the problems as UHMBT* in 2010 and 2011 when the Trust was registered and subsequently reviewed by CQC and judged to be compliant with Essential Standards. This is both important and very concerning as CQC has publicly indicated that it would have acted differently had it known of the problems at the time. The blame was put on the Trust for failing to disclose a report it had commissioned on its maternity services (the Fielding Report) but it is clear

that CQC was aware that this review had been undertaken and was fully aware of the problems which were described in detail (which I have seen) by the CQC regional director at the time in December 2009.

Thus as late at December 2009, there is evidence of serious and systemic concerns at UHMBT. Yet the Trust is registered by CQC as fully compliant with Essential Standards on 1 April 2010—just three months later—which is reinforced in July 2010 following a CQC review of maternity services. The Trust was granted foundation trust status on 1 October 2010. A letter to Monitor from CQC dated 16.4.10 states: "I therefore confirm that the trust is registered without compliance conditions, we are not investigating UHMBT and no investigation by the CQC is planned". The letter refers to a "minor concern" around staffing.

It is of note that during this period, 2009–11, there was an increase in mortality rates and SUIs at UHMBT. A recent FOI request has shown that in the period 2009–12 the number of incidents/claims doubled: 40 (2009); 60 (2010) and 93 (2011). The number of civil claims against the maternity services between 2009–12 is, to date, 33 (with 15 of these in 2011).

I have also seen evidence of a conversation between Ann Abrahams, the Ombudsman, and Cynthia Bower that took place in September 2009 (described in a file note to Ann Abrahams from the deputy Ombudsman): "In your conversation with Cynthia Bower shortly before your leave, the suggestion arose that if we could assure Mr and Mrs T that as a result of their experiences CQC are now taking robust action to ensure improvements in the quality of maternity services in the Trust, you might decide not to investigate". The Ombudsman subsequently decided not to investigate on this basis.

It wasn't until late 2011/early 2012 when the extent of the problems re-surfaced that CQC suddenly decided to launch an investigation.

The issues relating to Morecambe Bay have gone beyond capability. There are serious questions about probity to be answered. There has been a steadfast refusal by both CQC and the DH to answer questions. However it is crucial that this happens as we are talking about serious human suffering, including life and death situations. This is important for those affected but also for the future in ensuring the "whole system" is fit for purpose in preventing further horrific scandals.

One of the reasons I decided to approach the PI was my concern at the proposed change to CQC's regulatory approach. It was clear that the development work behind the proposals was superficial and weak. The proposals were developed quickly, reactively and without adequate consideration of the impacts and effectiveness (I sought further information to this effect). Additionally the consultation for the changes was wholly inadequate not least because the proposals were already being implemented.

I also looked at the Barking Havering and Redbridge case and found a worryingly similar scenario. This Trust was registered with 8 conditions. Within a few months 7 of these were lifted. Later, when the extent of the problems re-surfaced, CQC launched an investigation. However in the interim the Trust had worryingly high mortality and Serious Untoward Incident rates. There are other examples such as United Lincolnshire, Hull and East Yorkshire and Basildon and Thurrock hospital trusts.

I recall conversations in 2009–10 about "nervousness" that there may be another Mid Staffs lurking around and that this had to be avoided at all costs. However the emphasis was on minimising concerns rather than seeking to identify and tackle them. I had a sense that this was, at least in part, directed by the DH but I am clear that decisions taken by the CQC executive during this period (2010–11) were not informed by patient safety and the quality of care.

People should be able to trust the regulator to act in the public interest. CQC has been too influenced by political drivers and the need to salvage reputations rather than the quality and safety of health and social care services. This continues to the present day with a media and communication strategy aimed at communicating "messages" of tough action ahead of (potentially) events including the HSC and the Mid Staffs Public Inquiry report. The board and the executive team of the organisation have indulged in and sustained conduct over a lengthy period of time that is not commensurate with that expected of senior office holders and officers of a national public body. This conduct entails both omissions and deliberate actions, and as such, must raise serious questions about the trust the public can reasonably have in these individuals.

*November 2011—present day*

Throughout I have sought to raise these serious issues reasonably and appropriately through the appropriate channels. I have been repeatedly stonewalled by both CQC and the DH. I have written to Jo Williams and the DH on several occasions about how I am being treated (which perhaps could be seen as akin to a grievance) but to no avail. In fact the DH has studiously avoided communicating with me in any meaningful way and has not provided any response of substance to the issues I have raised, either about CQC or concerning my treatment. There have been numerous and ongoing attempts to "shoot the messenger", not least in the recently published CQC Annual Report which states that the effectiveness of the board has been compromised by a board member giving evidence at the Public Inquiry. Of course the reason I approached the PI was because the board was ineffective…

## The Future

Whilst there are some very serious issues outlined above, it is also important to think of the future. I am in no doubt that patients and the public need CQC to protect and promote their interests through ensuring the quality and safety of health and social care services. It is clear that stakeholders also believe this and there is a strong desire for CQC to be successful. The organisation has been badly led and governed which is beyond dispute. I believe that with strong and appropriate leadership CQC can become an effective high-performing organisation. There are many skilled and committed people working for CQC. It is also the case that many skilled and committed individuals have left and it has been difficult to attract people with the level of expertise that the predecessor organisations enjoyed. The new CEO, David Behan, is well respected and his appointment has been widely welcomed internally and externally. I have pledged my support to David. I believe he has the capability and credibility to take the organisation forward in a robust and sustainable way. I very much hope to support him in this.

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